**Title**

Medicating Vulnerability through State Psychiatry: An Ethnography of Client Manipulation in Involuntary Outpatient Commitment

**Author**

Dougherty, Ryan John

**Publication Date**

2021

UNIVERSITY OF CALIFORNIA

Los Angeles

# Medicating Vulnerability through State Psychiatry:

## An Ethnography of Client Manipulation in Involuntary Outpatient Commitment

A dissertation submitted in partial satisfaction of the
Requirements for the degree of Doctor of Philosophy
in Social Welfare

by

Ryan John Dougherty

2021

# ABSTRACT OF THE DISSERTATION

# Medicating Vulnerability through State Psychiatry:
An Ethnography of Client Manipulation in Involuntary Outpatient Commitment

by

Ryan John Dougherty

Doctor of Philosophy in Social Welfare

University of California, Los Angeles, 2021

Professor David Cohen, Chair

In mental health policy, a central ethical dilemma concerns involuntary outpatient commitment (OPC), which aims to treat vulnerable individuals with serious mental illness who decline services. The first concern regards whether coercive services undermine the quality of clinical interactions within treatment, particularly as it relates to psychiatric medication use. The second concern is the unexamined role that OPC, and coercive psychiatric programs more broadly, plays in the broader landscape of social welfare policy. To examine these concerns, the purpose of this dissertation is to analyze how the management of psychiatric medications in involuntary outpatient services is undergirded by (a) provider and client interpretations of psychiatric medications effects and (b) moral discourses related to coercion and client autonomy. To achieve this aim, I examined data from a team-based ethnography that consisted of 1000 hours of participant-observations and 56 semi-structured interviews with 20 clients, 21 providers, and 12 client family members with diverse backgrounds. I analyzed how medication compliance was discussed, monitored, and enforced in an involuntary outpatient program. My analysis demonstrates that medications were interpreted as a technology to control clinical symptoms (*clinical control*) though, particularly among clients, were also viewed as a method to control client mental experiences, behavioral expression, and autonomy (*social control*). Providers believed that medications were a necessary component of services (*compulsory compliance*) and could reduce client vulnerability to violence victimization and perpetration related to clinical symptoms (*medicating vulnerability*). To address client noncompliance, providers employed several strategies that I categorized as *client manipulation.* These strategies included providers, family members, and court officials strategizing ways to undermine client autonomy without clients' knowledge (*concealed collusion*), deceiving clients into believing that medications were mandated when they were not (*performing coercion*), and minimizing the role of client consent and preferences in decision-making processes (*circumventing consent*). These findings demonstrate the pervasive role of manipulation to gain client medication compliance in OPC, which I named *institutional coercion*. They also highlight that the broader moral justifications for manipulating clients relate to their status as structurally vulnerable in their community settings and a growing relationship between the erosion of the welfare state and psychiatric coercion.

The dissertation of Ryan John Dougherty is approved.

Laura Abrams

Philippe Bourgois

Joel Braslow

David Cohen, Committee Chair

University of California, Los Angeles

2021

This dissertation is dedicated to Jasmine, and to all individuals who have been committed by state psychiatry, through time, and whose stories were never told.

# TABLE OF CONTENTS

# ACKNOWLEDGEMENTS

I would like to thank my advisor, David Cohen, for his continuous guidance through my graduate studies. I was blessed to have an advisor who, throughout my program provided unconditional support and challenged me to confront issues of psychiatric power with courage. I am thankful for the support of Laura Abrams, who saw my potential in my first year and supported me as I took my first leap into social theory. I would also like to thank Philippe Bourgois and Joel Braslow, both of whom invited me to join the Center for Social Medicine and Humanities. Philippe inspired my passion for ethnographic research and always challenged me to dig deeper in the field. Joel's expertise in psychiatry, and his commitment to revealing the large political economy that has shaped community mental health services today, has been central to engaging with the complex AOT data. I would like to thank the entire Center and the members of the AOT evaluation team, including Erin Kelly, Marcia Meldrum, Ron Caldron, Charlotte Neary-Bremer, Sarah Starks, Enrico Castillo, Laurie Kein Hart, Ann Nguyen, Blake Erickson, and Rachel Ohman. I would also like to thank MarySue Heilemann who trained me in qualitative interviewing. I must also thank the participants of my project, especially the clients and family members who opened up their worlds to me.

Last, but not least, I would like to thank my parents Edward and Kathleen Dougherty who supported throughout my education and instilled my deep commitment to ethics. Similarly, I would like to thank my siblings Sean and Kaitlyn Dougherty, and Colleen Triezenberg, for their love and support. I am also indebted to my closest friends for their love and intellectually challenging throughout my journey, particularly Sarah Wizinsky, as well as Kevin Goodman, Zarina Kraal, and Omar Allen. And of course, I must thank my companion, Sheba, for the comfort she provided me throughout my writing.

**Ryan John Dougherty**
Curriculum Vitae

## EDUCATION

| | |
|---|---|
| 2017 | M.S.W., University of California, Los Angeles |
| 2014 | B.S., Biopsychology, Cognition, and Neuroscience, University of Michigan, Ann Arbor |

## PUBLICATIONS

### Peer-Reviewed Journal Articles

Pahwa, R., Smith, M. E., Kelly, E., Dougherty, R. J., Davis, L., Thorning, H., Brekke, J. & Hamilton, A. (2021). Definitions of community for individuals with serious mental illnesses: Implications for community integration and recovery. *Administration and Policy in Mental Health and Mental Health Services Research, 48*, 143-154. doi: 10.1007/s10488-020-01055-w

Pahwa, R., Dougherty, R.J., Kelly, R., Davis, L., & Brekke, J. (2020). Is it safe?: community integration for individuals with serious mental illness. *Research on Social Work Practice,* 1-13. doi: 10.1177/1049731520951628

Dougherty, R. J. (2019) The psychological management of the poor: prescribing psychoactive drugs in the age of neoliberalism. *Journal of Social Issues*, *75*(1), 217-237. doi: 10.1111/josi.12313

Kraal, A. Z., Arvanitis, N. Moll, A., Ward, K., Dougherty, R., Ellingrod, V., Grove, T., & Burghardt, K. (2019). Metabolic syndrome is negatively associated with cognition among endothelial nitric oxide synthase (eNOS)-786C carriers in schizophrenia-spectrum disorders. *Journal of Psychiatric Research, 117*, 142-147. doi: 10.1016/j.jpsychires.2019.07.006

Grove, T. B., Burghardt, K.J., Kraal, A. Z., Dougherty, R. J., Taylor, S. F., & Ellingrod, V. L. (2016) Oxytocin receptor (OXTR) methylation and cognition in psychotic disorders. *Molecular Neuropsychiatry, 2*(3), 151-160. doi: 10.1159/000448173

Holloway, I.W., Dougherty, R., Gilder, J., Beougher, S., Pulsipher, C., Montoya, J. A., Plant A., & Leibowitz, A. (2017) PrEP uptake, adherence, and discontinuation among California YMSM using geosocial networking applications. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 74*(1), 15-20. doi: 10.1097/QAI.0000000000001164

### Conference Proceedings

Dougherty, R. J., Kraal, A. Z., Grove, T., & Ellingrod, V. (2015) *Sexual Dimorphism of the Catechol-O-Methyltransferase gene and Social Functioning in Schizophrenia*. Poster presented at the 15th International Congress on Schizophrenia Research, Colorado Springs, CO. Abstract published in March 2015, *Schizophrenia Bulletin, 41*(1)*,* S201.

Kraal, Z., Dougherty, R. J., Grove, T. B., & Ellingrod, V. L. (2015) *Gender and Antipsychotic Differences in Metabolic Functioning in Schizophrenia.* Poster presented at the 15th International Congress on Schizophrenia Research, Colorado Springs, CO. Abstract published in March 2015, *Schizophrenia Bulletin, 41*(1), S128-129.

Rottenstein, A. & Dougherty, R. J. (2012) *Development and Facilitation of an On-Campus Disability Awareness Campaign.* Poster presented at The Society for Community Research and Action 2011 Conference, Chicago, IL. Poster and abstract published in Feb 10, 2012 *Global Journal of Community Psychology Practice, 2*(3).

## CONFERENCE ACTIVITY

### Symposium Organized

Kelly, E., Dougherty, R., Meldrum, M., Starks, S., Castillo, E., Neary-Bremer, C., Calderon, R., Ohman, R., Bourgois, P. & Braslow, J. (2018) *Assisted Outpatient Treatment in Los Angeles County: Implications for Involuntary Outpatient Services Nationally.* Symposium presented at the 24th NIMH Mental Health Services Research Conference, Rockville, Maryland.

### Peer-Reviewed Paper Presentations

Pahwa, R., Smith, M. E., Kelly, E., Dougherty, R., Thorning, H., Brekke, J., & Hamilton, A. (2021) *Structural, Functional and Experiential (SFE) Model of Community for Individuals with Serious Mental Illnesses: Implications for Community Integration and Recovery.* Paper accepted for the 25rd Annual Conference of the Society for Social Work and Research, virtual.

Dougherty, R., Bourgois, P., Meldrum, M. & Braslow, J. (2019) *A Hard Pill to Swallow: An Exploration of Social Relationships and Antipsychotic Drugs in Involuntary Outpatient Commitment.* Paper presented at the 23rd Annual Conference of the Society for Social Work and Research, San Francisco, CA.

Dougherty, R., Pahwa, R., Kelly, E., Davis, L. & Brekke, J. (2018) *The Rationality of Reliance on Services: Rethinking Community Integration and Therapeutic Termination in Mental Health Services.* Paper presented at the 24th NIMH Mental Health Services Research Conference, Rockville, Maryland.

Dougherty, R., Kelly, R., Meldrum, M., Starks, S., Castillo, E., Neary-Bremer, C., Calderon, R., Ohman, R., Bourgois, P. & Braslow, J. (2018) *Violence and Victimization for Participants, Family Members, and Providers in Assisted Outpatient Treatment*. Paper presented in symposium at 24th NIMH Mental Health Services Research Conference, Rockville, Maryland.

# CHAPTER 1

# A BRIEF INTRODUCTION TO GOVERNING MADNESS

Every society manages madness. Throughout time and across societies, management has taken on many forms. At times, the management of mad people is left to the private lives of families. In these societies, if abandoned, mad people may be left to roam streets unattended to by any formal system. Conversely, management may mean their total institutionalization. Behind locked doors, patients may be subjected to constant surveillance, to torture or an outright neglect of their basic needs. In some instances, mad people are incorporated into their communities, taken in by strangers and cared for. The ways societies manage madness stem from the collective beliefs on the nature of normalcy, madness, and government. These beliefs in themselves are continuously in flux, bound by time and place (Scull, 2015). For example, madness may be viewed as a moral failure that, consequently, requires religious purification or even ostracization. At other times or places, madness is a hereditary illness to be exterminated from the gene pool for the betterment of a nation's strength. At still other times or places, madness is a result of the lack of opportunities or oppression directed at subordinated individuals or groups. More frequently, madness is viewed as an undefined combination of all of the above.

None of these understandings reflect an objective reality of what madness truly "is." Similarly, none of these modes of management reflect how madness *must* be dealt with. Instead, these approaches are rooted in social constructions (Berger & Luckman, 1967): assumptions shared across people that shape our individual and collective behaviors towards groups of people. Examining social constructions are not just a question of abstract philosophy: they have serious and concrete implications for the lives of mad people. Systems of beliefs bore destructive, though socially approved, modes of management.

To interrogate these constructions in a given time and place, I pose three questions to serve as a heuristic: (1) how should citizens behave? (2) what is the nature of madness? and (3) how is madness to be governed? I will start by evaluating the first question: how should citizens behave? Madness sits in contrast to culturally bound concepts of "normalcy"; a social construction of how citizens should appear and function both in private and public life (Conrad & Schneider, 2010). Without an understanding of who people *should* be like, we cannot have the concept of its inverse: madness. The concept of "normalcy" can be both located in implicit beliefs or explicitly defined in social institutions. Should citizens be pious and private, industrious and dedicated to producing capital, or bound to their homes as primary caretakers? Within societies, these expectations and their enforcement may vary by a host of intersecting social identities of age, race, gender, sex, sexuality, or (dis)ability.

The second question expands beyond the first. It is not just about identifying madness but explaining its existence. This answer may entail an "etiological" explanation: what is the origin of madness? Is madness a "thing" located in material world? If so, what causal (mechanistic) chain of events leads to its development — and what in this chain needs to be prevented or "fixed" in the individual? Or is madness to be located in the person's environment or culture? Such explanations, as I explore later, are imbedded in the dominant understandings of human behavior. Today, state services for managing madness rely primarily on medical explanations (Szasz, 1961), though also rely on mix of legal, moral, and social meanings as well. Throughout time, humans have looked to family systems and parenting, illicit drugs and substances, and even the spirits and gods (Scull, 2015). As I explore later, prominent scholars in anti- and critical psychiatry and madness studies have demonstrated the limitations of such medical explanations.

The meanings of normalcy and madness provide us with an incomplete picture of the logic of managing madness. I will also consider how human behavior in societies is governed and how these forms of governance are rationalized (Foucault, 2009). Broadly, governance entails how behavior is monitored, shaped, or intervened upon and for what ends. Forms of governance may be explicit exercises of rule and power. We might finally ask our third question: *how* is madness to be governed? Through what specific means and mechanisms? To what degree should citizens monitor or modify their own behaviors? If external agents like states and their representatives are to intervene upon madness, how is it morally justified? And for what purpose? Do citizens have basic rights to *not* be intervened upon due to their madness? And what becomes of people who refuse to become incorporated in these subjective and bureaucratic systems of governing? To answer these questions, we might look to formalized state institutions. For example, the criminal justice system incarcerates mad people and may morally justify its actions as a means to protect communities from perceived dangerousness. Further, we might look to state-contracted institutions, such as medicine, and its historic role in detaining mad people in hospitals and delivering chemical interventions onto mad people.

Together, these questions begin to approach the problematic of managing madness and can be more simply stated as: “targeted at *whom*, by *what means,* and for *what ends*?” On the surface, this framework risks oversimplification. An analysis to reveal the undergirding logics to managing madness may not always be obvious. For example, some theorists, inspired by the works of Foucault, have argued that citizens in Western democracies largely think of themselves as independent actors from the state and, without their explicit awareness, engage in self-governance in ways that align with the state’s interest (Dardot & Laval, 2014). Thus, not all forms of governing involve explicit actions from a state institution onto individuals. As another example, in the modern United States, individual freedoms are a core democratic value, yet about 40% of people diagnosed with a serious mental illness have been incarcerated in their lifetime ( Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Thus, broader political belief systems do not always intuitively align with the reality of governance. Indeed, a precursory examination of governing madness hints at the central role of coercion in governance. This was a concern of early Western political theorists who discussed liberal forms of governance. For some of these theorists, such as Hobbes or Locke, individual rights and liberties are paramount in society. Yet, these philosophers also believed that coercion may play a necessary role in maintaining basic social order, such as protecting private property or protecting the public from the unruly or dangerous course of nature (Anderson, 2011). As previously mentioned, the primary institutions that manage madness today, including the psychiatric and criminal justice systems, rely on coercion to impose behavioral order. Indeed, scholars have explored psychiatric interventions as an issue and exercise of coercive power (Kirk, Gomory, & Cohen, 2013). In this sense, many have theorized that medicine, specifically psychiatry, is a major institution of governance to impose social control (Szasz, 2007) and modify deviant behavior "in the name of health" (Conrad & Schneider, 2010, p. 259).

To understand the current design and logic of mental health services, and consider the role of coercion in services today, we may look historically at the rise and fall of mental institutions through the end of the twentieth centuries, where the forms and justifications for coercive intervention drastically changed. In the wake of deinstitutionalization, where tens of thousands of former patients were emptied into communities, community mental health centers were established which aimed to integrate individuals into their local communities (Mechanic, McAlpine, & Rochefort, 2014). More recently, the recovery paradigm, which posits that people can and should make full recoveries from their mental illness, pervaded services, and can also be understood as form of social governance: individuals are expected to live in their communities and live independent from continued state intervention (Braslow, 2013). In the sociology of medicine, the management of populations to maximize their individual health and decrease their dependency on the state is recognized as a form of neoliberalism (Foucault, 2009; Miller & Rose, 2008). Coercion, in this landscape, can take the form of short-term inpatient hospitalizations (for when individuals are at-risk of harming self or others) or in assertive and/or mandated community treatment programs. How should we understand the ways neoliberalism shapes the properties, logic, or limits of how psychiatric coercion is applied? In the wake of deinstitutionalization, how do values of liberty and control function in real-world settings and processes? Or the contradictions of how these values intersect with others? While complicated, analyzing the logics behind how we manage madness reveals fundamental, and at times concealed, principles in governing the general welfare of citizens.

One approach to understand how modes of management are morally understood and justified is through the philosophy of ethics. For the purposes of this dissertation, I focus on two aspects of ethics. First as it relates to the philosophical branch of normative ethics to inform medical decision-making: bioethics (Beauchamp & Childress, 2009). Normative ethical principles are used to evaluate the ethical permissibility of actions (i.e., to determine whether an action is or is not considered "ethical"). In this sense, philosophers try to seek normative principles that can be viewed as universal and exist "outside of history and practice" (Brodwin, 2008, p. 143).

While normative principles may inform our theoretical understanding of what is permissible, *descriptive ethics* allows us to understand how moral understandings of situations are produced and applied in their everyday actions. In examining the project of managing madness, this refers to the frontline workers of psychiatric services – social workers, case managers, and peer advocates – who regularly interface with mad people to deliver state-sanctioned interventions such as psychotherapy, welfare, or psychiatric drugs. Their work is guided by *moral discourse*, which refers to local understandings of what is and is not permissible and is produced through the daily experiences of working on the ground with their clients. As the name implies, moral discourse emerges from and is incorporated into how providers assess situations, weigh their own values, and proceed with decisions. We may understand these two forms of ethics (normative principles and local moral understandings) as coproduced in the field of medicine (Brodwin, 2008). Higher order and normative principles in policy inform practice and, in turn, these principles are informed by daily decisions in the field. Thus, examining modes of management – and working towards an understanding of what would be the most ethical mode of providing for the welfare of mad people – entails understanding both higher-order ethical principles and moral reasoning on the ground.

For social workers, investigating the governing logic of mental health services can aid in our project of protecting the welfare and rights of people with serious mental illness, who historically are exceptionally vulnerable to interpersonal, community, and state violence and abuse. Our ethical commitments, outlined by the National Association of Social Workers (2008), compel us to understand the ethical implications of the work we carry out and to safeguard the rights of individuals. As social workers play a central role in the development and implementation of mental health services, our discipline has a duty to critically investigate the purpose of these services in relation to the project of governance and consider the implications of the daily work we carry out.

## The Union of the State and Psychiatry

Today in the United States, madness is managed through multiple and intersecting state institutions including criminal justice, state psychiatry, and social welfare systems. In these institutions, there exists a broad array of meanings related to madness and moral discourse of its management. One of the primary meanings is described as *the medical model* in psychiatry: the notion that madness is rooted in biophysiological illness in the brain and requires a medical intervention. The language used to describe and understand madness reflects this model. Today, madness is described as a mental illness. In prisons, psychiatric services (community-based and hospitals), and welfare services, people are given diagnostic labels and codes from the *Diagnostic and Statistical Manual of Mental Disorders* for clinical and billing purposes (Mechanic et al., 2014). A primary intervention, psychiatric drugs, are understood in the medical model as well: they are medicines believed to cure or treat underlying pathologies of the brain (Moncrieff & Cohen, 2005).

My primary interest is related to the management of people who are labelled with a *serious* mental illness. Serious mental illness (SMI) is used to describe a subpopulation of people with mental illness who experience profound disability due to symptoms. One of the primary institutions is state psychiatry, which refers to enjoined legal, medical, and social welfare institutions that employ psychiatry to manage serious mental illness today. While the term is ambiguous, I intend the term to encompass both private and public institutions that carry out policy initiatives related to serious mental illness including community mental health centers, private state-contracted service agencies, and hospitals. Notably, not all psychiatry is enjoined with the state, such as private mental health practitioners, however state psychiatry is particularly interesting for several reasons. Primarily, as institutional ethnographies reveal, state psychiatry has wielded extraordinary power over the lives of individuals across time and place (Burstow, 2015). Psychiatry relies on the state for funding and authoritative legitimacy. It is endowed with its own powers, a so-called biocracy “complete with incarceral capacities and police powers” to institutionalize people and surveil communities (p. 71). Similarly, as previously explored, the state is invested in projects of managing populations. For example, it may be invested in protecting its population from foreign and domestic terrorism, establishing a sound market-economy, or ensuring order and law-abiding behavior. At times, the state may rely on psychiatry to achieve these ends. Thus, what emerges is a union between the state and psychiatry, both invested in modifying the behaviors of citizens.

State psychiatry can manage madness through restraining individual liberties. This may include court-ordered inpatient and outpatient services or psychiatric drugs. One of the central debates for bioethicists, psychiatric, and social welfare scholars is to define what constitutes an impermissible violation of individual liberties. Coercion can be used to describe the nature of a social institution as well as a type of interpersonal interaction whereby providers use force or threats to change client behavior to align with providers’ preferences (Nozick, 1969). Policies that permit coercion (or coercive policies) can include forced hospitalizations or involuntary outpatient treatment (OPC), typically grouped under the rubric of “civil commitment.” Hospitalizations are intended to address acute crises, including suicidality, while OPC is intended to provide longer-term intensive services for people experiencing grave disability. Within both voluntary and involuntary outpatient treatment programs, providers report using a broad array of strategies – including persuasion or incentives – to change client behavior (Lovell, 1996). How do we understand the relationship between these strategies to one another, the moral discourse of how and why they are used, and evaluate their ethical permissibility?

In an attempt to understand broader ethical issues related to governance, medicine, and serious mental illness, my primary focus for this dissertation project is OPC. OPC combines the mandate of hospitalizations with the community-based model of assertive community treatment through leveraging and/or employing court-mandates to compel full participation to treatment plans. OPC is a major source of ethical controversy. The first set of issues deal with its efficacy in achieving social policy and clinical goals. While OPC involves a court-mandate, major evaluations of the programs do not clearly indicate how the addition of a court-mandate influences the delivery of services and its direct influence on client outcomes (Ridgely, Borum, & Petrila, 2001). This is because OPC can involve various components, including assertive community treatment, intensive case management, and even psychoeducation for the families of clients.

The second set of issues relates to the ethical implications of the impact of coercion on clients. First, court orders are linked to perceptions of being coerced (Pridham et al., 2016). Perceived coercion is associated with decreased perceptions of the quality of services and therapeutic relationship to providers among clients (McNiel, Gormley, & Binder, 2013). Fears related to perceived coercion, or even regularly influential techniques to gain compliance, may also serve as a barrier to treatment (Swartz, Wagner, Swanson, Hiday, & Burns, 2002). A second major critique comes from Gomory (1998) who, in evaluating ACT, has argued that no long-term evidence indicates clients continue with treatment plans once disenrolled from coercive programs. Rather, adherence may be a result of clients avoiding consequences or harm that is leveraged in coercive interactions; once coercion is removed, the “treatment effect” desists. Thus, coercion may be failing the policy aim to establish long-term compliance. Third, OPC is targeted at people with frequent experiences of homelessness and incarceration. Swanson et al.

(2009) suggest that these populations are likely to live in impoverished communities of color. To this end, OPC may be unfairly targeting people of color to partake in coercive services, who may otherwise benefit from properly funded voluntary services. Fourth, OPC involves the delivery of psychiatric drugs. The use of these drugs within coercive settings raise serious ethical questions in and of themselves (Barnes & Badre, 2016).

### Drugs as a Mainstay Intervention

Psychiatric drugs (also known as prescribed psychotropic drugs or psychiatric medications) are a category of chemicals delivered by various medical and helping professionals to address mental suffering and disability. Psychiatric drugs are particularly informative sites for understanding psychiatric state power. First, psychiatric drugs can be considered to be a social phenomenon (Cohen, McCubbin, Collin, & Pérodeau, 2001). Their use today represents the ideological emphasis on biological mechanisms that are argued to underpin mental illness (Moncrieff & Cohen, 2005). Insofar that psychiatric drugs directly intervene upon the subjective experiences and behaviors of its users, their use and interpreted effects may reveal the larger project of the state to manage, modify, or suppress madness. Further, their delivery does not only involve constructs of medicine. Their use is also intimately wrapped up in issues of governing poverty. For example, in welfare clinics, being prescribed psychiatric drugs can indicate illness and disability, which can qualify people for entitlements (Hansen, Bourgois, & Drucker, 2014).

Psychiatric drugs play a central role in community mental health services. Multiple ethnographic works have demonstrated how their use enjoins treatment teams and that drug compliance is a primary goal of services (Brodwin, 2013; Estroff, 1985; Floersch, 2002). The project of interpreting drug effects and ensuring compliance involves every member of a treatment team (Longhofer, Floersch, & Jenkins, 2003). In the daily work of frontline services, providers and clients interpret how drug effects are impacting the client's subjective experiences and behaviors, and the implications this may have on their quality of life, housing, employment, and social relationships in the community. For example, ethnographies of services have reported that providers may adjust medications based on single reports of dysfunction, such as uncleanliness. At times, signs of dysfunction or disruptive behaviors are also interpreted to relate to noncompliance; in response, providers may try new influential techniques to gain compliance. In the context of psychiatric drugs, compliance is defined as behaving in accordance to prescribed treatment plan without fail, including consuming a pill daily or attending clinic visits for injections. Ethnographic work has demonstrated that compliance to psychiatric drugs is viewed by providers as a necessary step to create self-sufficient clients that will no longer rely on welfare services. Thus, the use of psychiatric drugs in psychiatric services is, in part, a larger project to create citizens independent from welfare institutions (Floersch, 2002).

Despite their centrality in services, psychiatric drugs are also a contested issue of ethics due to research on their efficacy and effects on users. There is limited evidence on the efficacy of psychiatric drugs to treat serious mental illness in real world settings (Kirk et al., 2013). For example, studies have conclusively spelled out serious adverse effects for users of antipsychotics, which are associated with medication discontinuation (Lieberman et al., 2005). Moreover, psychiatric drug effects are profoundly complicated. While providers and client may rely on medical explanations of psychiatric drugs to understand their effects, at times these explanations fall short. Treatment teams and their clients frequently navigate the ambiguity between the actual and expected effects of drugs (Longhofer et al., 2003). These highlight the importance to address the ethics of prescribing psychiatric drugs in settings like OPC, which uses coercion to compel drug consumption among a highly vulnerable population. Barnes and Badre

(2016) set out to ask this exact question in *Psychiatric Services*: how can one justify enforcing an intervention that may not be appropriate or safe? Questions like these have led some scholars to believe that psychiatric drug use should be a shared decision made between providers and clients (Drake & Deegan, 2009), yet is this concept – and other calls for client empowerment in services – meaningful in frontline work? In response to Barnes and Badre's critique of antipsychotic drugs in OPC, Sharfstein, Lieberman, & Talbott (2016) state that psychiatric drugs cannot, by definition, be mandated in OPC programs. Yet, their observation raises a whole new set of questions: *are* drugs mandated in OPC? How should we understand *coercion?* Is coercion only passed through court-orders, or does it encompass other forms of influence, such as using incentives or persuading clients? Even if not, are these other influential techniques worth ethical investigation? Barring the possibility of forced medication injections, how much influence do clients have in decision-making over their medications? What about the use of more subtle techniques of control on the behalf of providers, such as compliance in return for precious resources like housing?

These questions are reflected in the persistent moral ambiguities related to psychiatric drugs in outpatient services. Providers rely on non-coercive and influential techniques to achieve drug compliance with their clients (e.g., offering incentives for drug compliance; Lovell, 1996). In doing so, providers encounter ethical dilemmas that stem from their desires to address the dire life circumstances of clients while also respecting their autonomy. Brodwin (2013) termed this *everyday ethics* of frontline work. Moral reasoning for providers is further complicated in having to deliver and monitor psychiatric drugs. While providers and clients navigate the complicated and adverse effects of drugs, providers are exposed to the dire living situations of clients who are vulnerable to poverty, violence, incarceration, and homelessness. While providers may wish to help clients, providers also come to question the safety and efficacy of drugs as well as their right to interfere with the personal autonomy of their clients (Brodwin, 2011)

While providers encounter these ethically ambiguities in care, there is little support to navigating these difficult ethical questions (Brodwin, 2011). On a broader level, this may be connected to the fact that little research in mental health services provides conceptual clarity on coercion used in care (Hem, Gjerberg, Husum, & Pedersen, 2018). Further, little research has investigated the various influential techniques in care, which may each bear different ethical significance and considerations (Blumenthal-Barby & Burroughs, 2012). Connecting these ethical examinations of treatment techniques to psychiatric drug use, especially in the context of an OPC program, may guide researchers and practitioners in developing more ethical forms of care in mental health services.

## Statement of Purpose and Research Questions

The purpose of this dissertation is to analyze how the management of psychiatric medications in involuntary outpatient services is undergirded by (a) provider and client interpretations of psychiatric medications effects and (b) moral discourses related to coercion and client autonomy. In doing so, I aim to explore the ethical implications of medicalized and coercive approaches to social services for vulnerable populations labeled with a serious mental illness. Further, I aim to explore how the practices of psychiatric medication use demonstrate the broader role of involuntary outpatient commitment in social welfare governance.

My dissertation explores the following question: *how do providers and their clients incorporate their understandings and interpretations of drug effects into their moral reasoning in decision-making as it relates to coercive or influential techniques with their clients?* This entails two separate sets of questions. The first set of questions are: *How do OPC providers and* *their clients interpret drug effects? How are client subjective experiences and behaviors interpreted in relation to drug effects and compliance?* The second set of questions are: *What techniques do OPC providers use to deliver drugs to, and monitor and enforce drug consumption by clients? How do providers respond to clients' compliance? How do providers respond to clients' non-compliance? How are client preferences incorporated into decision-making?*

## Research Approach

To answer these questions, my research setting is an involuntary outpatient treatment program in Los Angeles County, California. I ethnographically examine how coercion and psychiatric drugs are understood and negotiated within the working relationships between providers (outreach workers, case managers, therapists, psychiatrists), legal officials (public defenders, judges), and the adult clients mandated to participate in the treatment program. Specifically, my ethnographic data consists of participant-observations of treatment spaces (field-based services, board and care facilities) and courtrooms where some clients are mandated to partake in OPC. These data document how psychiatric drugs are discussed, delivered, and monitored by these various actors in treatment. Further, I conducted semi-structured interviews with providers and clients to explore the meanings they assign to coercion and psychiatric drugs.

## Implications for Social Work Practice and Theory

My research contributes to the social work practice and theory in two ways. First, I intend to contribute to the literature on OPC and psychiatric drugs. One review of OPC programs conducted by RAND concluded that the role civil commitments have in measured outcomes is unclear and, further, whether they have any policy advantage compared to typical assertive community services (Ridgely et al., 2001). This points to the question of exactly how civil commitments function in the actual day-to-day work of staff and clients in OPC. However, by documenting the real-time processes of service delivery through ethnographic methods, I demonstrate when, how, and why court-orders are evoked by providers to gain compliance. Further, I also analyze other non-coercive and influential techniques used in intensive community-based services to gain compliance. This contributes to the broader discussion on the union of medical and judicial powers in intervening in the lives of people (Dallaire, McCubbin, Morin, & Cohen, 2000).

Second, I intend to contribute to our understandings of ethics and psychiatric drugs. The discussion of psychiatric drugs is particularly important for social work. Some social work scholars have called for critical thinking on the topic of psychiatric drugs, particularly as our professions and roles as case managers, therapists, policymakers, educators and researchers are entangled in medical and legal systems which promote the use of psychiatric drug consumption (Cohen, 2009; Hughes, Narendorf, & Lacasse, 2017). As Rose (2009) demonstrates, by centering the experiences of staff and clients, I hope to challenge current coercive approaches and provide new visions of services grounded in both evidence and ethics. In developing a framework, I hope to expand our understanding of the different types of ethical considerations that scholars, policymakers, and providers ought to consider in evaluating the permissibility of the different forms of delivering drugs and ensuring compliance in mental health services.

### On Language and Terminology

The use of language in studies on madness, mental health and illness, and in psychiatric services studies, is greatly contested and there are inherent limitations to the terms I have chosen. So far, I have used the term *madness* to describe extreme psychological experiences and behavioral variations which often produce personal and social distress and disability. As I noted previously, what is identified as *madness* varies across time and place, and only encompasses specific forms of deviant behaviors. I have selected this term, as opposed to *serious mental illness*, as an analytical linguistic tool to demonstrate the ways in which certain mental experiences and behavior have become, and are continually, understood as a type of medical illness.

I have used the term “psychiatric drugs” as opposed to “prescribed psychotropic drugs” or “psychiatric medications.” I selected “psychiatric” to emphasize their relationship to psychiatry and selected “drugs” because I am seeking to examine how certain substances are constructed as a type of medicine. Similarly, OPC has received a wide variety of terms, including assisted outpatient treatment (AOT) and alternative treatment orders (ATO). I have selected “involuntary outpatient commitment” because it highlights the core tenants of the program: it is outpatient, involuntary, and involves a civil commitment. However, I switch to the colloquial terms that I observed in my ethnography when analyzing and discussing my field notes. This includes continued use of term “client,” as well as “serious mental illness,” “psychiatric medications,” “meds,” and “Assisted Outpatient Treatment.” Importantly, I do not leave these terms unexamined. Their use and implied meanings were incorporated into my analysis on meaning-making, madness, and medicine.

# CHAPTER 2

# LITERATURE REVIEW

The purpose of this literature review is two-fold. First, I introduce my readers to the literature on psychiatric drug effects and community-based services. My intention is not to conduct an exhaustive review, but instead, to orient my readers to the major scientific findings and critical discourses related to these topic areas. Second, I introduce my two conceptual frameworks that will guide my study: *the coproduction of moral discourse* and *psychiatric drug effects as a social construction.* Together, I demonstrate the need for research on the use of psychiatric drugs in coercive psychiatric programs such as OPC.

To accomplish this, I divided my literature review into three sections. In part one, I introduce my first conceptual framework: *the coproduction of moral discourse.* To do so, I first introduce key concepts related to ethics and coercion in community services. This includes introducing principles of bioethics (*beneficence, respect for autonomy, non-maleficence, and justice*) and moral dilemmas. Next, I discuss coercion. This includes presenting its various definitions and frameworks and a brief history on its use in psychiatric services. Lastly, I introduce prominent theorists who have critiqued state psychiatry and coercion.

In part two, I discuss OPC. I discuss the design and implementation of OPC in the United States. Then, I introduce a major evaluation of New York's OPC program. I included this evaluation due to its programmatic similarity to LAC's OPC program. I examine the data related to its broader policy aims (e.g., hospitalizations), data related to medications, and clients' perceptions of pressure and coercion in the program. Then, I introduce prominent critiques of OPC.

In part three, I discuss psychiatric drugs. First, I introduce my second conceptual framework: *psychiatric drug effects as a social construction.* I demonstrate their construction in relation to the medical model. Then, I introduce literature on psychiatric drugs from clinical and critical perspectives. Lastly, I introduce qualitative research that examines the processes of delivering, monitoring, and enforcing drugs in services, and analyzes these data to the concept of ethics in psychiatric services.

## Bioethics and Coercion in Psychiatry

A central concept to my dissertation is ethics. In selecting a conceptual framework on ethics, I considered the following questions: how are we to evaluate whether or not a medical decision is “ethical”? How does this relate to the moral discourse among medical and helping professionals on what is and is not permissible in treatment? To answer such questions, I turned to the concept of *the coproduction of moral discourse*, introduced by medical anthropologist Paul Brodwin (2008). To fully introduce this framework, I will first introduce bioethics.

Bioethics is a branch of normative ethical theory used to determine the permissibility of an action in medicine (i.e., “how one ought to act”). In an approach termed principlism, bioethicists Beauchamp and Childress (2011) established an ethical theory intended to guide practitioners in evaluating their daily decisions. For over forty years, their principles have had far reaching implications for theory, policy, and practice (Lawrence, 2007). Beauchamp and Childress define four principles: *beneficence, respect for autonomy, non-maleficence, and justice.* For this dissertation, I focus on beneficence, respect for autonomy, and non-maleficence. Beneficence is an ethical principle that states providers have a commitment to improve the general wellbeing of their patient. In other words, when providers evaluate the permissibility of providing a medical intervention, they must prioritize interventions that will improve a patient’s physical and mental health. Respect for autonomy (or, for shorthand, autonomy) is a principle that states that patients have the right to determine decisions about their own medical treatment. Generally, autonomy requires that an individual is intentional in their decision. Second, the client must have knowledge about the risks and benefits of available options. This means that patients must have the mental capacity to make a decision. To protect the value of *autonomy*, the concept of *informed consent* has been incorporated into medical practice and research. Informed consent involves explicit steps to meet the conditions for autonomy, such as educating the client on the characteristics and effects of the treatment and other options or respecting their decision to partake in treatment or not (Beauchamp, 2011). Lastly, *non-maleficence* is about the commitment to not do harm to patients.

While these four principles are intended to guide medical decision-making, many issues can emerge in their application. First, there may be inconclusive or ambiguous available medical evidence for the available options. In these scenarios, the boundaries of beneficence and non-maleficence can dissolve. Second, ethical principles can conflict and indicate two mutually exclusive decisions for providers. In normative ethics, this is termed a moral or ethical dilemma. One common dilemma in bioethics is known as “beneficence versus autonomy.” Consider this case of a physician: a hospitalized patient is diagnosed with a terminal but curable bacterial infection. The doctor explains the nature of the patient’s condition and recommends a treatment option. However, the patient refuses treatment because the recommended medical intervention violates their religious beliefs. In accordance with beneficence, the doctor should perform the medical intervention; yet, in accordance with autonomy, the doctor must comply with the patient’s wish to decline treatment. Here, the conceptual framework provided by bioethics allows philosophers to distill key ethical values and highlight their tension.

An important critique of bioethics argues that a milieu of factors in any given scenario may complicate, or even simplify, what one "ought" to do. Let us return to the previous case of the patient with the bacterial infection. If we were to change the conditions of the thought experiment and state that the bacterial infection is highly infectious, other local values, such as protecting the public good, could make the doctor's forced administration of treatment appear more permissible for the doctor. As Turner (2009) argues, such critiques of normative ethical theory has not gone unnoticed by the discipline. In response, he argues that bioethics is a broad discipline with other theoretical and methodological approaches beyond principlism that can capture such nuance. Further, principles in bioethics are to be understood as "starting points" to evaluating decision-making, not metaphysical claims on their objective existence (Beauchamp & Childress, 2009). The point of an ethical theory is in its universality and utility.

Brodwin (2008) argues that bioethical theory serves as the foundation for everyday medical decision-making. Yet, anthropologists often make the distinction that bioethics are "higher order" concepts divorced from the daily realities of providers. Moral discourse is concerned with how decisions are evaluated as permissible by providers on the ground, or "the framework used by ordinary front-line practitioners as they handle particular illness episodes" (p. 128). To resolve this conflict, he argues that medical and cultural anthropologists can contribute to our understandings of medical ethics through a new framework that acknowledges the "coproduction" of bioethics and moral discourse. The coproduction of moral discourse, as defined by Brodwin, is a conceptual framework that emphasizes how providers' moral discourse is shaped by bioethical theory, as bioethics informs the policies that medical providers are situated in. It also acknowledges how moral discourse shapes bioethics by reifying, modifying, or transforming elements of bioethical theory in its everyday application among providers. In other words, its coproduction can be thought of as an iterative or circular process between higher order principles and everyday experiences.

## Conceptualizing Coercion

A key aim of this dissertation is to identify the range of techniques used to coerce people in treatment. However, coercion has proven to be an opaque and nebulous concept to operationalize. In part, psychiatric services are equipped with various techniques to modify or change client behavior. The designation of what constitutes coercion among these techniques is debated in the literature. Take, for consideration, the editorial in *Psychiatric Times* by Guinart & Kane (2020) who argue that incentivizing drug compliance is not coercion. Their distinction lies in the idea that coercion is about forceful persuasion, whereas incentivize merely makes an option more attractive. Conversely, others argue that the *method* does not particularly matter: if the client's voice is not incorporated into the decision-making, it constitutes a form of coercion (Diamond, 1996). While I set out to better define the concept and introduce other related concepts in psychiatric services, it should be noted that there is little consensus on the concept of "coercion," both in terms of its operationalization and ethical permissibility.

While *autonomy* is enshrined in philosophical principles and professional codes, social policies grant psychiatry (and other allied health disciplines, like nursing, social work, and clinical psychology) the authority to override personal autonomy in the United States. Through policies like the Lanterman-Petris-Short Act (1967) and *Riese v. St. Mary's Hospital and Medical Center* (1987), providers can commit people to short-term hospitalization and outpatient services and seek court approval for forced medication administration. This form of coercion might be understood as a form of institutional coercion. That is, a governing, administrative, or bureaucratic body forces an individual to partake in a program or an aspect of a psychiatric intervention. Another form of coercion regards interpersonal interactions, wherein providers may use various techniques to gain compliance to treatment plans, which could also include enacting a form of institutional coercion through invoking a court-order.

### ***Conditions for Coercion***

There are many dimensions to the discussion of coercion. First, what is coercion? What types of acts should the concept of coercion include and exclude? More specifically: what are the necessary and sufficient conditions required for an action to be considered coercive? The second set of questions relates to its ethical permissibility in health care settings. Of course, these two questions are related: we may find that some forms of influence or coercion are justified under certain scenarios. The concept of coercion was explored by Enlightenment philosophers who were concerned with understanding the relationship between states and their citizens (Anderson, 2011).

Many contemporary definitions of coercion in philosophy, however, can be traced to Robert Nozick's article titled "Coercion" (1969). In this piece, Nozick proposed the necessary and sufficient conditions for an event to be considered *coercive,* which was then more clearly summarized by Anderson (2011) in the following manner:

1. *P* aims to keep *Q* from choosing to perform action *A*;
2. *P* communicates a claim to *Q*;
3. *P*'s claim indicates that if *Q* performs *A*, then *P* will bring about some consequence that would make *Q*'s *A*-ing less desirable to *Q* than *Q*'s not *A*-ing;
4. *P*'s claim is credible to *Q*;
5. *Q* does not do *A*;

6. Part of *Q*'s reason for not doing *A* is to lessen the likelihood that *P* will bring about the consequence announced in (3)

In order to make these conditions clearer, I will translate it into a scenario that could plausibly occur in outpatient psychiatric services:

1. A therapist aims to keep their client from drinking alcohol;
2. The therapist communicates a claim to the client;
3. The therapist's claim is that if the client were to drink, the therapist would not pay for the client's rent, which would make the client's decision to drink alcohol less desirable than not drinking alcohol;
4. The therapist's claim is credible to the client;
5. The client does not drink alcohol;
6. Part of the client's reason for not drinking is to lessen the likelihood that the therapist will bring about the consequence announced in (3).

Nozick's definition of coercion is markedly different than how liberty and coercion were discussed by liberal philosophers. He established a narrow set of conditions concerned with actions that occur between individuals as opposed to broader notions of state and how it functions (though the two are not mutually exclusive). In the above scenario, the therapist presents a conditional threat that changes the client's dispositions to the available options. Specifically, the client views the option to drink alcohol as less desirable than the option to abstain, due in part to the therapist's claim. In framing coercion this way, Nozick has focused the definition on *the individual's perception of the available options and their consequences*. Further, the coerced individual is framed as a rational actor who considers the available options, weighs the consequences of each, and then acts accordingly. Lastly, as I explore later, Nozick does not consider other forms of influence (such as offers) to be coercion: he only includes credible threats.

What is the reasoning behind Nozick's conditions for coercion? First, Nozick states that his concern regarding coercion relates to *liberty*; or the ability to do an action free from other actors. He notes that there are many cases in which somebody is made unfree to perform an action (i.e., their liberties are restrained), but these do not always fit our intuition of what a definition for coercion should entail. For example, Nozick states: "If I lure you into an escape-proof room in New York and leave you imprisoned there, I do not coerce you into not going to Chicago though I make you unfree to do so" (p. 440). Thus, he reasons that coercion is about a *specific* form of limiting liberties. This entails the coercer forcing the coercee to act in ways they normally would not through the introduction of threat. The threat must be communicated (though does not need to be verbal); the coercer must know that the threat will worsen the consequence associated with the coercee's preferred decision; and that the threat merely needs to be seen as *credible,* regardless of whether the coercer actually can and/or intends to bring about the threatened consequences. Another important aspect of Nozick's conditions is that coercion changes the "normal and expected course of events" of the coercee's actions (p. 450). Or, more specifically, the coercee would have normally performed another action if it were not for the intervention of the coercer and their threat.

Nozick presents some distinctions that will be important to understanding different forms of influence in medical settings. For Nozick, threats constitute coercion, though offers (rewards) do not. Offers are defined as exchanging a particular decision with a benefit. He reasons that if we were to include offers in our definition of coercion, then coercion would apply to many interactions: "every employer coerces his employees, every employee his employer […], every seller of an object coerces his customer […], and every customer the person from whom he buys" (p. 447). Aside from making the concept of coercion too encompassing, he also argues that this distinction is important because a definition should distill what can be morally problematic about coercion. In this sense, Nozick argues that coercion infringes on personal autonomy whereas offers do not. To demonstrate this, let us consider a person, Q, who must select one of ten options that do not entail any threats or offers from P. We will call this scenario a "presituation." Nozick reasons that Q would be willing to move from the presituation to a situation where they have the same options, yet one of which would now involve an offer. Alternatively, Q would not be willing to move from the presituation to another situation where they must make the same decision, yet their desired option entails a threatening consequence (p. 463).

In many cases, the distinction between an offer and reward is unclear. Nozick's provides a compelling demonstration of this, which I modified for clarity (p. 449-450). Let us consider the case of two people at sea, Q and P. Q is in a kayak in the water, far from the shore. Q is out of energy and at risk of being swept away by the current and dying. A man in a motorized boat, P, is nearby and recognizes the danger that Q is in. In response, P offers to bring Q safely ashore if Q agrees to pay $10,000. Is this an example of a threat or an offer? If we believe that P is morally obligated to save this person regardless of Q's ability to pay, we might consider his conditions as a threat. He is intentionally making the desirable decision (to be rescued) less desirable or unattainable (especially in the case that Q does not have any money). However, Nozick changes some of the conditions of this thought experiment. Perhaps P has good reason to believe that once Q arrives on shore, he will go on to perform "monstrous deeds" (p. 450). One may argue that P is morally obligated to not rescue Q, in hopes to prevent the deaths of many, and as such, rescuing P might be considered an offer. By exploring this scenario, Nozick demonstrates that our reasoning of what constitutes a threat or an offer rests on our notions of what people are morally obligated to do.

Nozick admits that his framework is open to many criticisms and questions. How are we to understand condition 6, where "part of Q's reason" is due to the threat of the coercer? Is there a necessary or sufficient condition where the coercer's claim is *strong* enough to change the coerced individual's disposition and, consequently, decision? Let us return to the example of the client who was coerced into quitting alcohol: what if the client had already been considering becoming sober, and that the therapist's threat (of removing housing) was only negligibly considered? According to Nozick's conditions, if the claim was "part" of the client's decision, it would be considered coercion; however, this appears to be less problematic than if the threat overwhelmed the client and was their only consideration in becoming sober. Further, as Nozick demonstrates in the case of the two people at sea, a framework for coercion does not do the work of normative ethical theory for us either. In applying this framework to psychiatric services, we also must ask what are our moral obligations to clients? For example, are clients entitled to housing, regardless of their alcohol use? If so, telling a client you will remove them from housing is arguably a threat. Alternatively, if housing is not an obligation, then providing housing is arguably a reward for achieving sobriety.

What are the implications for Nozick's definition of coercion in relation to the non-coercive but influential techniques used by providers in services? To better understand these questions, and consider how we might answer them, I now turn to how bioethicists and psychiatrists who have discussed coercion in healthcare.

### ***The Ambiguity of Influence***

As previously stated, not all techniques to gain treatment compliance are coercive. Some bioethicists refer to the techniques used by individuals to change the way another relates to the available decisions as "influence" (Beauchamp & Childress, 2009). Bioethicists have used different categorization schemas to understand what constitutes as "influence"; unfortunately, the concept, like coercion, remains elusive. For example, Faden, Beauchamp, and King (1986) introduced two categories of influential techniques: rational persuasion and manipulation. Rational persuasion involves argumentation that appeals to an individual's logic, while manipulation involves strategies that are both nonrational and non-threatening (in most cases, an emotional appeal).

Still, Blumenthal-Barby (2012) noted that "manipulation" is too broad of a category and could be said to encompass everything from misleading people, guilt, suggestion, or incentives. To account for this, they replaced "manipulation" with the two following types of influence: nonargumentative influence and omission. Next, Blumenthal-Barby distinguished two forms of nonargumentative influence. First, *nonargumentative influence reason-bypassing* type refers to techniques which change the pros and cons of a decision. This could entail changing the framing of the decision or adding incentives. In contrast, *nonargumentative influence reason-countering type* refers to influence that counters a person's reasoning capacities. This could include manipulating a person's emotional state or appealing to desires. Importantly, nonargumentative influence is still distinct from threats, which is considered coercion.

The framework offered by Blumenthal-Barby (2012) informs our understanding of coercion in a few ways. First, the relationship between autonomy and rationality is a central organizing concept. Bioethicists posit that by appealing to rationality, a provider is effectively respecting the *autonomy* of clients (p. 352). To this end, non-coercive methods entail a discussion where the client is fully informed of the pros and cons, and proceeds with a decision based on these facts. It is by changing how a client may relate to these factors, pros and cons, or their decision that other forms of influence function

While coercion involves force or threats, there are a broad array of nonargumentative strategies that are used to gain compliance and, upon closer examination, entail techniques that have different ethical implications (Blumenthal-Barby & Burroughs, 2012). For example, when using incentives, we might ask "The amount and kid of incentives used" (p. 8). Thus, the area between "coercion" and "rational argument" warrants closer examination.

How might we understand the relationship of these techniques in a framework? Frequently, scholars placed techniques on a spectrum. One such framework was introduced by Lovell (1996). She establishes "social control" as a higher order concept and defines it as a range of coercive and non-coercive tactics used to change client behaviors. With this concept established, Lovell organizes strategies of social control on a scale:

*Coercion -> Coerced voluntarism -> Utilitarian compliance -> Persuasion*

Each strategy emphasizes the extent to which a client is provided freedom to make decisions. At one end is coercion. Lovell defines coercion as the explicit use of force where the coerced individual lacks agency to decide otherwise. Next, Lovell defines coerced voluntarism, a concept introduced by Peyrot (1985), in which a client is provided the autonomy to decide but warned that if they do not comply, they will receive a negative sanction or punishment. With utilitarian compliance, the provider leverages resources in exchange for behavioral compliance. For example, clients may be expected to be medication compliant or sober to receive housing. Lovell argues that this form of social control is used with clients in marginalized and underserved communities who lack social capital and resources. Lastly, Lovell defines persuasion: a conversation on the risks and benefits of treatment between the provider and client. Here, the client is aware of the provider's intent to sway them yet are able to discuss their preferences and dialogue about alternative options.

Szmukler & Appelbaum (2008) established a similar framework to identify strategies to gain compliance. The authors use for the concept of treatment pressures to guide the development of a broad framework that captures a varying degree of techniques used with clients. First, the authors provide two common justifications for treatment pressures: (1) "the treatment is in the health interests of the client; or (2) treatment is needed for the protection of others" (p. 234). From the most to least amount of treatment pressure, their framework is as follows:

*Compulsion -> Threats -> Inducements -> Interpersonal leverage -> Persuasion*

Compulsion is described as involving the greatest degree of treatment pressure as it involves a legal statue to compel participation and compliance. In community services, this can entail OPC. Next, in order, are threats and inducements are conditional responses. Here, a client is made aware that a specific action will result in a specific response by the provider. Threats involve punishment whereas inducements involve rewards. The authors describe threats as involving more pressure than inducements because in threats clients worse off if they do not comply. Next, interpersonal leverage is when a provider, having established rapport with their client, uses emotional disapproval or disappointment to pressure a client to comply. The authors place interpersonal leverage after inducements because interpersonal leverage does not deal with material resources. Lastly, there is persuasion, which entails a conversation that appeals to rationality and logic. In this scenario, providers and clients discuss the perceived benefits and risks of a treatment plan. Co-author Szmukler (2015) subsequently published that he considers "compulsion" and "threats" to both fall under the category of coercion, and that techniques such as inducements, interpersonal leverage, and persuasion are not. Clearly, there are some key overlaps between these two frameworks. The most extreme strategy (compulsion or coercion) involves eliminating a client's capacity to do otherwise through legal mandates or force. Second, conditional responses (threats, inducements, or coerced voluntarism) leverage resources or threaten punishments. Here, clients have the capacity to do otherwise, but must weigh additional consequences from the provider. Beyond manipulating material resources, Szmukler and Appelbaum (2008) make distinct the ways emotional repercussions are used to shape client behavior as well. Lastly, both frameworks include and define persuasion at the end of their spectrums. Here, clients are provided the autonomy to make their own decision, though not without a conversation about the risks and benefits of their choices with providers.

To summarize my introduction on definitions of coercion: there are many ways to conceptualize coercion itself. It also can be related to other techniques used to gain compliance that are not coercive. For the purposes of my dissertation, I use the term coercion to describe as interactions where a coercer uses a threat to change an individual's decision. I selected Nozick's definition because my project is focused on interpersonal interactions (between providers and their clients). In contrast, I use the term *influential techniques* to describe non-coercive (non-threatening or forceful) techniques used by providers to gain compliance with their clients. As I develop a framework based on my ethnographic observations, I also draw from the work of bioethicists to differentiate different forms of non-coercive yet non-rational forms of influence and consider their various ethical implications, such as have Blumenthal-Barby & Burroughs (2012) have urged us to do.

### ***Ethical Considerations***

There are various ways to evaluate the ethical permissibility of coercion. I use the framework offered by Beauchamp & Childress (2009) who frame the question of coercion in relation to the principle of *respect for autonomy*. First, they argue that overriding autonomy may be justified in certain acts of paternalism, which they define as:

> [T]he intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences or actions are overridden (p. 208)

Importantly, they make a distinction between "hard" and "soft" paternalism. Soft paternalism deals with overriding personal preferences or behaviors of clients who are thought to lack person autonomy. To revisit: autonomy requires intentionality and an understanding of the consequences. This justification is common in mental health services, where people labeled with a serious mental illness are viewed as incompetent (or lacking an understanding of the consequences of their actions).

O'Brien (2003) raised concerns on the construct of "competency" in mental health services. A person might be incompetent in one area of thought or functioning, but this may not apply to every domain of their functioning and every situation they encounter. They use the term "situational competence" and argue that if a provider is going to justify coercion in the case of incompetence, they must determine whether that specific scenario entails incompetence. Lastly, the paternalism of a coercive action does not justify *every* type of coercive action. "[W]e can only justify the *least coercive* means of achieving the good end" (p. 171). Further, while coercion may be thought to prevent harm, it can also introduce harm for the client. In this sense, for O'Brien (2003): "coercion is only justified if the client is incompetent in that situation and the harm caused by coercion is much less than the harm caused by the action they would have chosen if left uncoerced" (p. 172).

Yet, what are the harms of coercion? Research on coercion has established its multiple harms for clients. Clients have reported that coercion in mental health services is related to feeling humiliated and oppressed (Nyttingnes, Ruud, & Rugkåsa, 2016). Further, some clients have reported that methods of coercion can be disproportionate to what was needed in care, such as physical force or restrains on non-dangerous clients or forceful injection of medications without the presence of psychotic behaviors (Norvoll & Pedersen, 2018). Even non-coercive and influential techniques, such as leverage, can be perceived as coercive by clients in services. One multisite study in California of 198 outpatients found that client perceptions of coercion harmed treatment satisfaction, yet reports of experiencing leverage were not associated with compliance to medications or appointments (McNiel et al., 2013). The harms of coercion are not only its potential to violate an individual's autonomy, but to violate bioethical principles to not cause psychological and physical harm (*non-maleficence)* to clients.

How do ethicists evaluate the permissibility of influential but non-coercive techniques? According to Blumenthal-Barby (2012), bioethicists are divided on whether nonargumentative influence pose a threat to autonomy. A standard view posits that such techniques explicitly work to undermine rational decision-making and thus may threaten violate autonomy, but this may depend on our metaphysical understanding of the self and autonomy. As Buss (2005) has argued, all our actions can be said to be influenced by factors outside our control – our moods and inclinations of the day, incomplete information on the consequences of our choices, even the music we might be listening to – but does this really mean that one's autonomy is constantly under threat? She argued that appealing to *autonomy* as a principle in itself does not necessary tell us *why* an influential technique may unethical, at least not without a deeper metaphysical argument of the self and its relationship to autonomy. Blumenthal-Barby & Burroughs (2012) argue that while autonomy is at risk, we might also consider how different technique entail different ethical implications as well.

### ***Critiques of Current Frameworks***

Providing conceptual clarity to "coercion" – especially detailing its relationship to other techniques to change client behavior – may inform normative and policy level discussions of ethics in mental health services. In identifying and demonstrating the relationships of these strategies, Szmukler and Appelbaum (2008) argue these frameworks can serve as a heuristic to evaluate the permissibility of coercion in certain scenarios. They argue that greater forms of social pressure must match the direness of a situation. For example, if a client's continued noncompliance is interpreted to be related to their rapid decompensation, providers may be justified in moving from "persuasion" to "inducement." However, I disagree in that I believe the current frameworks have major limitations. To better demonstrate the limitations of these frameworks, I will introduce and compare the following two scenarios:

> *Scenario A:* A client is enrolled in a community mental health program. They are independently housed and employed. The client is compliant to their several prescribed psychiatric drugs, though reports experiencing monthly panic attacks. In response, the psychiatrist prescribes a minimal dose of an antidepressant. The client declines. The psychiatrist informs the client that if they agree to take the antidepressant, the client would be able to join a weekly cooking group offered at the clinic which they otherwise have not been able to enroll in. The client takes this offer to be credible. Based on the incentive reward, the client agrees.

> *Scenario B:* A client is homeless. The client is desperate for stable housing. They have spent the last five years cycling through homeless shelters and, despite being on a waitlist for that time, have not received a voucher for subsidized public housing. The client enrolls in a voluntary treatment program to receive help with mental distress yet declines psychiatric medications due to negative past experiences, including mental confusion and drowsiness. When enrolled in psychiatrist services, the psychiatrist promises the client immediate enrollment in housing if they agree to injectable medications. While the client prefers not to take the medication, the client agrees based on the offered reward.

In framing coercive and influential techniques on a spectrum of "treatment pressures," the authors effectively erase other dimensions that could inform our moral evaluation of these techniques. For example, the frameworks suggest that in comparing *persuasion* versus *force*, the *only* underlying difference is in the degree of pressure used. Yet, when we evaluate *force,* does it have the same *types* of moral considerations (such as consequences to client, or in relation to bioethics principles) as *persuasion*, yet only to a greater degree?

In the scenarios I provide, offers are used to influence clients. According to the current frameworks, inducements are considered lesser forms of treatment pressure compared to coercion or threats. In scenario A, the incentive for compliance is an admission to a group activity. In scenario B, the incentive for compliance is housing. Yet, describing these techniques as *offers,* or describing the actual incentives, tell us little about the *decision* that the client had to weigh or the *consequences* of their decision. This is most obvious when considering scenario B: the client is being provided an incentive that they deeply desire and will greatly increase their quality of life. In theory, the incentive of housing may be so attractive for the client that it may take precedent in their reasoning over their consideration to the benefits and risks associated with psychiatric drugs. By comparison, the client in scenario B may rationalize that the addition of a minimal dose of an antidepressant may be worth the social company and life skills offered in the cooking group. I reason that refusing to take the medications in scenario B does not bear the same types of consequences as scenario A, as a cooking group will not dramatically alter a person's quality of life in the same sense that housing can. The moral ambiguity here becomes even more problematic when we do a cross-comparison between techniques. For example, let us consider a third scenario where a client is told that if they do not comply to medications, their case manager will stop bringing a cup of coffee during their daily medication drop offs. The threat here can be understood as a removal of a positive, though not necessary, offer for a client. Is such a punishment truly a "lesser" degree of treatment pressure compared to Scenario B? This is not to argue that threats are more ethically permissible than inducements; rather, the current ordinal and one-dimensional organization of these constructions is an oversimplification.

I argue that in examining these techniques to manage madness, each case has factors that may change the ethical implications of any given technique. My comparisons also demonstrate that social ecological factors matter as well. This is evident in front line psychiatric services where precious resources may be offered to members within resource-deprived communities, and who have experienced and continue to face structural stigma. By attending to social ecological factors, we may consider how different techniques have varying ethical implications beyond any one-dimensional scale of pressure.

Another limitation of these frameworks is that they depict treatment pressures as discreet and momentary exchanges between provider and clients. Yet, treatment is temporal and interactions between providers and clients are regular. Providers may evoke these techniques in a particular fashion or order based on the moral discourse of treatment pressures. Further, treatment pressures are also nested within a specific set of policies that must be attended to. For example, how would might a discussion between a client and psychiatrist differ in the context of a hospital, where a client is unable to walk away from the interaction and is aware that noncompliance could extend their stay, compare to a similar discussion in a voluntary outpatient program? Similarly, the use of any one technique does not necessarily exclude the possibility of another being used (Blumenthal-Barby, 2012). A person may be offered two options with *both* a threat and an incentive.

In summary, these frameworks risk conflating various forms of techniques to gain compliance in treatment. In doing so, they risk reducing our conceptual clarity of coercion and ethics and blur important undergirding concepts that researchers and policymakers should consider when evaluating the moral permissibility of each of these techniques. As Blumenthal-Barby (2012) eloquently states: “conceptual categories give us hints about the ethical issues that should be considered, but they do not themselves do substantive normative work” (p. 349).

In the interests of an ethical evaluation of managing madness, I argue that there is a need for better conceptual clarity around these concepts. Further, I question how considering the clinical context of intensive psychiatric services (voluntary nature of the program, the types of interventions in question, the specific outcomes and risks, ongoing therapeutic relationship between actors) will shape our moral reasoning about what techniques are and are not ethically permissible. To bring in the focus of OPC and psychiatric drugs, I will first discuss the history of coercion in psychiatry.

## History of Coercion and Psychiatry

What role has coercion played in state psychiatry in the United States? While the history of psychiatry is deeply informative in understanding how madness has and is currently managed through coercion, a full historic review is outside the direct aims of this literature review. Indeed, the concept of madness, and its various interventions, has an extraordinary rich history of interpretations which intersect with various religious, political, and economic factors throughout time and place (Scull, 2015).

The history of managing madness in the United States begins in Great Britain. Before the 1600s, mad people were treated with great neglect, left to roam the streets and driven out of cities. In the 1600s, madhouses began to appear in Great Britain. These served as boarding homes for wealthy families and a private market for madhouses emerged (Szasz, 2007). In the early decades of the United States, communities began adopting a similar approach. These madhouses and asylums were not intended to "treat" or "rehabilitate" people from madness. And, of course, not all people experiencing madness were institutionalized in madhouses and not all institutionalized people were experiencing madness as we understand it today. Szasz (2007) notes that early critiques of madhouses were that wealthy families used them as ways to alienate or eliminate family members from lines of inheritance. Here, coercion was used to managed madness by removing it from the everyday lives of citizens.

During this era, medical professionals began to organize to gain authority. This included new laws in London that allowed the state to fine unlicensed practitioners, which alienated other healing professions at the time, such as astrologers (Burstow, 2015). The management of madness transformed during the advent of moral treatment in the 1800s. Moral treatment was a philosophical movement brought on by the French physician Philippe Pinel (Burstow, 2015; Szasz, 2007). Here, moral does not refer to morals or ethics, but refers to an individual's emotional and spiritual well-being. Pinel argued that underneath madness, the person was "still there" and that the aim of services should be to restore their prior state of functioning (Szasz, 2007). This hope for the rehabilitation of madness and restoration of normalcy undergirds the medical model today. Unfortunately, while moral treatment sought to reform people's emotional well-being, people were subjected to horrendous physical, sexual, and emotional abuses with the intent to restrain, subdue, and reform madness.

Another major contribution of the moral treatment movement was the expansion of asylums (now termed "hospitals") and the belief that hospitals should be state-run institutions (Szasz, 2007). The expansion of psychiatric powers to detain and confine people was made possible through the legal precedent of *parens patriae;* or the state's right to intervene upon people unable to take care of themselves (Burstow, 2015). Dorothea Dix emerged as a prominent social figure in American history in this regard. She was a leading advocate who pushed to have federal funds for new mental hospitals. While this specific effort failed, Dix is credited with the creation of the public mental hospital system. By 1955, the institutionalization of mad people had peaked in the United States at 560,000 (Scull, 1984). As I explore later, the medical model took hold in psychiatric hospitals. Both Gelman (1999) and Scull (2015) document a wide range of techniques – including tranquilizer chairs, frontal lobotomies insulin-induced comas – that were seen as treatment.

The era of indefinite confinement started to unravel in the late 1950s. In a process known as deinstitutionalization, mental hospitals began to close and ex-patients were emptied into communities. By 1967, the Lanterman-Petris Short Act was passed in California which ended the indefinite institutionalization of people with serious mental illness and established dangerousness criteria for involuntary (and shorter term) hospitalization. Deinstitutionalization also included a second stage: the establishment of community mental health centers aimed to integrate people with serious mental illness into their local communities. The onset of deinstitutionalization is explained by economic, cultural, and political factors. Primarily, states were overburdened with the costs of maintaining hospitals (Scull, 1984). Alternatively, outpatient services were promised federal funding through the Community Mental Health Centers Act of 1963. Similarly, the Social Security Act of 1965 arrived in the United States, which introduced Medicaid and Medicare. Medicaid did not allow states to bill for institutions for mental disease (IMDs), which encompassed state mental hospitals (Frank, 2000). Politicians capitalized on the mounting pressures for “more humane” visions of community-based care to switch to these de-centralize community services and reduce state budgets (Scull, 1984). As Floersch (2002) and Scull (2015) have argued, this was accompanied with a growing anti-institutionalist sentiment targeted at centralized government programs; for many, asylums represented centralized and oppressive governmental powers. Along with these new community centers, a new set of vocabulary emerged. Instead of being “patients” in socialized institutions, mad people (or, increasingly termed as “the mentally ill”) would become “consumers” dispersed throughout the community and become “rehabilitated” or, as the NIMH termed it, “normalized.” This vision for normalization included entering employment and schools and contributing to local and national economies (Wolfensberger, 1970). Here, coercion exists in two forms. First, hospitalizations which are intended to address emergencies. Second, community service programs which use coercive or influential treatment techniques and are intended to mitigate hospitalizations and incarcerations.

The promise for community integrative services was never fully realized. In part, the failure of deinstitutionalization to enact adequate services is often invoked as the reason for the modern crises associated with madness: homelessness, incarceration, and frequent hospitalizations. As I explore in the proceeding section, one such program proposed to handle these outcomes is OPC (Torrey & Zdanowicz, 2001). But first: what were the specific failures of community integration? First, federal funding promised for community-based facilities was cut by multiple administrations. Most notably, this includes the Reagan administration which halted the passing of the Mental Health Systems Act and effectively dismantled any possibility for federal funding of it through his "new federalism" initiatives (Mechanic et al., 2014). This was followed by federal reforms to dramatically shrink welfare programs. Fulfilling his campaign promise, Bill Clinton "end[ed] welfare as we know it" in passing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This bill created stricter requirements to receive welfare benefits with devasting consequences for people living in poverty (DeParle, 2004). Second, a federal coherent vision for psychiatric interventions never materialized. The most prominent program formation originated in Wisconsin, known as the program for assertive community treatment (PACT or ACT). Yet, its implementation varied widely by state, with the addition of stricter time limits for services, which has made evaluating the efficacy of such programs difficult (Deci, Santos, Hiott, Schoenwald, & Dias, 1995; Teague, Bond, & Drake, 1998).

An important component to the history of psychiatry is the rise of the medical model. As previously explored, medical approaches to managing madness took power due to the professionalization and consolidation of medical practitioners (Burstow, 2015). Of course, definitions of what constitutes "the medical model of mental illness" vary. I borrow from Conrad & Schneider (1992) who, in their sociological research on deviant behaviors, distill two core principles. First, the medical model states that disruptions or deviations in a person's emotions, cognitions, and behaviors are related to abnormalities in the person's structure and/or functioning, typically in their brains. Second, it states that such disruptions can be cured with the introduction of a medical intervention (p. 35).

Psychiatry uses the medical model of mental illness to explain psychiatric drug mechanisms and effects. Throughout time, societies used various psychoactive substances to treat different forms of madness and distress (Scull, 2015). However, the first official psychiatric drug – prescribed by medical authorities – was introduced to markets in 1954; a phenothiazine named chlorpromazine (Shen, 1999). At the time, chlorpromazine was not known as an "antipsychotic." In fact, it was not until eleven years later that the term "antischizophrenic" was introduced by Guttmacher (1964) in a clinical trial on their efficacy to manage psychotic symptoms in hospitals. Rather than seen as a *treatment* for a *disease-state*, as Gelman (1999) explains, chlorpromazine was prescribed for its sedative properties. In hospitals, doctors could administer it to quell disruptive behaviors. Its introduction sparked popular interests for prescribing medications in order to manage mad people. It also sparked neurobiological research as scientists sought to discover their impact on physical structures and functions in the brain. In discovering chlorpromazine's impact on dopamine receptors, van Rossum (1967) proposed the "dopamine hypothesis." This stated that because chlorpromazine reduces psychotic behaviors and affects dopamine receptors, "dopamine receptors could then part of the aetiology [of schizophrenia]" (p. 327). When discussing psychiatric drugs more specifically, I introduce critiques of this logic, which has been extended to other psychiatric drugs and diagnosable mental illnesses. My main point is that psychiatric drugs were secured as a primary intervention of psychiatric services, nested within the medical model of mental illness. Today, this logic dominates education and services in mental health (Beecher, 2009; Gomory, Wong, Cohen, & Lacasse, 2011). Even among practicing psychiatrists, there is a growing concern that that services are disproportionately emphasizing medication consumption and compliance over other forms of psychosocial support (Torrey, Griesemer, & Carpenter-Song, 2017).

### Critiques of Psychiatric Coercion

Psychiatry has received a wide variety of critiques. These stem from social movements, including the consumer/survivor/ex-patient movement, mad studies, anti- and critical psychiatry, and prominent theorists and practitioners in law, medicine, social work, and nursing. These critiques are based on a wide array of theoretical perspectives too, from Marxism to libertarianism, and at times intersect with anti-oppressive movements including critical disability, queer/trans, feminist, and anti-racist perspectives. My concern with critiques of psychiatry is to locate perspectives that (a) have been largely influential and undergird much of the moral discourse on psychiatry and the medical model, and (b) discuss the relationship between personal autonomy and governance in the United States. Thus, in this section, I briefly introduce some key challenges to psychiatry and the medical model.

The first set of critiques focus regard the medical model. In challenging psychiatry's claims of objectivism, some have pointed to how systems of racism, sexism, and heterosexism influence the processes of psychiatric pathologization and treatment. For example, Metzl (2009) demonstrates how definitions of psychosis shifted to capture the "agitated" behaviors of civil rights protestors. Other critics point to the influx of prescribed psychotropic medications into both public and private practice, indicating a profit-driven motive to pathologize, categorize, and prescribe deviant behaviors out of existence (Moncrieff, 2008; Whitaker, 2005). Indeed, the emergence of the medical model of mental illness granted psychiatry immense cultural and state power. Some have argued that biopsychiatry is merely a result of the medical-industrial complex tapping into the state's interests in managing and regulating human behavior, rather than a scientific discovery and discipline. This was a major argument of Thomas Szasz, a twentieth century practicing psychiatrist and writer who rose to fame with his 1961 publication *The Myth of Mental Illness*. His work has served as the foundation for activists and scholars in anti- and critical psychiatry. Szasz's central critique was that the medical model of mental illness was a false construct. He reasoned that physical ailments have objective and observable physiological disease-states, whereas madness does not. To this end, the practice of managing madness should not involve medicine, especially without the full consent of a client. For Szasz, psychiatry is a primary tool of the state. In *Cure Through Coercion: A Critical History of Psychiatry,* Szasz (2007) argued that through the Enlightenment, religious institutions lost their power to control human conduct. To fill the void, psychiatry gained authoritative legitimacy by mimicking the procedures and language of physical medicine and secured itself as a viable institution for social control for the state. Aside from abolishing the medical model of psychiatry, Szasz wanted to divorce any helping disciplines of any form of state power. Importantly, Szasz's critiques, and the work of his contemporaries, appeal to libertarian constructs of individual liberties. This notion assumes that people are individual actors whose rights should not be impeded on by the state, especially if they are innocent of crimes. Any form of coercive behavioral intervention by the state is a violation of this principle.

A second, and contrasting, line of critique stems from Foucault. Foucault was concerned with how societies come to understand certain ways of thinking as true and employ these understandings in our institutions and daily interactions. While Foucault's first book, *Madness and Civilization: A History of Insanity in the Age of Reason* (1971), examined the rise of psychiatry, Foucault would go on to examine constructions of gender and sexuality, jails and prisons, and medicine as techniques of state surveillance and power. In regard to madness, he was less interested in explaining what madness actually *is.* Instead, Foucault wanted to understand how madness came to be understood as a medical ailment and managed through, what he termed, disciplinary power. Here, power is understood not as solely an institutional force onto an individual. Rather, power is embedded in the ways individuals come to understand themselves and modify their own behaviors, especially in relation to institutions of power which surveil us (Foucault, 2009).

Another major contribution of Foucault was his analysis of how neoliberalism in Western democracies emphasize the importance of individual liberties. Foucault (2009) highlighted that at the turn of the modern era, societies became less concerned with managing territories (i.e., colonial expansion) and more focused on maximizing the productivity of their populations in relation to labor markets through public health initiatives. In this sense, states intensified their commitments to capitalism. Similarly, Foucault underscored how modern societies lacked public spectacles of punishment compared to earlier eras and instead relied on disciplinary institutions so that citizens follow social norms and expectations (Foucault, 1975). Modern theorists suggested that state psychiatry and medications play a role in producing productive citizens (Rose, 2007; Floersch, 2002). Further, as Braslow (2013) argues, neoliberal ideology is evident in the recovery discourse that pervades community mental health services. This logic can be further identified in the meanings assigned to psychiatric medications (Dougherty, 2019). Importantly, in neoliberal states, individuals are expected to manage their own behaviors or, as he called it, governmentality (Dardot & Laval, 2014), thus not all forms of neoliberal governance are about overt exercises of power. Governmentality is a useful framework to understand how individuals come to relate to and regulate their behaviors because we can then identify shared practices and beliefs which may demonstrate the presence of coercive discourses or ideologies that are covertly guiding individual behaviors.

While Szasz and Foucault varied greatly in their approaches, many critical examinations of psychiatry, such as Burstow's institutional ethnography (2015), have drawn from both. I incorporate these critical perspectives in my own scholarship in two regards. First and foremost, both Foucault and Szasz point *the construction of psychiatric knowledge as a primary method of sustaining power*. Examining power entails understanding how psychiatric knowledge is passed down and used in decision-making. Second, there is the question of the individual subject. For Szasz, people are independent actors who are entitled to basic liberties and state interventions violate this. Conversely, Foucault emphasizes how societies construct subjects in order to rationalize forms of rule (Foucault, 1982). While both entail different metaphysical accounts of the self, it is evident that how psychiatry understands the relationship between madness and autonomy is central to its ability to detain mad people. Thus, for my dissertation, I examine *how providers come to think about the madness and the decision-making capacity of their clients*.

To end the section of my literature review, I will introduce my own arguments on coercion and influential techniques. Based on the previous literature, I argue that non-coercive but influential techniques may pose certain harms for clients in services, including undermining their sense of voice and purpose in a therapeutic relationship. This may be particularly important in regard to psychiatric drugs, whose effects bear directly on their subjective experiences, and whose effects should be communicated and considered by providers so that treatment teams and their client can make the least harmful decisions in their care. I also believe that coercion is unethical, except for situations in which clients are immediate harm to themselves or others. Still, even by believing in the permissibility of a policy, I do acknowledge that a policy may permit its use in unethical ways (Beauchamp & Childress, 2009). I assert that a major priority for mental health researchers should be eliminate unethical uses of coercion and influential techniques in mental health services.

## Involuntary Outpatient Commitment

The primary focus of this dissertation project is involuntary outpatient commitment (OPC). OPC represents a concerted effort to extend psychiatric commitment policies into community-based settings. In this section, I briefly introduce the structure and intended function of OPC programs. First, I introduce how OPC programs are broadly designed and its inclusion in the Californian Welfare and Institutions Code. Included in this discussion, I discuss key theories and conceptual models introduced by researchers to theorize how OPC functions to achieve its intended aims. Following this, I discuss the outcomes literature on OPC and its criticisms.

As the name suggests, OPC is an outpatient (community-based) psychiatric treatment program and is implemented in over 45 states (Meldrum, Kelly, Calderon, Brekke, & Braslow, 2016). OPC services typically involve three core components: case management services, medication management services, and court mandates. Case management services can include ACT or intensive case management (ICM), which entails field-base services to connect individuals to community-based resources. In outpatient services for serious mental illness more broadly, case management is intended to facilitate the integration of disabled peoples into community settings. The concept of community integration can include connecting clients to basic resources (housing, food), occupational roles (employment, education), and social connections.

A second core component is medication management. In OPC services, prescribers (psychiatrists, nurse practitioners) are tasked with prescribing and adjusting psychiatric drug regiments, while case managers and therapists are responsible for delivering and enforcing drug compliance. The third major section of this chapter is dedicated to understanding the various ways medication management is conducted. Lastly, court mandates, which are optional in some states, are used to gain compliance and include regular court hearings with clients to track treatment progress.

As a mandated program, the policy aim of OPC is to increase treatment compliance of people with serious mental illness through the combination of (1) increased service intensity and (2) court-mandates (Swanson et al., 1997). In regard to service intensity, OPC researchers Swanson and colleagues (1997) have argued that the intensive service design mobilizes both formal and informal (e.g., families) support systems to monitor and support clients through treatment. In regard to court-mandates, some proponents of OPC have argued that judges assert a "black robe effect," which is a theory that the mere presence of a judge (who dons black robes) serves as a symbol of power that will sufficiently pressure clients to partake in treatment. There are two important caveats to court-mandates. First, in some states like New York and California, court-mandates are optional and up to the discretion of providers to apply. Second, there are no formal legal repercussions for failing to comply to the conditions of the court-order. The implications of court-mandates in relation to my broader inquiry of coercion is explored later in this section.

While I have provided a broad introduction to how OPC is typically designed, how is it implemented by state? How does the use of OPC coincide with other political interests of state legislatures, community mental health organizers and providers, and local community members? Meldrum et al. (2016) explore the question by conducting a national evaluation of OPC policies. By discussing OPC policy with 45 states, the researchers categorized OPC programs as fulfilling three functions. First, OPC is used as a method of discharging people from jails and/or hospitals. Second, OPC is used to keep people identified as gravely disabled and noncompliant involved in long-term treatment. Lastly, OPC is used to surveil people in the community who are identified as being dangerous and a threat to others.

AOT was introduced to the Californian state legislature in 2002 under the title of “Laura’s Law.” The bill was named after Laura Wilcox, a receptionist at a mental health in Nevada County, who was shot to death by Scott Harlan Thorpe in 2001. The reports of what led to the events vary, though in a proceeding court case, a case worker reported that the clinic failed to hospitalize Thorpe as his delusional beliefs and agitated behaviors intensified. Thorpe’s shooting spree, which resulted in multiple deaths, received national attention. Assembly Bill 1421 was introduced and, in 2002, was passed by Governor Gray Davis. Laura’s Law was largely based on New York’s assisted outpatient program, named Kendra’s Law. Similar to California, Kendra’s Law was named after a woman who was killed by a man receiving mental health services and was passed in 1999. While the law is used to mandate psychiatric treatment, according to the California Welfare and Institution Code § 5348, psychiatric medications cannot be mandated in AOT. This means that if a client receives a formal court order, the legal terms of the mandate cannot include a requirement for psychiatric medications in client treatment plans.

### Evaluations of OPC

Major evaluations of OPC programs belong to two generations (Ridgely et al., 2001, p. 98). While the first generation were analyses of administrative datasets, the second generation of studies consist of randomized clinical trials of OPC from New York and North Carolina. I will be evaluating the data from the New York study due to the limited generalizability of the North Carolina evaluation. In the latter study, investigators ensured that civil commitments were used when applicable, the population was limited to clients discharged from hospitals, and the project funded client services (p. xv-xvi). This greatly limits the applicability of their analysis as it relates to California's OPC program.

New York's Kendra's Law was renewed in 2005 and required an evaluation of its outcomes. Swartz, Swanson, Steadman, Robbins, & Monahan (2009) performed an in-depth evaluation of the services by reviewing administrative data (including clinical records and Medicaid data) and conducting interviews with case managers and clients in services. At the time of their evaluation, OPC was implemented in five counties (Albany, Erie, Monroe, Nassau, New York, and Queens), though 71% of all cases in their data were located in New York City. Swartz and colleagues identified forms that OPC took between counties. In the majority of cases, clients received a court-order to enroll in services. They termed this the "AOT First model." However, some clients were approached to enroll in services voluntarily. At a later time, some of these clients received a court-order. This model was called the "EVS First Model." Overall, there were 8752 AOT orders and 5684 renewals of treatment orders.

According to Swartz and colleagues, there were several improvements related to psychiatric medications. First, clients were more likely to receive psychiatric drugs that, according to the authors, matched their psychiatric condition. With the Medicaid data, the authors determined whether the prescription would supply recipients with enough pills that would last during 80% or more of the days in a month. If medications matched these two criteria, they named it "medication receipt." The number of cases that matched these criteria increased from 35% (pre-AOT) to 44% (1-6 months) to 50% (7-12 months). Further, case managers (from 1999- 2007 of n = 5,634 recipients) rated whether or not clients could manage medications "without substantial help" which increased pre-AOT (67%) to 6 months (74%) to 12+ months

(77%). Lastly, case managers reported improvement among clients in managing their appointments and medication compliance. From case managers reports (from 1999- 2007 of n = 5,634 recipients) at enrollment, 47% of clients were described as non-adherent. At 6-months, 33% of clients were described as adherent, but at 12 months, it was back at 43%.

What about perceptions of AOT services from clients? The authors compared people currently receiving OPC services (n = 155), had received OPC services 6 months ago or never (n=134), and who were not enrolled in OPC but were in the last six months (n=28). They were surveyed in three domains: (1) AOT beliefs and attitudes, (2) treatment autonomy, relationships, and satisfaction, and (3) coercion, pressures, and barriers. Each of these domains consisted of several subscales that were then compared between groups. As it relates to my interests in psychiatric drugs, the second domain (treatment autonomy) included the Drug Attitude Inventory (DAI). It also included a 33-itemized scale (binary scores, yes or no, for each item) that examined whether clients experienced warnings, sanctions, medication oversight, and commitment pressure (p. 36). Overall, the authors did not find differences in the three groups, except for two subscales: perceived AOT effectiveness (higher for current and recent AOT) and barriers to treatment (lower for current and recent AOT).

In evaluating this data, there are differences between AOT and non-AOT clients in attitudes toward treatment and experiences of pressures. This may be because perceptions of treatment do not really have to do with the court-order or AOT itself, but other factors. In terms of medication delivery and compliance, it also appears that AOT ensures that medications are being delivered more consistently and that clients are learning how manage medications, but this does not necessarily translate to clients being more compliant. Based on the New York evaluation, we might ask: if clients do not perceive OPC services as being any more or less coercive than voluntary services, is there an ethical *need* to evaluate OPC services? Further, OPC has a voluntary component – does this relieve us of some of the urgency to evaluate the ethical permissibility of AOT services?

## Coercion in OPC

The New York data on *perceptions* does not inform us whether an interaction was coercive or not. There is an important distinction between coercion versus perceived coercion. A person can be coerced into something without perceiving it as coercion. Similarly, people can be influenced to do something (through a non-coercive technique) and perceive it as coercion (Anderson, 2011). In evaluating whether OPC is coercive, it is important to evaluate perceived coercion, though that is a different type of evaluation compared to determining whether or not it is, in principle, actually coercive. Further, these perceptions cannot (in themselves) tell us whether the coercion was justified in the normative sense. A coercive interaction might occur between a therapist and their client who is immediately at risk of committing suicide. Coercion in this context may carry different ethical implications compared to that of a therapist coercing their client to take medications. Again, I argue that context is important, and a "yes/no" scale cannot possibly inform us regarding the types of decisions being made. Lastly, and similarly, these data do not illuminate the decision-making processes – how these events sit in relation to the broader experience of care and the therapist-client relationship. This points to the importance of ethnographic work.

To demonstrate how AOT is coercive, even with the addition of a voluntary component, I introduce three plausible scenarios in which providers try to have clients enroll in services: (1) providers use offers without threats, (2) providers use threats without offers, and (3) providers use both threats and offers:

1. A provider (P) wants a client (Q) to enroll in services (A1). Q prefers to not enroll in services (A2). P offers Q resources if Q agrees to A1. P omits the fact that if Q choses A2, P will seek a court-order for Q to choose A1. In part due to the offer from P, Q choses A1.
2. P wants Q to choose A1. Q prefers A2. P threatens Q with a court-order if Q choses A2. In part due to the threat from P, Q enrolls in services.
3. P wants Q to choose A1. Q prefers A2. P offers Q resources if Q choses A1. P also threatens a court-order if Q choses A2. In part due to the offer and threat from P, Q choses A1.

First, some may object to equating a "court-order" to a threat. However, my working definition of threats are about a coercer bringing about consequences that are viewed by the coercee as credible and undesirable. In this case, a court-order may be undesirable because it brings about an action they do not want (A1) and/or entails additional legal proceedings (legal paperwork, court hearings) that in themselves are undesirable to clients.

Second, in each of these scenarios, the client choses to enroll in services (A1) due to conditions communicated by the providers. Yet, consider scenario 1, where only an offer is made. If I were to revise this scenario so that the client chose not to enroll in services (A2), then the provider would have enacted the threat of the court-order. If the court-order is seen as a credible threat to the client, the client may enroll in services at this point (A1). While they were free to make a decision in the first step, immediately afterward they entered a new scenario of decisions which entailed a provider presenting the previously omitted threat. In this revised scenario, the client ultimately had no choice but to choose to enroll in services (A1). Does this mean that in the original scenario of 1, where the client selected A1 due to the offer alone, is a non-coercive interaction? According to Nozick, perhaps, because there was no credible threat perceived by the client in that first decision. However, I would turn to bioethicists here: the provider purposefully withheld information in order to change a client's behavior, which is known as omission (Blumenthal-Barby, 2012). To this end, I argue that a voluntary component to the outreach program does not inherently relieve OPC of being coercive. As Kirk, Gomory, and Cohen (2015, p. 85) ask: does having coercion as an available mechanism to providers at all times means that OPC is inherently coercive? Is it plausible that there are scenarios where coercion is never used in OPC? That is, if a client goes through the entire program without a provider ever using the threat of a court-order, does that demonstrate that OPC is not inherently coercive? Such questions further demonstrate the importance of understanding *how* coercion and influential techniques are enacted in services

### Defending and Critiquing OPC

What are some of the ethical justifications and critiques for OPC? Defenses for OPC are related to paternalistic attitudes about psychiatric treatment. Underlying many endorsements for OPC is the belief that people labeled with a serious mental illness do not have autonomy, and therefore coercion is paternalistic and justified. One prominent argument for OPC is that although it entails coercion, people have their civil liberties effectively restored through psychiatric treatment (Swanson, Swartz, Elbogen, Wagner, & Burns, 2003). Consider the following quote used to advocate for its implementation:

> We argue that the real liberty question regarding individuals with severe psychiatric disorders is whether they are in fact free when ill. If one's thoughts and behavior are driven by delusions and hallucinations because of a disease process of the brain over which the person has no control, is this truly liberty? (Torrey & Zdanowicz, 2011, p. 340)

Viewed in this light, coercion is not about restraining people's rights, but in fact restoring them. Another line of argument relates to the broader policy aims that OPC has come to represent. OPC was designed to increase behavioral compliance to treatment orders; yet, in the eyes of the public and policymakers, it has been argued to be the cure of many pressing social issues for mad people. State-sponsored evaluations of OPC programs use the outcomes of homelessness, incarceration, and hospitalizations as indicators of the program's efficacy. For example, major advocacy groups have published on the capacity for OPC to decarcerate mad people (Torrey et al., 2010). This is not to undermine the importance of addressing these issues or question the relevance of examining these outcomes. Rather, I am demonstrating that the discourse frames these pressing social issues as a problem rooted in behavioral compliance to treatment.

Of course, there are major critiques of OPC. Previously, I have raised the harms of psychiatric coercion, and the violation of both *autonomy* and *non-maleficence*. There are other broader critiques of OPC as well. One line of critique considers the undergirding logic of the program. Fisher & Drake (2007) discuss how programs like OPC rely on pathologizing and reforming individuals, instead of addressing broader social ecological determinants in social welfare policy that result in homelessness or mass incarceration. This might include expanding the availability of housing for mad people. Another important line of critique can be located in an examination of treatment effects in PACT by Gomory (2004). He argues that results of ACT program are purely tautological. Instead of a treatment effect, studies that demonstrate behavioral compliance are merely capturing techniques by clients to avoid punishment. However, once coercion is removed, so are the effects of treatment. In this sense, OPC may be expending precious resources on an ineffective treatment program. Similarly, another line of critique regards research studies on the efficacy of OPC. Because OPC programs implement various psychosocial and chemical interventions, it is methodologically difficult to examine the specific influence of a court-mandate on clinical outcomes (Ridgely et al., 2001), and no research has examined its long-term effects after disenrollment. Thus, it could be the case that other element of the program – such as having more staff available – could be the main effect of the program, and not the coercive elements. Lastly, a major line of critique pertains the use of psychiatric drugs in OPC. As I explore next, psychiatric drugs are correlated with adverse subjective and physical effects and high rates of discontinuation (Lieberman et al., 2005). This has raised serious ethical concerns regarding their use in long-term coercive settings (Barnes & Badre, 2016).

In this section, I have only discussed coercion as it relates to enrolling clients in OPC. However, OPC involves more than just enrollment; it is a six-month treatment program where providers and clients make daily decisions. At any point, a client may decide to decline aspects of treatment, even to interventions that they had previous consented to, and in response, a provider may try to change a client's decision through various techniques (coercion or influential techniques). How might we ethically evaluate the full spectrum of influential techniques in OPC, particularly where clients' circumstances of poverty and isolation, therapeutic attachment and rapport, and compliance are all factored into medical decision-making? Or alternatively, how is the court-order itself actually leveraged in interactions? And how does the optional oversight of a judical system shape the clinical interactions between providers and their clients? I argue that these questions regarding ethics, coercion, and OPC are particularly urgent as it relates to psychiatric drugs, where noncompliance is common, yet compliance is expected. To demonstrate the importance of evaluating moral decision-making as it relates to psychiatric drugs, next I will introduce the literature on drugs.

## Psychiatric Drugs as a Social Phenomenon

In my dissertation, I consider how psychiatric drugs are a social phenomenon (Cohen et al., 2001). More specifically, I am interested in how psychiatric drugs and their effects are socially constructed. This conceptual framework allows me to examine drugs beyond their materiality or physiological effects and instead examine how interpretations of their "effects, uses, and meanings" are derived from larger social, economic, and political systems (p. 443). Further, the framework offered by Cohen and colleagues calls for a critical examination of drugs that analyzes how power shapes the construction of drugs and their effects. To this end, this section of the literature review introduces literature in biopsychiatric and services research to understand this social construction. While I include scientific literature on their effects, I also turn to critical evaluations of this body of literature. Then, I introduce key qualitative texts that have examined how the social construction of psychiatric drugs emerge in and shape their delivery, monitoring, and consumption.

Psychiatric drugs belong to four classes: antipsychotics, antidepressants, mood stabilizers, anxiolytics, and stimulants (Read, 2009). While I focus on the concept of psychiatric drugs as a whole, my primary focus is on antipsychotic drugs for several reasons. Antipsychotic drugs are an appropriate site of analysis due to their use in managing disabling psychotic and/or manic symptoms. Epidemiological research indicates a high prevalence of their prescription among welfare beneficiaries. According to the 2015 Centers for Medicaid and Medicare, one-fifth of Medicaid funding on medications was for antipsychotic medications (Centers for Medicare and Medicaid Services). Further, while each class of drug has associated risks and benefits for users, antipsychotics also bear particular significance for my dissertation due to the controversy surrounding their effects and use in OPC (Barnes & Badre, 2016). Despite this emphasis on antipsychotics, I will also briefly introduce the other types of psychiatric drugs.

## Understanding Psychiatric Drugs

In this section, I introduce two types of research on psychiatric drugs. The first stems from literature in the psychiatric sciences. I introduce studies that examine the relationship between psychiatric drug consumption on various scales of psychiatric symptoms, disability, and physiological effects. Next, I introduce literature that critically examines the claims in and derived from these studies.

I selected studies on psychiatric drugs that would be informative to understanding their real-world efficacy and application. Indeed, there are many randomized control trials of psychiatric drugs. Yet, an important concept in medical and quantitative research is the trade-off between internal and external validity. Randomized controlled trials allow scientists to eliminate external factors to isolate treatment effects (internal validity); however, this is at the cost of reducing the applicability of results to real-world scenarios (external validity), where countless factors could influence treatment outcomes (Steckler & McLeroy, 2008). Studies with high external validity will be particularly informative to understand how providers and clients experience and interpret their effects on users.

Several studies investigated the efficacy of psychiatric drugs in real-world settings. The NIMH-funded Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study compared the efficacy of antipsychotics and drew major implications for their tolerability (Lieberman et al., 2005). The study examines rates of discontinuation among 1493 clients diagnosed with schizophrenia across 57 sites in the United States. Clients were randomly assigned to one of three atypical antipsychotics (olanzapine, quetiapine, risperidone, ziprasidone) or a typical antipsychotic (perphenazine). The researchers found a 74% discontinuation rate within 18 months of treatment. The authors report two reasons for discontinuation. The percentage of discontinuation due to the intolerability of drug side-effects ranged from 10% (risperidone) to 18.7% (olanzapine). The percentage of discontinuation due to lack of efficacy ranged from 15% (olanzapine) to 28% (quetiapine). The study also demonstrated the effects of antipsychotic drugs on metabolic functioning, including increases to weight, blood glucose, cholesterol, and triglycerides. The main findings of the study point to the "substantial limitations in the effectiveness of the drugs" (Lieberman et al., 2005, p. 1218).

Kirk and colleagues (2013) pointed to two studies that demonstrate shortcomings for antidepressants and mood stabilizers. The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) trial studied the real-world efficacy of selective serotonin reuptake inhibitors (SSRIs), a major class of antidepressant drugs (Trivedi et al., 2006). The study was conducted among 2,876 clients with nonpsychotic depression in psychiatric and primary care settings and their primary outcome of interest was remission from depressive symptoms. The authors used the Hamilton Depression Rating Scale as their primary outcome, which is a 17-item scaled questionnaire with outcomes scores that range from 0 ("normal") to over 23 ("very severe depression"). In this study, remission was defined as scoring below a 7. The authors found a 28% remission rate. Further, the Systematic Treatment Enhacement Program for Bipolar Disorder (STEP-BD), published by Perlis and colleagues (2006), examined the efficacy of psychiatric drugs (primarily mood stabilizers) and adjunctive psychosocial support among 1469 clients. Their results demonstrate that only slightly over half (58.5%) achieved recovery within two years. Together, these two studies demonstrate the low applicability of these drugs in real-world settings.

## Deconstructing the Magic Bullet

Moncrieff & Cohen (2005) introduce a framework that deconstructs medical assumptions about how psychiatric drugs work. They identify and contrast two models to explain drugs and their effects: the “disease-centered” and “drug centered” models. The disease-centered model assumes that mental disorders are a result of a physical abnormality in the brain, such as a “chemical imbalance,” that drugs directly correct. (It is related to the symptom-centered model which supposes that drugs disrupt pathways that produce psychopathological symptoms.) This model stems from the medical model of mental illness. However, Moncrieff and Cohen advocate for the drug-centered model. This model does not assume drugs make brains more biologically “normal”; instead, they produce global and abnormal mental states and behaviors that “may or may not be experienced as useful in certain social and interpersonal situations, including clinical situations” (p. 146). Similarly, in discussing the tranquilizing effects of antipsychotic drugs, Cohen (1997) demonstrates how the categorization of drugs effects into “main” and “side” is in itself a social construction. Indeed, the sedating effects of antipsychotic drugs were the very reason their use in psychiatric hospitals became popular (Gelman, 1999). The distinction of main and side effects is rooted in a treatment team’s perception of what does and does not have utility in a particular situation and, as I demonstrate later, the treatment team's power to impose that perception even if the client disagrees. To this end, Cohen proposes that drugs produce “global neurological effects” (p. 204). To further demonstrate this point, Moncrieff, Cohen, & Mason (2009) examine 436 reports on subjective experiences with antipsychotics through a mixed-methods analysis. In relation to psychological experiences, respondents discussed experiences of being sedated, slowed cognition, and dulled emotional experiences. While these can be seen as adverse experiences, for some users they helped reduce the intensity of distressing mental experiences. This blurs the distinction between "main" and "side" effects, suggesting a more global and non-specific effect of drugs, as for some users their clinical utility can be seen as a product of their adverse effects.

## Psychiatric Drugs in Services

So far, I have introduced a conceptual framework on the *coproduction of moral discourse* in psychiatric services. Relatedly, I have explored the issue of coercion and its critiques in psychiatric services, including OPC. Lastly, I have discussed both psychiatric and critical evaluations of psychiatric drugs, and my other key conceptual framework: *the social construction of psychiatric drug effects.* The last component of this literature review is to examine how issues of ethics, coercion, and drugs emerge in psychiatric services. I turn to qualitative research on the community-based psychiatric services. I seek to understand the ways in which drugs are understood and constructed on the ground by providers and clients. Of course, there is a wealth of qualitative literature on psychiatric services. The research I have selected, however, has specifically analyzed the delivery of drugs to understand the broader project of managing madness in the United States. Similar to my framework, I have also selected ethnographic work rooted in the constructivist tradition. Broadly, these works document the ways drugs, mental illness, and treatment goals are social phenomena.

Sue Estroff (1985) published an ethnography of community psychiatric services titled *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community.* This ethnography took place in a Program for Assertive Community Treatment (PACT) in Madison, Wisconsin from 1975-1977. Her work primarily concerns the ways in which madness is understood and reified through medical practices in the era of post-deinstitutionalization. A major contribution of Estroff's work is her observation that each member on the treatment is involved in the delivery system of medications (p. 82). Each staff member is involved, at some point, in ensuring that the drug is effectively delivered and consumed by the client. Another key component to this is the interpretation of drug effects and client behavior. Estroff notes how providers are compelled to continuously respond to their interpretation of clients' attitudes towards psychiatric drugs. When providers were concerned that their emphasis on compliance would harm their rapport, providers would stop discussing medications. At other times, providers were interested in instilling biopsychiatric logic into client's beliefs. For example, Estroff noted that if clients expressed repeated negative feeling towards medications, the staff would make a repeated argument for taking meds, which often left clients resigned to comply (p. 83).

One of Estroff's central argument is that medications are a symbol for clients that they are, in fact, "ill" and "crazy." In terms of illness, she argues that the medications are an extension of medical power that seek to sedate and submit clients. Thus, any form of refusal of medications by clients is interpreted as contesting power (p. 116), which is particularly problematic given that refusal may emerge due to the disabling adverse effects. The term "crazy" refers to its "everyday" use in popular culture and media – that clients are bizarre and incomprehensible (p. xiv). Labeled as such, clients in this ethnography are excluded from their local communities; thus, their primary social community is with other clients and their providers. To this end, Estroff's ethnography established a relationship between social stigma and biopsychiatry. In her conclusions, Estroff noted that the current management of psychiatric drug effects is unsustainable. Simply: the adverse effects are too strong and the tension that emerges in compelling compliance compromises therapeutic alliances. In concluding her ethnography, she advocated for less medications and more staffing to support clients. Further, she argued that more data is needed on medication effects from the perspective of clients to help develop policies that provide clients more autonomy in medical decision-making in services (p. 252-253).

Jerry Floersch (2002), a social work researcher, conducted an ethnography in a community mental health program in Oaklawn, Kansas. His ethnography, *Meds Money, and Manners: The Case Management of Severe Mental Illness,* provides an in-depth analysis of the daily tasks of case managers who were trained under paradigm of "strengths case management." A major point of analysis for Floersch is the role case managers play in the era of post-deinstitutionalization, where resources are distributed across suburban landscapes and there is a lack of centralized systems for monitoring client behavior and progress. Similar to Estroff, Floersch noted the centrality of medications in services. While providers sought to "exchange" psychotic symptoms for lethargy through medications (p. 203), managing medications entailed a complicated process of ongoing interpretation of their effects. This is because, despite a supposed schema for organizing drugs, their effects can have profound differences in users (p. 151). Further, providers were often delivering and managing multiple drugs at once, making it difficult to distill the particular effect of one drug on a client (p. 157).

Floersch's main argument is that in the era of post-deinstitutionalization, a new discourse emerged that constructed mad people as *consumers* or *clients* (instead of patients) who should self-direct and be responsible for their own wellbeing in community settings. In this view, the end goal of treatment is to create a client who can monitor their own drug consumption without the need for further intervention for case managers (p. 167). Yet, similar to Estroff's observation, there are several contradictions which emerge in the case management of drugs. Staff must establish and maintain therapeutic rapport with the clients, otherwise they risk losing buy-in from clients and treatment plans can fall apart. Yet, case managers are also tasked with delivering and monitoring psychiatric drugs, which can create tension and compromise the therapist-client relationship. Second, he noted a contradiction in the hope for rehabilitation and drug effects. While drugs are argued to play a role in making clients more "able" and independent, their disabling effects may result in further disability.

With the same ethnographic source material, Longhofer, Floersch, & Jenkins (2003) introduce the conceptual framework of "the social grid of management" to guide social scientists in examining the processes of drug delivery in community-based treatment. Their work first introduces two key concepts. First, drug delivery invokes a complex hierarchical web of people who have their own personal beliefs and attitudes about mental illness, services, and the drugs. Second, compliance does not constitute a single event or action taken between a provider and client; instead, it should be understood as a broader process put into action by a client's social network. To explain this, they introduce the social grid of management. The social grid identifies the specific role each actor plays in psychiatric drug use. These actors include the client, informal supports (e.g., family), and formal supports (e.g., program staff). They describe five elements related to medication use: the presenting problem, prescription assessment, delivery and access, monitoring for compliance and effect, and reporting. Each of these stages involves a process where a social actor in the client network (family member, prescriber, case managers) interprets a client's experience and behavior in relation to the supposed drug effects. While Floersch described the formal meetings of treatment teams where drugs are discussed, the interpretations of drugs were most pronounced and meaningful in the "ebb and flow of daily living in the community" (p. 77). Here, when the gap between the *desired* and *actual* effects of drugs emerged (or as they term: aporia), actors in the social grid responded either passively or actively. When aporia was identified for clients who are identified as being unable to "self-monitor," actors increased the intensity of their duties. For example, a psychiatrist more closely evaluated and interpreted drug effects to adjust the client's drug prescription. As another example, a case manager may interpret undesirable behaviors from a client as relating to noncompliance to drugs. In one ethnographic example, a client's dirty apartment indicated to his case managers that the client needed to have an injectable drug to ensure compliance, which was presumed to lead to hygienic behavior from the client (p. 76).

In summary, Estroff (1985) and Floersch (2002) articulate that drugs represent the primacy of biopsychiatric discourse and power in the structure and delivery of community-based services. Drugs are intended to suppress symptoms and make clients more manageable, even independent and self-regulating in the community. Yet, clients may reject drugs as a rejection of medical interpretations of their experiences or to avoid the numerous adverse effects they produce. When noncompliance was identified (either through the client's own reports or through interpreting client behaviors as resulting from noncompliance), providers took on various tactics to intervene on clients and compel drug consumption. Often, this included increasing the intensity of tactics used or switching clients to injectable forms of medications. Lastly, both discuss how psychiatric medications are seen from many providers as a sufficient replacement of social support in services. Particularly for Floersch, compliance stems from broader political and economic motivations to create self-monitoring clients who are no longer dependent on the state.

While not explicit, there is an evident moral discourse involved in these ethnographic works. Here, placing people in a system that compels drug consumption is seen as justified because it will benefit the client (*medical paternalism*). Or, in other words, coercion and influential techniques were seen as justified and necessary to protect clients from perceived harms associated with mental illness, especially in community contexts. Further, providers did use a range of influential techniques. This included leveraging resources and offers. However, providers relied on persuasion and appealing to rationality first, which is consistent with other qualitative data (Angell, Mahoney, & Martinez, 2006). Estroff noted that persuasion was used repetitively with clients until clients agreed with providers or simply gave in. While this does not meet the criteria for formal coercion, it does suggest that techniques based in rational argument can be used to pressure clients into drug compliance. This may be related to the broader compulsory nature of drugs in psychiatric services. Of course, not all providers and clients experience drug effects the same. At times, providers recognized the capacity for the drugs to cause harm (*non-maleficence*) and questioned whether they were infringing on the liberties of clients (*autonomy*).

### ***Brodwin's Everyday Ethics***

How are we to understand these various social, economic, and political meanings of psychiatric drugs in relation to the moral discourse of providers? In an ethnography of an assertive community treatment program in the Midwest, Paul Brodwin (2013) examines the moral discourse of frontline staff performing case management services. Brodwin examined how ethical dilemmas are understood and resolved between overburdened frontline staff and clients with "psychiatric symptoms and profound social disenfranchisement" (p. 2).

First, Brodwin identified how enjoined systems of governmental and biopsychiatric power structure the duties and actions of frontline staff. Specifically, the staff abided by the county, state, federal, and clinical guidelines for decision-making in their work (p. 46). Staff were required to monitor client compliance of drugs and employed a "wide range of tactics" to do so (p. 58). Various techniques were employed with consideration to the importance of maintaining rapport. Regular “med and money drops” structure daily interactions between staff and clients. Brodwin writes:

> The medications, the daily schedule, and the back-and-forth transactions between clinician and client all embody the biopsychiatric viewpoint. This viewpoint structures virtually everything case managers do as the prosthetic extension of the psychiatrist. (Brodwin, 2013, p. 59)

In this sense, drugs were a symbol of biopsychiatric power which, like glue, held together the operations of psychiatric services.

Yet, Brodwin argued that these frontline staff were not mere extensions of state psychiatric power. In their daily work, they encounter the clinical and ethical shortcomings of their work which, at times, related to psychiatric drugs. Providers came to confront their own power to make decisions that would deeply impact the livelihood and wellbeing of their clients. Further, in fulfilling a role that encompass all areas of person’s life, frontline staff became intimately familiar with their clients – their daily lives, living spaces, friends and family, hopes and fears. Importantly, they directly observed the grave disability and vulnerabilities to poverty and victimization their clients were. In this sense, providers were deeply aware of what is at stake. At times, these vulnerabilities were seen to indicate the need for a medical intervention.

In a few moments, Brodwin indicated how drug effects were mapped onto moral reasoning. In one example, a doctor discusses slightly increasing the dosage of an injectable Haldol if they think the client looks “rough” (p. 103). This moment demonstrated how a disease-centered model of drug action can be incorporated into a moral framework: receiving consent from a client would not be necessary because the extra dosages are justified through their treatment potential. Of course, staff opinions vary regarding the efficacy of drugs to suppress symptoms and rehabilitate clients: some embraced this biopsychiatric narrative, others are more concerned regarding the client's right to decline. It is in these observations that Brodwin argues that bioethical principles emerged within the moral discourse of frontline psychiatry (p. 15), a phenomenon he terms as "everyday ethics." Through the lens of everyday ethics, it is evident that both the adoption of paternalistic and biopsychiatric logic, and providers' closeness to and desires to help clients that they can both justify or question coercion in psychiatric services.

Brodwin asks us to consider how strong endorsements or critiques of coercion (including normative ethical claims) may be too abstract for providers who see the "visible, concrete details of clients' lives" (p. 176). This is not to denounce the importance of such principles. Rather, Brodwin calls for us to understand the coproduction of moral discourse:

> [Bioethics] help[s] create the roles that clinicians play, the guidelines and goals for interventions with patients, and their moral perspective on everyday work. In this sense, moral discourse—the emergent, experience-near commentary on the rightness and wrongness of clinical action—is coproduced by formal bioethics and by the daily contingencies of work (Brodwin, 2008, p. 30)

In his observations, while providers considered aspects of beneficence, non-maleficence, and autonomy in their work, these values were distributed and mapped onto their evolving attitudes towards biopsychiatry and conditions of their clients' daily lives.

## Conclusions and Summary

To summarize, my literature review set out to understand how providers and their clients navigate decision-making related to psychiatric drugs in intensive outpatient services. To do so, first, I turned to philosophers to locate core principles in bioethical theory. While these higher-order concepts can guide our discussion, they do not necessarily specify the nature of decision-making in psychiatric services. To this end, I turned to the conceptual framework on the coproduction of moral discourse by Paul Brodwin, I explored the works of philosophers and psychiatric scholars to understand the concept of coercion. Borrowing from Nozick's definition, I explored coercion as an interaction where a coercer uses a threat to change an individual's decision. Further, I demonstrated that this concept of coercion does not include many other types of influential techniques used in care to gain compliance which also warrant ethical examination.

Next, I turned to the literature on OPC to understand the purpose and mechanisms of the program. I demonstrated that providers have a wide range technique (from little to total coercion) available to them, particularly due to the inclusion of both voluntary enrollment and court-orders in OPC. Next, I demonstrated limitations with previous OPC evaluations which, by quantifying coercion and influential techniques, cannot inform us how these techniques themselves actually emerge in treatment.

To understand psychiatric drug effects, I turned to both clinical and critical literature on drugs. I established that drugs are associated with adverse effects and, particularly with antipsychotics, are associated with high rates of discontinuation. Further, I established that psychiatric drugs bear meaning beyond clinical understandings: they produce a complex set of effects on users. Bringing these findings together, I explored three major ethnographies on community-based services. Here, some of our previous understandings of moral decision-making and psychiatric drugs are identifiable including their complex effects (and also responses by users) and the moral grey area for providers in enforcing their consumption through various influential techniques.

## Future Directions

There are several limitations to the existing research. First, while the introduced frameworks on coercion bear potential utility, I argue that such frameworks risk depicting acts of social control and coercion as transactional moments between a provider and client. At one moment, a decision on medications may involve inducement and, at the next, a decision on housing may involve persuasion. Yet, how do broader social, economic, and political elements shape the ways these various strategies are taken up by providers? A framework that can describe the real-time processes of employing coercion in relation to psychiatric drug effects and link these techniques to broader sociopolitical elements may help us better evaluate ethical claims related to coercion.

The ethnographic research suggests some plausible answers to these questions. For example, when drug effects were not seen as powerful enough (usually due to perceived non-compliance), providers reported being justified to use influential techniques to gain compliance again. Yet, the ethnographic findings presented here do not establish a conceptual model to clarify the relationship between various influential techniques used, the moral reasoning of providers, and interpretations of drug effects. For example, do specific perceptions of drug effects indicate to providers that specific types of influential techniques are justified? Or what factors do providers consider in their moral reasoning when using a coercive or influential technique particularly in regard to the intended and actual effects of psychiatric drugs? Lastly, how do we bridge the effects of what “is” in services (descriptive ethics) to what “ought” to happen (normative ethics)? A framework that addresses the complexities of drug use and coercive/influential techniques may help us ask the necessary questions to formulate an ethical theory of psychiatric services.

This literature demonstrates an overwhelming lack of support for providers and clients in managing the complex myriad effects of psychiatric drug effects. Yet, bureaucratic policy and biopsychiatric logic dictate that compliance is a key component to recovery. Here, at the intersection of compliance and the daily work of interpreting drug effects, providers have a wide range of strategies available to them. Which strategies they take up may vary depending on their own interpretation of the moral discourse and effects of psychiatric drugs; these strategies themselves may impact the ways in which drugs are delivered, monitored, and consumed. In the following sections, I describe how I analyzed these strategies and revealed their undergirding logics in involuntary outpatient commitment.

# CHAPTER 3

# METHODOLOGY

In this chapter, I revisit the purpose and aims of my dissertation. Next, I introduce my major methodology and the interpretive and conceptual frameworks that I use to guide my analysis. Next, I discuss my research design which includes information on my research setting and participants, methods for data collection, and strategy for data analysis and synthesis. I follow this with a discussion on ethical considerations and methodological limitations. Lastly, I discuss preliminary assumptions and findings in my analysis.

The purpose of this dissertation is to analyze how the management of psychiatric medications in involuntary outpatient services is undergirded by (a) provider and client interpretations of psychiatric medications effects and (b) moral discourses related to coercion and client autonomy. In doing so, I aim to explore the ethical implications of medicalized and coercive approaches to social services for vulnerable populations labeled with a serious mental illness. Further, I aim to explore how the practices of psychiatric medication use demonstrate the broader role of involuntary outpatient commitment in social welfare governance.

## Major Methodology

I selected qualitative inquiry to achieve my research aims. Broadly, qualitative inquiry provides descriptive representations and interpretations of social phenomena (Creswell & Poth, 2017). To do so, qualitative researchers examine specific social practices and the role of both their own and their subjects' phenomenological experiences and social meanings assigned to objects in shaping these processes. Observed social processes can encompass interactions between individuals and groups, particularly in relation to institutional or cultural norms. A key characteristic of qualitative inquiry is its emphasis on researcher subjectivity. In most qualitative traditions, the researcher is considered the instrument of research itself. In this sense, data and findings are discussed as rooted in the researcher's own theories, perspectives, and positionality.

The primary qualitative methodology of my dissertation is ethnography, where researchers become embedded in a social setting to directly observe phenomena of interest and interview participants. In their analyses, ethnographers identify patterns in participant behaviors and relate these to the worldviews held or expressed by their participants. This allows researchers to understand how complex and interacting systems work together to shape human behaviors, experiences, and social practices (LeCompte & Schensul, 2010). Further, it allows researchers to better understand the logics of cultural and social institutions that participants operate within (Creswell & Poth, 2017).

I selected qualitative inquiry and ethnography in order to achieve my research purpose and aims for several reasons. First, qualitative inquiry allowed me to gain an in-depth understanding of how people conceptualize drugs and moral values in treatment settings. Second, it allowed me to describe social practices related to psychiatric drugs, including how they are introduced in treatment, delivered to clients, and managed over time. Through this, identified patterns in the practices of psychiatric drug use in OPC services. Together, with both participant observation and interview data, I demonstrate how specific interpretations and practices related to psychiatric drug use reveal undergirding logics of involuntary outpatient commitment.

## Interpretative and Conceptual Frameworks

Interpretative frameworks establish philosophical assumptions about the nature of reality (ontology) and what constitutes knowledge (epistemology). By detailing the relationship between ontology and epistemology, researchers can select compatible methodologies and then employ specific processes for collecting and interpreting data to produce theories (Creswell &

Poth, 2017). The interpretative framework I selected is critical realism (CR). CR is a framework based in realism, which is a broad metaphysical theory that posits the existence of a reality independent of human observation. CR is concerned with analyzing the conditions that allow social phenomena of interests to emerge. To accomplish this, CR posits a specific ontological and epistemological framework which I explain in the following section.

CR was developed by Bhaskar (2013) to provide social scientists a framework rooted in realism, but avoids the shortcomings of positivism that has, as he argues, "usurped the title of science" (p. xxix). Broadly, positivism is an epistemological theory that posits that the scientific process provides a direct window into the laws that govern reality which scientists can then aptly describe. A major critique of positivism, however, is that it does not acknowledge the ways science is a product of human activity and informed by sociohistorical events. In this sense, scientific data is not a direct reflection of reality; instead, its production and interpretation to produce *knowledge* reflects shared understandings on the nature of reality and science (Kuhn, 2012). Further, Bhaskar (2013) contends positivism is particularly problematic in the social sciences. Objects of inquiry exist in an "open system" which consist of influences from human psychological processes and behaviors, social institutions and structures, broader discourses and cultural logics that the researcher themself is also embedded in. In contrast, physical scientists conduct research "closed systems" where scientists can eliminate confounding variables in a controlled experimental setting in order to identify causal mechanisms.

One response to the issues posed by positivism is social constructionism. Social constructionism is a sociological theory of knowledge articulated in *The Social Construction of Reality* by Berger & Luckman (1967). Broadly, this theory posits that every day knowledge consists of assumptions that people share with one another, which then directs their everyday interpretations of the world and behaviors. Further, these human actors take for granted these everyday understandings as constituting ontological truths in and of themselves. Constructionism allows researchers to consider the central role of language, which in itself restricts actors to communicate their experiences and ideas within constructions, and the role of social institutions as constructing these linguistic worlds people are born into. Strong social constructionism, the object of Bhaskar's critique, contends that the production of knowledge co-constructs reality itself. Or, in other words, that the creation of scientific discourses creates the conditions for which social reality is established and then reified through knowledge production. However, through this framework, researchers risk portraying actors as extensions of broader political discourses. It also denies the researcher grounds to pursue pragmatic implications of their work – if their interpretations of reality *create* reality, how can a researcher establish what exists in the world and what should change to improve it?

To create a new framework that responds to the shortcoming of positivism and strong social constructionism, CR posits a specific set of epistemological and ontological conditions. First, epistemologically, CR considers science as a product of human activity by distinguishing between intransitive versus transitive entities. Intransitive entities are mind-independent phenomena (i.e., objects of reality). Transitive entities are the theories developed to understand objects of study. Through this distinction, scientific inquiry can be understood as a cultural pursuit to propose explanatory theories (transitive entities) about reality (intransitive entities). Together, this allows researchers to understand knowledge as partially socially constructed, though still capable of pursuing truths about the nature of reality.

How does Bhaskar explain the relationship between intransitive and transitive entities or, in other words, to what extent do transitive entities represent intransitives ones? This question returns us to ontology in CR. Bhaskar purports a three-fold stratified ontology: *the real, the actual, and the empirical.* Each of these are consider emergent domains of reality. The *real* is constituted by structures that underly all reality. This includes physical (e.g., medications), psychological, (e.g., cognitive processes) and broad social (e.g., mental health policies or psychiatric discourses) structures. These structures have generative mechanisms; that is, they have the *capacity* to produce events which may or may not happen; or, in other words, these structures set conditions for events to take place. The *actual,* the second domain, consists of events that are generated when mechanisms are activated. (For example, a medication may be taken which activates a biological event in the body.) Third, the final domain, *the empirical,* emerges from the *actual.* The empirical consist of events that are observed and experienced by humans, which can be measured or described through scientific inquiry. (For example, the biological event of taking a medication produces an observed change in a person's psychological experience.)

This ontological stratification allows us to understand that social phenomena are emergent from undergirding physical, psychological, and social structures, without needing to make assumptions on the tendencies of structures to produce said phenomena. The relationship between research and object is not characterized by positivism either because the researcher is not studying structures in and of themselves. Instead, researchers produce knowledge about reality through understanding the observable events that emerge from the structures. By having to induce how structures function in *the real* by only having access to *the empirical*, there is room for human interpretation, bias, and error to shape the process of knowledge production. To this end, the goal of scientific inquiry guided by CR is to understand the capacity of structures to be conditions for social phenomena of interest to emerge. Part of this process entails researcher reflexivity: to understand how one’s own positionality shapes the interpretation of data, which allows the scientific community to account for human bias in the interpretation of events and develop a more accurate depiction of reality.

How do these assumptions pertain to my ethnography? First, I assumed there was a shared reality between all the participants and researchers, which gave rise to the various social phenomena of interest, including the delivery, consumption, and management of drugs medications. These phenomena, however, was interpreted differently by each individual due to their unique perspectives and positionality that, in part, was emergent from broader social structures and discourses. The goal of my inquiry was to identify the role that these interpretations play in giving rise to the shared reality across participants.

In regard to the aims of this research project, my level of analysis mainly remained in the realm of language. I took a soft social constructist lens and avoided abstracting issues of power and violence as issues of discourse alone. Through CR, I aimed to emphasize the multifaceted nature of social issues which, in part, included the role of discourses and the ways scientific knowledge has shaped mental health services. Guided by Bourgois (2002), I considered ethnography as a tool to explore the complex process of meaning-making, though with the intent to confront “power relations in flesh and blood” (p. 419) and advocate for structural changes in the real world.

While CR is an interpretive framework to ground my ethnography, I identified two conceptual frameworks to guide my analysis of my data. These frameworks include *the coproduction of moral discourse* and *psychiatric drug effects as a social construction*, which were formally introduced in Chapter 2. While these conceptual frameworks emphasize the social nature of meaning, they are still comprehensible in the broader philosophy of CR. My philosophical assumption regarding psychiatric drugs was that they have real effects on users outside of any socially constructed meaning or their neurobiological mechanisms alone. I made similar assumptions regarding moral reasoning: providers weighed moral decisions regarding the material conditions of their clients. To this end, while these frameworks emphasize language and meaning, I did not view research participants and their actions as products of discourse alone. Similarly, I considered that participants may understand or describe their experiences outside of discursive power, particularly when a discourse falls short. For example, a drug effect may be incomprehensible to a client when using the preexisting language provided by biopsychiatry; in response, they might create their own conceptual frameworks, including their own language, to understand their experiences.

## Research Design Overview

My ethnography examined an involuntary outpatient treatment program. To answer my research question, I produced two types of data. First, I produced data that revealed the *psychological interpretations* of (a) psychiatric medications and their effects, and (b) moral discourses of coercion. In relation to psychiatric medication effects, I produced data that explored the meanings assigned to medications, including descriptions of their expected and actual effects. This data was produced from clients who are prescribed medications, their providers who are tasked with delivering and managing medications in OPC, and any other related observers or actors such as family members. In relation to moral reasoning, I produced data that explored how clients and their providers interpret the role of *morals* in relation to decision-making. Broadly, *morals* refer to principles that are used to evaluate, reject, or justify behaviors as permissible, particularly as it relates to client autonomy in decision-making (and related constructs such as coercion) related to psychiatric drug use. Moral reasoning refers to the ways these moral in themselves and incorporated into decision-making and their behaviors (e.g., a provider may reason that the moral of *client autonomy* is the most important principle and thus agrees to allow a client to decline prescribed medications). Moral discourse refers to patterns in moral reasoning and can be identified across providers. In my analysis, I examined the relationship between the interpretations of psychiatric medication effects and the moral discourses of coercion through a process termed memoing.

Second, I produced data that demonstrated patterns of how psychiatric drugs were delivered, consumed, and monitored. This data was produced from observations of providers and clients within the OPC program. Delivery refers to the ways in which drugs are discussed, prescribed, and physically distributed to clients throughout their treatment period. Consumption refers to whether clients ingest medications at all, the ways in which clients *do* ingest the medication, and the ways their medication consumption is structured into their daily lives. Relatedly, management refers to the activities performed by providers to ensure clients are consuming medications, the interventions produced to address compliance/noncompliance, and adjustments made to medications. Within and across this data, I identified patterns related to coercion and influential techniques. Specifically, I produced data to demonstrate the role of coercion and influential techniques in delivering medications. For example, a key aspect of client autonomy relates to whether clients are able to act on their treatment preferences. To evaluate this, I identified patterns that indicate whether their consumption is through their own accord or through an imposed structure. Through analytic memoing, I examined the ways in which the relationship between interpretations of medication effects and moral discourses of coercion related to how medications are managed in treatment.

While my data primarily represented clinical encounters related to medication use, an important source of data pertains to the ways psychiatric medications were discussed and managed outside direct clinical interactions between providers and their clients. This included examining how psychiatric medications were discussed between outreach and frontline providers during team meetings, administrative staff who review client referrals to AOT, and in courtrooms (including between staff, such as judges or public defenders, and clients). This information demonstrated the broader logic of psychiatric medications and the context that supports the use of psychiatric medications in AOT-LA clinical interactions.

Together, these data represented the ways in which the interpretations of psychiatric drugs and the moral discourse of coercion emerge in and shape the real-time processes of psychiatric drug use. To this end, my two data collection methods included participant-observation and interviews. Through interviews, I gained a deeper understanding of how individuals described their interpretations of psychiatric drug effects and the moral discourse of coercion. Through participant-observations, I directly observed and described the processes of delivering, consuming, and managing psychiatric medications. The relationships between the components of my project are identified and explored through my analysis. The specific strategies for synthesis and analysis – memoing – are explored later in this chapter.

## Research Approach

This dissertation project exists within a broader evaluation of an OPC program in Los Angeles County (LAC). My dissertation project differed from traditional ethnography. While some ethnographies entail the in-depth subjective experiences of researchers, the ethnographic field notes and interviews for this project are produced from an interdisciplinary team. The advantage of this approach is twofold. First, the OPC program examined here does not have a central site. It is organized into bureaucratic layers, including various administrative bodies, overhead staff at contracted agencies, and hierarchies within the treatment teams. Through a team-based approach, my analysis was able to examine data produced from many sites and participants. Second, the data was produced and analyzed with participants of varying social identities, positionalities, and perspectives, which hopefully contributed to the rigor of the results. Later, I discuss how my research team accounted for this diversity. I listed the names, degrees, and contributions of each ethnographer in Appendix B. My specific contributions to the project are identified through the description of my research methods.

### ***Ethnographic Setting***

My ethnography examined the OPC program in Los Angeles County Department of Mental Health (LACDMH). The local name for this program in LA is the Assisted Outpatient Treatment (AOT) program, or AOT-LA from this point forward. AOT-LA was selected as an ideal site to study psychiatric drugs and coercion for several reasons. First, LACDMH is the largest county mental health organization in the United States and covers a diverse metropolitan area. This resulted in a rich heterogeneous set of observations and interviews in regard to race and ethnicity, class, and sex and gender. Second, AOT-LA included an outreach and engagement (O&E) component that aimed to have clients voluntarily agree to services. If clients decline, they must sign a settlement agreement or receive a court order. Thus, the program design provided treatment teams various strategies and tactics to achieve client compliance, some more overtly coercive than others. This allowed me to observe and analyze a broad spectrum of coercive and influential techniques in treatment. Third, my dissertation project was part of a broader evaluation of the AOT-LA. I gained access to many types of data and treatment spaces, which are traditionally difficult to access.

*AOT-LA evaluation.* In 2016, The Los Angeles County Department of Mental health (LACDMH) contracted the UCLA Center for Social Medicine and Humanities at the Semel Institute for Neuroscience and Human Behavior to evaluate AOT-LA. My ethnography was part of this evaluation. The project was a mixed-methods evaluation using reviews of administrative records, provider questionnaires, and ethnographic observations of treatment. The research team consisted of psychiatrists, medical residents, psychologists, and anthropologists, and me as a social worker. The ethical implications of conducting an ethnography as part of an evaluation is explored in a section dedicated to ethics, after I described the specific methods that we employed. The methods described in this chapter were developed as part of the evaluation.

*Ethnographic settings.* There were three major ethnographic settings. The first two were the two phases that clients flow through: (1) outreach and engagement and (2) treatment. The third ethnographic setting is the Mental Health Court of Los Angeles County. I now discuss each of these settings separately. The activities of O&E were centralized at two sites where administrative and frontline staff meet to evaluate and assign caseloads to frontline outreach staff. The two sites were located in the neighborhoods of Little Tokyo and Lomita of Los Angeles. The frontline staff conducted mobile services in the field across Los Angeles County. As the name implies, frontline outreach staff located and regularly met with referred clients in order to gain voluntary enrollment. (Note: “in the field” refers to any services located outside of office spaces where clinical services are conducted and can include clients’ homes and shelters or non-residential settings such as shops or restaurants.)

In regard to the treatment phase, LACDMH contracted 21 private mental health agencies to conduct AOT-LA services. No directly operated LACDMH clinics conducted AOT-LA services. AOT-LA services were a mix of field-based services (or full-service partnerships, FSP) and board-and-care facilities (enriched residential facilities, or ERS). FSP services were provided to clients residing with family members or caretakers, in their own housing, non-AOT board-and-care facilities, homeless shelters, and in make-shift encampments across Los Angeles County. In contrast, ERS facilities were board-and-care facilities contracted by LACDMH to deliver AOT-LA services. These facilities generally included shared bedrooms for clients, common living spaces, and spaces for clinical services and group therapy.

The third ethnographic site was the Mental Health Division of the Los Angeles County Superior Court. The Mental Health Division was responsible for overseeing AOT-LA clients who received petitions or mandates to partake in services, typically once the O&E team believes the client will not voluntarily enroll. Broadly, the Division is staffed with several judges who are assigned courtrooms and cases pertaining to mental competency, mentally disordered offenders, and civil commitment hearings. Court hearings related to AOT-LA occur weekly. In the courtrooms, petitioned and enrolled clients met with judges to discuss the details of their case and treatment progress. Clients were assigned a public defender. At times, outreach and treatment staff attended hearings to support clients and/or the judges. Only clients who signed a settlement agreement or were mandated were required to attend monthly progress reports with judges. In court hearings, judges discussed psychiatric medications and compliance with clients and their providers.

### ***Research Population***

As an ethnography, this research project observed individuals who represent distinct roles in AOT-LA, including judges, policymakers, administrative staff, residential staff, law enforcement, family members and caretakers, and health and mental health professionals from various disciplines. However, two key populations – providers and their clients – were recurrent in our observations and semi-structured interviews and I considered them central informants for answering my research questions for several reasons. They were directly involved in the delivery of medications and previous research demonstrates that frontline providers make daily judgements regarding how to manage psychiatric medications in relation to their perceived decision-making capacity and well-being of clients (Brodwin, 2013). Guided by CR, I argue that the ways medications are mandated, in real-time, are emergent from underlying social structures and discourses regarding the medical management of populations with serious mental illness. However, true to the ethnographic tradition, my analysis remained open and examined instances in which psychiatric medications were discussed or managed across ethnographic settings (i.e., administrative settings, outreach and engagement, treatment, and mental health court). While the delivery of medications was the central focus of my research question, I aimed to identify the logics that informed modes of medication through examining other spaces.

The first major population was the various frontline staff of AOT-LA. Frontline staff were responsible for delivering outreach and treatment services. Each component of the AOT-LA program (outreach, treatment, and courts) has its own distinct set of frontline staff. The outreach frontline staff consisted of social workers, psychologists, and nurses who were employed directly by LACDMH under the Emergency Outreach Bureau. The treatment frontline staff consisted of individuals who were employed by the various private organizations contracted by LACDMH to deliver AOT-LA services. In our early conversations with administrative staff from AOT-LA agencies and prior to beginning ethnographic observations, our research team learned that each AOT-LA program differed in terms of the frontline staff composition. Generally, frontline teams consisted of the following: (a) therapists who are tasked with delivering psychosocial interventions; (b) case managers who were tasked with conducting community integration services and often had a bachelors or master's degree in social work; (c) psychiatrists who prescribe and manage medications, and (d) team leaders who were responsible for overseeing the management of cases. Therapists, case managers, and team leaders had degrees in the *psy*- or related helping professions, though these roles were also fulfilled by students in-training. Lastly, the courtrooms consisted of judges, legal representation and aid (lawyers), and the Los Angeles Sheriff's Department. Notably, for this dissertation project, I was primarily interested in understanding the behaviors of providers who are tasked with delivering and managing psychiatric medications. To this end, the specific roles that I observed at each agency differed depending on how responsibilities are distributed. In my analysis, I discuss the professional background, role in services, and characteristics of the key providers in the ethnographic notes. As a note: in my dissertation I refer to the social grid of medication management, which includes any and all individuals involved in the delivery and management of medications, including administrative staff, frontline providers, and caretakers.

The second major population were the people who were referred to and enrolled in AOT-LA. In this section, I describe who is eligible for the program and the sociodemographic information of enrolled AOT clients. Mental health providers, peace officers (i.e., police), and family members of clients are permitted to refer individuals to AOT-LA. As previously explored, this is the eligibility criteria for enrollment in AOT as written in the California Welfare and Institutions Code , Division 5, Chapter 2, Article 9, 5346 a1-9:

(1) The person is 18 years of age or older.

(2) The person is suffering from a mental illness as defined in paragraphs (2) and (3) of subdivision (b) of Section 5600.3.

(3) There has been a clinical determination that the person is unlikely to survive safely in the community without supervision.

(4) The person has a history of lack of compliance with treatment for the person's mental illness, in that at least one of the following is true:

> (A) The person's mental illness has, at least twice within the last 36 months, been a substantial factor in necessitating hospitalization, or receipt of services in a forensic or other mental health unit of a state correctional facility or local correctional facility, not including any period during which the person was hospitalized or incarcerated immediately preceding the filing of the petition.
>
> (B) The person's mental illness has resulted in one or more acts of serious and violent behavior toward themselves or another, or threats, or attempts to cause serious physical harm to themselves or another within the last 48 months, not including any period in which the person was hospitalized or incarcerated immediately preceding the filing of the petition.

(5) The person has been offered an opportunity to participate in a treatment plan by the director of the local mental health department, or the director's designee, provided the treatment plan includes all of the services described in Section 5348, and the person continues to fail to engage in treatment.

(6) The person's condition is substantially deteriorating.

(7) Participation in the assisted outpatient treatment program would be the least restrictive placement necessary to ensure the person's recovery and stability.

(8) In view of the person's treatment history and current behavior, the person is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would

be likely to result in grave disability or serious harm to the person or to others, as defined in Section 5150.

(9) It is likely that the person will benefit from assisted outpatient treatment.

According to the latest report by the AOT-LA evaluation team (Braslow, Starks, Kelly, Meldrum, & Bourgois, 2020), AOT-LA received 2307 referrals. Only 1187 (51.45%) of these referrals met AOT criteria. I will describe the demographics of referred and eligible clients to the AOT program as our ethnographic observations includes participants who are in the outreach and engagement phase but may not enroll. Of the eligible clients, the mean age was 37.74 (*SD* = 12.78). The majority of referred and eligible AOT clients were male (*n* = 755, 64.6%), 34.6% were female (n = 420), 10 identified as transgender. Of the trans-identified clients, 2 identified as female-to-male and 8 identified as male-to-female. Of referred and eligible AOT clients, 389 (31%) were White, 370 (31%) were Hispanic/Latinx, 291 (24%) were Black and/or African American, 110 (10%) were Asian and/or Pacific Islanders, and 27 (2%) had other or unlisted racial or ethnic identities. In regard to the clinical diagnoses of referred and eligible AOT clients, 834 (73%) were diagnosed with schizophrenia, 142 (12%) were diagnosed with schizoaffective, 69 (6%) were diagnosed with psychotic disorder NOS, 80 (7%) were diagnosed with bipolar, and 14 (1%) were diagnosed with mood disorders.

### ***Sampling***

Our sampling was guided by purposeful sampling, a method where researchers intentionally selected participants so that their overall sample represents a specific set of demographics and characteristics. Guided by traditional ethnographic approaches, this method examined the ethnographic field as widely as possible to achieve maximum variation (Creswell & Poth, 2017). Our sampling was conducted in an iterative process alongside our preliminary analyses in order to identify emergent themes and guide future case sampling. Subsequent sampling identified key informants who represented “information-rich cases” which allowed us test, verify, and falsify patterns or theories we constructed through the data analysis process (Suri, 2011, p. 5). We ended data collection when our research team believed it had reached theoretical saturation. In this section, I discuss how our team reached theoretical saturation more specifically in relation to the participant-observation and semi-structured interviews.

Through the participant-observations, we gathered approximately 1000 hours of data. The ethnographic research team divided their participant-observations into the three settings: (a) outreach and engagement, (b) treatment, and (c) court rooms. Charlotte Neary-Bremer, an anthropology doctoral student at UCLA and visiting physician from the UK, conducted an intensive ethnographic examination of the O&E phase (see Appendix B). In regard to the treatment phase, the ethnographic research team aimed to make at least one observation with each contracted agency. After an initial examination of the agencies, the ethnography team conducted imbedded ethnographies with the agencies that regularly are assigned OPC clients who represent a broad set of clinical needs. In order to achieve my research aims related to participant-observations, I sought theoretical saturation to understand the processes related to the delivering, consuming, and managing of psychiatric medications. To achieve this, sampling focused on treatment sessions where providers conducted medication management services with their clients. Lastly, one ethnographer regularly attended weekly court hearings at the Los Angeles Superior Court. Ron Calderon, a social work student and coordinator for the Center of Social Medicine and Humanities, conducted an intensive ethnographic examination of the courtroom.

Semi-structured interviews were conducted with key informants in our participant-observations. In total, 56 interviews were conducted among 20 clients, 21 providers, and 12 client family members. Interviews helped inform our understandings of observed behaviors among staff, clients, and their support systems in the field notes. To achieve maximum variation, I interviewed cases where clients were totally compliant to medications, sometimes compliant to medications, and totally noncompliant to medications. This allowed me to understand how various attitudes towards medications may relate to specific medication behaviors. Further, it allowed me to identify how providers respond to and justify a full range of medication behaviors from their clients. In order to achieve my research aims related to semi-structured interviews, I sought theoretical saturation in relation to understanding the interpretations of psychiatric drug effects and moral discourse of coercion of both providers and clients.

## Data Collection Methods

In this section, I discuss the specific steps taken by me and my research team to collect data. First, our team embedded ourselves into the ethnographic settings. To do so, we first discussed the project with administrative staff at contracted agencies. This is because administrative staff and program directors serve as gatekeepers to sites where clinical interactions take place. (The ethical implications of gatekeeping are discussed later.) In discussing the project with the administrative staff and program directors, we discussed the design and delivery of AOT-LA services at their program. We asked questions about the size, and clinical and social demographics of their assigned caseload. During this time, we discussed the AOT-LA evaluation project, including ours aims and methods. Further, the ethnographers were introduced to the treatment providers. The ethnographers discussed how and why participant-observations were being conducted and responded to questions or concerns by the administrative and frontline staff. Once we discuss the research project with the administrative staff at agencies, the ethnographers sought permission to conduct observations at their local sites. Next, I met clinical teams at one of their weekly staff meetings. Here, I introduced myself and the overall aims and approach to my research. I asked providers if I could conduct observations of their services. Once I gained verbal consent of the providers to conduct field observations, I began my observations of treatment sessions. In contrast, the courtrooms are open to the public to attend. The ethnographers sat in the audience and took notes on the interactions between judges and clients. The ethnographers also introduced themselves to the O&E staff, who frequently attend court hearings to discuss client cases with judges.

### Participant-Observation

Primarily, participant-observation was used to collect data at three sites: O&E, treatment, and court rooms. For the first site, an ethnographer examined the outreach and engagement process to observe the tactics used to enroll referred people. For the second site, an ethnographer examined the treatment process to observe the tactics to engage clients and achieve medication compliance. For the third site, an ethnographer examined the court hearings to observe the interactions between judges and court-mandated clients in AOT. In my participant-observations, I observed how clients and providers interact over multiple treatment sessions. I paid particularly attention to discussions and behaviors related to psychiatric drugs and their effects.

Our research team standardized the process of writing field notes. The ethnographers wrote field notes immediately after each field visit. The notes included descriptive observations of the O&E, treatment, and court room processes. We standardized the inclusion of key information in the title of the notes, including the date of the observation, the location of the observation, and the initials of the ethnographer. In the notes, the ethnographers wrote their direct observations. This includes the content of conversations between referred and enrolled AOT clients, provider and administrative staff, and/or family members; the behaviors of these individuals in relation to delivering or receiving services; and their experiences interacting with these individuals in the field. The ethnographers included personal reflections at the end of notes, including their own emotional experiences, speculations, and ideas related to theory building. The notes were de-identified to protect the identities of the research participants. Once completed, the notes were uploaded onto a shared and protected database. Throughout data collection, the AOT-LA evaluation and ethnography team met to read and discuss emerging themes in the data. These discussions helped ethnographers identify areas that needed further investigation or biases in their field notes. A central theme included both the issues of consent/coercion and psychiatric drug effects. Overall, our team collected over 1000 hours of research observations across the three research settings (courtrooms, outreach and engagement, and treatment).

### Semi-Structured Interviews

The ethnographers conducted semi-structured interviews with administrative staff, providers, clients, and their support systems. In the interviews, the ethnographers sought to deepen their understanding of individuals' personal beliefs and perspectives on AOT-LA. Except for the client medication interview, the protocols were developed by the qualitative directors of the project, Marcia Meldrum and Philippe Bourgois, in order to standardize our team's interviews.

Interviews were conducted with three populations: providers, their clients, and key informants. Interview protocols are listed in Appendix A. Interviews with providers examined their role and duties in AOT services, their previous experiences in delivering services, the facilitator and barriers to client recovery, and their beliefs on the efficacy of medications and coercion. Interviews with clients explored how they became involved in AOT-LA, their experiences with treatment providers and medications, what they would like to receive from AOT-LA services, and whether they view AOT-LA as helpful. The second interview protocol for clients related to client medication experiences. This interview protocol explores how people interpret their experiences with psychiatric drugs, whether or not they feel supported in drug decision-making, and how they understand their decisions in whether to comply. Interviews with key informants were conducted at the discretion of the ethnographers in order to gain a more thorough description of client history and experiences with psychiatric treatment. A major source of these interviews was clients' family members and providers. Lastly, all clients who partook in the interviews received at $20 gift card to Target.

The semi-structured interviews were recorded. They were conducted on password protected and encrypted electronic devices. Researchers were only able to upload the electronic audio files onto a computer in our research laboratory. Ethnographers transcribed their own interviews onto a Word file, which were then later checked for accuracy by a second researcher. After they were checked, the interview transcriptions were uploaded onto a shared and protected database. Similar to the ethnographic notes, the interviews were labeled by date and with the initials of the ethnographers. The transcripts were analyzed alongside ethnographic notes and informed our analyses of one another.

## Methods of Data Analysis and Synthesis

All the data (field notes and interview transcripts from the entire ethnographic research team) were uploaded onto NVivo. Using a shared titling system, we organized the data in chronological order by date. In order to keep track of key research participants, we developed a second tracking sheet to list in which documents participants are located. This includes participants who were repeatedly observed in our ethnography, played central roles in shaping AOT-LA processes, or who had notable and informative experiences in AOT-LA.

Our data analysis was guided by thematic analysis. In thematic analysis, researchers code data with words or phrases to index phenomena of interest (Creswell & Poth, 2017). Then, researchers extract coded data to focus on specific themes. For our analysis, a coding tree was developed by the ethnographic research team and included codes related to psychiatric medications and coercion. To develop the coding tree, our ethnographic team reviewed field notes and constructed preliminary themes. Next, we used the preliminary themes by having each member of our team separately code selected field notes. We met to review agreements and discrepancies in our applications of the codes. After discussion, our team came to an agreement and revised the codes. This process was conducted over a year-long period until we established a consensus on the structure and logic of the coding tree. During the coding process, the codes were applied to discrete incidents in the data. For example, a fieldnote that describes a case worker visiting a client may be coded as "Case management." A portion of the fieldnote may describe a case worker and client discussing welfare; in this case, that portion of the field note is coded as "welfare."

In order to move from data to theory, I followed a specific process of memoing as suggested by Charmaz (2014) and Miles, Huberman, and Saldaña (2013). Specifically, three types of memos were written in the following order: textual, theoretical, and integrative. For the first stage of the analysis, I wrote textual memos. Textual memos were written during the process of coding. These memos extracted information in the notes related to my research questions. As an example, in an excerpt that involves a provider delivering psychiatric medications to their client, the textual memo outlined the specific behaviors and conversations that occur in the note. Textual memos also included initial impressions and reactions I have in reading the data.

The second set of memos were theoretical memos. In this stage, I first extracted all the data coded as "psychiatric drugs" and "coercion/consent" from the entire dataset. I organized the notes by chronological order and grouped them by key participants in order to analyze how specific client cases developed with time. I reviewed this data, their associated textual memos, and identify patterns related to my primary research question. In my theoretical memos, I began to form preliminary and emergent categories in the data related to my research question. For example, I developed a set of memos related to "rapport in coercive relationships." Within these memos, I pulled together both instances and quotes from the data as well as my own reflections in my textual memos.

In the last stage of my analysis, I conducted integrative memoing. To do so, I reviewed my theoretical memos to identify the relationships between key themes in my data. Specifically, I extracted each thematic category I constructed and considered the relationship it had to every other thematic category. This included revisiting both my data and textual memos to identify patterns in the relationship between key themes. While writing my integrative memos, I sought to identify a central organizing theory to explain the relationship between the prominent themes in my data.

## Methodological Integrity

The goal of the following procedures was to ensure that data accurately reflected the personal observations of researchers and participants, personal biases were accounted for, and multiple perspectives were incorporated into the synthesis of data in order to create knowledge that accurately depicts how social phenomena occur and emerge from social structures (Creswell

& Miller, 2000). I explored integrity using the four criteria introduced by Lincoln and Guba (1986): credibility, dependability, confirmability, and transferability. Notably, there are many methods of ensuring credibility and integrity in qualitative research. These specific criteria were selected because my interpretative framework, critical realism, aligns with Lincoln and Guba, who assume that there is a shared social reality which is constructed differently by individuals. As I explore with CR, I assumed that each researcher in my ethnographic team was observing social phenomena emergent from similar social structures, including the community mental health services and broader systems such as psychiatric discourses.

Credibility refers to whether the data accurately reflects the real-world processes and perceptions of research participants. This issue is partially addressed through our team-based ethnographic approach. Namely, by having multiple researchers in the field and collaborating in our data synthesis, we were able to triangulate our observations. In some instances, two or more ethnographic researchers contributed to the same ethnographic fieldnote. Further, during our analysis, we held meetings to discuss our interpretations of the notes and the primary authors clarified key questions related to their own observations. These meetings allowed researchers to challenge each other's biases and approaches to field observations, which aided in keeping researchers accountable to writing accurate notes through various perspectives. Lastly, our findings are triangulated with the quantitative health services data collected by LACDMH. This data includes rates of referrals, admissions, loss-to-follow ups, incarcerations, instances of violence, and termination of services.

Dependability, the second criterion of methodological integrity, refers to whether data has been collected in a consistent matter over a period of time. All our data collection had a clear audit trail. Our notes keep track of the date and place of observations. All meetings to review data and construct our thematic coding tree included clear minutes.

The third criterion, confirmability, refers to whether the results of the findings are demonstrably linked to a replicable process of data synthesis and analysis as opposed to the researcher imposing preexisting concepts onto the data without identifying them. To achieve this, I conducted regular memos where I critically reflected on the role of my identities, assumptions, and biases in collecting data. I accounted for these when producing and analyzing my notes. The last section of this chapter includes a list of my current assumptions and biases. Another approach taken to increase confirmability relates to the audit trail. Our analysis has a clear and replicable process through the production of our audit trail.

The fourth criterion of methodological integrity, transferability, refers to whether the researchers have developed "descriptive context-relevant findings that can be applicable to broader contexts while still maintaining their content-specific richness" (Lincoln & Guba, 1986, p. 205). In other words, while qualitative research does not aim for generalizability, it can identify or highlight key relationships between concepts or social processes that bear relevance to other contexts than those in which the research was conducted. In order to achieve this, our research project paid particular attention to the contextual factors that influenced the implementation of AOT services. Ethnographers were able to produce notes not only in the court room, and outreach and treatment phases, but also conducted observations of administrative staff and other key events that inform us how mental health services operate in Los Angeles County. This allowed us to create a rich description of not only the AOT processes that directly include clients themselves but consider and account for the role of various institutional practices and policies, and socioecological factors unique to Los Angeles County.

A related topic to these concerns regards the ethical use of source material given that each ethnographer provided unique written contributions to the project. Our team discussed whether and when ethnographers should be credited as an author for publications, given that materials and interpretation of said materials were key to synthesizing data and theory. In the early stages of the ethnography, I created a set of guidelines that we agreed to use for authorship (see Appendix C). Broadly, these guidelines are not a strict set of rules, but are instead intended to guide conversations between an ethnographer and any team member using their source materials to ensure proper credit is given for their intellectual labor. For this dissertation, as the person who coded and synthesized the analysis, I am the primary author though I have also indicated which team members wrote which notes throughout the results section.

### ***Researcher Description and Reflexivity***

My identities and experiences informed how research participants viewed and interacted with me, as well as informed how I produced and analyzed my research data. To my analysis, I bring over ten years of research, activist, and professional experience related to mental health. First, I worked several years as a research coordinator on clinical trials related to antidepressants and atypical antipsychotic effects at a major university. Through these experiences, I have experience with the biopsychiatric literature on drugs and their effects. Second, I engaged in disability and mental health advocacy at the same university. This included creating new procedures related to discriminatory responses to psychiatric emergencies in student housing. Specifically, I instituted policies that required student leaders in a housing association to receive training on conflict-resolution and how to support students who are in crisis. Third, I received training as a social worker that included two internship placements. I performed case management services for youth at a middle school. In my second placement, I was a policy intern at the Department of Mental Health's Office of the Medical Director where I wrote, revised, and evaluated policies and procedures related to AOT. These trainings have oriented me to the duties and responsibilities of social workers, especially as they relate to mental health services. Further, I am familiar with some of the frontline and administrative staff in AOT.

Prior to beginning my project on AOT, I was firmly opposed to mandatory treatment, except for instances in which an individual is at imminent risk of harming themselves or other people. Philosophically, my stance was rooted in my belief that psychiatric services incorrectly locates social distress as a phenomenon caused by human biology rather than social conditions related to inequity and oppression. In my view, a more humane approach to madness and distress would focus on creating social conditions that allow humans to flourish, rather than reactively through biomedical intervention. Further, I believed that biomedical approaches defanged political movements to address the structural roots of human suffering and, through delivering medications, subjected vulnerable patient populations to harm. Personally, I have witnessed close friends be hospitalized or coerced to take high dosages of multiple psychiatric medications, which left them feeling traumatized by our medical system. These experiences, though indirect, have contributed to my critical stance towards biopsychiatry.

My views evolved throughout the course of my ethnography. First, while I believe in a dramatic revisioning of the welfare state for people experiencing madness and distress, my exposure to the material conditions of people living with severe disabilities has demonstrated an urgent need for services that can assist disabled populations. While reform, or even abolition and a fundamental revisioning for social services, is needed, I also believe in the importance of short-term solutions for individuals in distress now. Second, I believe that the institution of medicine can play an important role in advocating for systemic change and supporting disabled populations. These populations need medical assistance and, perhaps, psychiatric medications can play a role in augmenting or shaping aspects of their subjective experiences that cause major distress or disability in their life. Whether medicine can play this role in ways that do not entail coercion or influence, I believe, is a central point of exploration in my dissertation project.

With these perspectives, I remain highly critical of coercion and influence in psychiatric services throughout. I understand the referred and enrolled clients of AOT as often ignored, misunderstood, and misrepresented in popular media and the broader scientific literature. This is evident in my approach to participant-observations and semi-structured interviews. I take time to listen to what participants are saying, explore their definitions for concepts, and center their meaning-making in the process. I often provide space for them to elaborate on their experiences, as I view these stories as important and valid insights to advocate for social change. Similarly, I am sympathetic to proponents of involuntary services, particularly the family members and caretakers who feel they have no other systems to support them. Understanding their justifications for perpetrating a system of coercion and control over disabled and mad populations may reveal the ways their logics are informed by their unique vulnerabilities or concerns.

**Working Assumptions**. I defined the working assumptions that guided my analysis. These assumptions relate to my previous experiences working with LACDMH as well as initial ethnographic observations in the field. For each assumption, I provided an explanation, examples, and explore underlying assumptions. By disclosing these working assumptions in my proposal, I was more reflexive in my data analysis and better identified my biases to avoid jumping to early conclusions.

My first assumption was that for providers, the primary goal of AOT is to make clients compliant to medications. I have observed that medications and medication compliance are given primacy over other interventions (including psychotherapy and case management activities) in OPC services. In some cases, providers explicitly state that medication compliance is the primary goal for their clients. In other cases, while providers acknowledge the importance of and incorporate other psychological and social interventions in their work, the primacy of medication and medication compliance is identifiable in analyzing their approach to service delivery with clients. For example, some providers are hesitant or outright decline to provide other services until they have achieved medication compliance with the clients. By addressing the biological roots of madness, providers believe they will be able to make clients more psychologically and behaviorally stable. At times, this rationale is rooted in the belief that madness is located in an individual's biology and/or most effectively remedied by intervening biologically through medications.

While some providers may employ biopsychiatric reasoning, I believe that not all providers will be resolute in their beliefs. Throughout the ethnographic data, there are clear instances in which providers share doubts on the importance or efficacy of medications, particularly in instances in which compliance creates tension in their relationship with their clients. To this end, another key assumption will be the role of institutional and interpersonal pressures in maintaining compliance. At an institutional level, providers may be aware that either administrative staff in AOT or court officials are tracking client progress, and thus may feel compelled to achieve compliance even in instances in which it goes against their personal beliefs. In other instances, providers may feel pressured by family members or caretakers to address medication noncompliance with their clients.

My second assumption was that some clients will prefer to decline medications in AOT due to their experienced and anticipated effects. While noncompliance is an enrollment criterion, a preliminary finding and key assumption in my analysis is that noncompliance emerges for diverse reasons for each client. Not all forms of compliance may be due to individual choice; instead, social ecological factors will be a key role in a person's willingness and capacity to maintain compliance. In some cases, noncompliance may emerge due to difficulties in coordinating public mental health services. For example, some clients may lack resources (e.g., transportation) or experience cognitive difficulties in scheduling appointments, retrieving prescriptions, or remembering to take medications daily. In other cases, non-compliance may emerge due to negative subjective effects related to their consumption. Some clients may believe that medications cause damage to their physical and mental well-being. Some clients may relate these negative effects as a barrier to pursuing broader life goals. For example, some clients may believe that medications be a barrier to starting a family or succeeding in high education. Negative effects may be also social in nature. For example, some clients may worry that consuming psychiatric drugs opens up the possibility for social stigma and discrimination. While I analyze the data, I will pay close attention to the individual story and rationale for each client and their noncompliance to medications.

My third assumption is that providers will rely on increasingly influential techniques to gain compliance yet will have to incorporate the role of rapport in their strategy. My last assumption pertains to coercive and influential techniques in the provider-client relationship in OPC. Overall, I believe that providers will rely on various strategies to gain compliance. So far in the data, I have observed the following strategies: continuous suggestion, rationalization, leveraging resources, use of threats, and court orders. This assumption is about the relationship between these techniques. Broadly, I believe that providers will attempt to gain adherence by first using lesser influential techniques. If providers perceive ongoing nonadherence from their clients, then providers will progress to more influential and coercive techniques. While a key aspect of my analysis will be to examine how providers think about and justify their approach to coercive and influential techniques, I believe there are two primary reasons for this order. First, I assume that many providers believe that they are ethically obligated to allow clients to choose to be compliant first. (This is, of course, separate from a normative evaluation of whether clients have autonomy in OPC at all.) Second, I assume that many providers will also prioritize rapport with their clients. In the data, rapport is central theme for many frontline providers who are attempting to gain the trust of individuals who have rejected therapy for sustained periods of time. In some instances, rapport is discussed as a type of currency providers have that can be used in exchange to persuade clients to comply with treatment orders. Thus, providers will avoid coercive approaches that could compromise rapport that could drive their clients away or lower the "social currency" that these providers have. Based on my preliminary analyses, I believe that the theme of rapport will continue to be an informative force in provider-client interactions. In some instances, providers used techniques not described in the literature review in order to pressure clients due to the emphasis on rapport. For example, providers may distribute the responsibilities managing medications to family members and caretakers in order to reduce tensions with their client.

## Limitations

There are two major limitations to my study. First, due to the qualitative nature of my research project, I was unable to make any conclusive claims of causality between events and relationships that I observed, described and analyzed. While I examined social and clinical interventions, I am unable to make claims regarding the efficacy of any programmatic element of OPC. The analysis was descriptive and analytical. I sought to describe and organize both personal beliefs and behaviors and connect these findings to broader theoretical concepts related to ethics, medicine, and governance.

Second, at times, the ethnographic research team encountered difficulties in accessing sites and establishing regular field visits with providers and clients. Because my access to these sites was through providers, sometimes I was unable meet with clients consistently. As discussed beforehand, this may have been due to suspicions of the evaluation itself or practical limitations related to time and resources. Further, sometimes clients disengaged or disappeared from the program entirely, leaving me with incomplete information on their experiences and decisions to withdraw from AOT-LA. This happened in particular with clients during the outreach and engagement phase and among clients with more disruptive and violent behaviors who could be incarcerated and no longer able to partake in the study.

## Ethics

As an overview, our project gained approved by both the UCLA Institutional Review Board (IRB) and the LACDMH Human Subjects Research Committee (HSRC) which included a review of all our research protocols, including informed consent, semi-structured interviews guides, plans for ethnographic observations, and methods for data storage and analysis. Second, as contracted evaluators for the county, all members of the research team gained training on the Health Insurance Portability and Accountability Act (HIPAA) through DMHLAC to ensure that our research activities protected the personal health information of clients.

Third, our ethnographic research team met regularly to discuss issues related to ethics and conduct in the field. This allowed us to revise, if necessary, procedures related to gathering informed consent or collecting data. In part, the ethical considerations explored in this section reflect questions that emerged in our research team conservations and discussed in academic literature regarding ethics in ethnography. To begin this section, however, I will first explore key ethical considerations to conducting our ethnography as guided by the *Ethical Principles and Guidelines for the Protection of Human Subjects of Research*. Also referred to as the *Belmont Report* (1979), this report is considered the standard for evaluating ethical conduct in research studies. The report outlines three core principles, including: *respect for persons, beneficence,* and *justice.* I will discuss each principle and its implication for our ethnographic research methods.

First, *respects for persons* refers to treating participants as autonomous agents, which the *Belmont Report* (1979) defines as individuals who deliberate on personal goals and whose conduct aligns with their decisions. A key application to *respects for persons* includes making research participation voluntary with an informed consent process. The report also clarifies that people with diminished autonomy are entitled to protections in research. This includes individuals who (1) have a physical or mental illness that would interfere with their capacity to deliberate and act on their preferences and (2) have "severely restrict[ed] libert[ies]" such as prisoners.

To this end, a particular focus in this discussion on research ethics is the vulnerability of individuals referred to and enrolled in AOT-LA given their status as both gravely disabled and with restricted liberties (in regard to their enrollment in AOT). The second principle, *beneficence,* refers to treating people in a manner that does not incur harm, and maximizes benefits while minimizing risks to harm. To this end, another key focus of this section is to discuss the measures we took to reduce risks to harm, which includes risks associated with participating in the project and confidentiality. Lastly, *justice* refers to considering whether the risks and benefits of research are fairly distributed. This is discussed in relation to the selection of research participants in the study.

**Informed Consent**

Informed consent is the primary means for researchers to respect the personal autonomy of individuals. Informed consent provides participants the choice to partake in the study with sufficient knowledge regarding their rights and responsibilities. While the informed consent process was standardized through the *Belmont Report*, ethnographic research presents unique challenges in relation to consent compared to clinical or biomedical research. Murphy & Dingwall (2007) explore these issues. First, while clinical or biomedical research involves a clear schedule of events, study observations, and interventions. In contrast, with ethnography the researchers' presence is continuously negotiated over an unset period of time and across various contexts that neither the ethnographer nor participant can fully anticipate. For example, while a treatment agency consented to my observations of their services, neither the agency nor I could predict that my observations would take me to any specific locations or witness any specific event. This raises a second issue: the emergent and exploratory nature of qualitative inquiry. Ethnographic data collection and analyses are conducted iteratively. New questions, concepts, or theories were identified and require further investigation in the field, which may shape the types of observations that are conducted or questions that are asked. Given this, participants cannot provide a fully informed consent in the same form that is provided in biomedical research. However, ethnographers can meet the ethical principle for *respects for persons* by describing their research project in terms of its main purpose, anticipated events, and exploratory and voluntary nature. This allows researchers and participants to come to an agreement on preliminary boundaries on what will and will not be studied as well as revisit the issue of consent in an ongoing fashion as the project evolves.

In our study, we developed three separate informed consent processes that reflect the different forms that participation. This includes informed consent for (a) semi-structured interview, (b) *open* participant-observation, and (c) *extensive* participant-observations. Open participant observations refer to when participants are present for brief ethnographic observations (for example: a researcher visits an ERS to observe participants in a life-skills group) or are not the primary focus of the observations (for example: recipients of outreach services are not the primary focus in observing how outreach staff conduct their daily operations.) In contrast, extensive participant-observations are conducted with individuals who are considered central or principal subjects and selected for repeated contacts.

For open participant observation, ethnographers conducted a verbal informed consent process. Specifically, ethnographers approached potential participants and identified themselves as volunteers with DMH and researchers at UCLA. Next, they disclosed that they are interested in observing how services are delivered in order to better understand the needs and experiences of clients. Next, ethnographers discussed the voluntary nature of their observations and asked for verbal consent. As part of the protocol, the ethnographers paid attention to social cues, especially from clients, and excused themselves from observations if their presence created discomfort. Lastly, ethnographers distributed their contact information in the form of business cards in case participants wanted more information on the research study. While this process of informed consent is abbreviated compared to signed informed consent process, it is optimal for a few reasons. First, risks associated with this form of participation are minimal. Conducting a signed consent form for each participant would take considerable time, energy, and resources, which could be interrupt to the daily operations of AOT services. This verbal consent process ensured that the ethnographers could make observations with minimal invasion in the space. Second, this type of informed consent allows ethnographers to remain flexible and open nature of observations. In observing service delivery, providers encountered many referred and enrolled clients within an observation period. The only exception to the informed consent process for participant-observations included individuals who fulfilled public roles (e.g., judges, public defenders, police officers) due to the public nature of their work.

Both semi-structured interviews and extensive participant-observations included a signed informed consent process. The informed consent form included information on the purpose and aims of the research, its voluntary nature, what will be asked of research participants, and potential risks involved in participating. Participants were informed that their decision to participate or not will have no impact on services. Lastly, participants were informed how researchers would protect their data and that researchers are mandated reporters who must break confidentiality if the researchers believe participants are at risk of harming themselves or others. Participants received a copy of the consent form which included contact information in case they wanted to follow-up.

### ***Consent in Organizational Ethnography***

In this evaluation of AOT-LA, UCLA was contracted by the LACDMH Office of the Medical Director, a governing bureau that oversees clinical policies across all public mental health services. This presented a power dynamic, as my presence in the field as an ethnographer to observe frontline staff was granted by their administrative overseers. The issue of informed consent poses unique challenges for ethnographies, particularly in the context of organizations (Plankey-Videla, 2012). First, there was a power differential between administrative staff and frontline workers. While administrative staff may approve of ethnographic observations of frontline staff, this did not constitute consent by frontline workers themselves. If administrative staff see the ethnography as important or beneficial, frontline workers may perceive or experience social pressure to participate. This may infringe upon their decision-making process as autonomous individuals. A second power dynamic existed between LACDMH and the contracted (non-profit) agencies that conduct AOT-LA services. In my social work experience, some contracted agencies do not trust the county to understand the needs and activities of their agency or client populations. So, despite having permission to access these spaces, I was regularly met with suspicion by treatment providers who were wary of being surveilled or audited by the county. For some providers, I risked appearing as not only a county worker, but as an administrative staff whose presence was to police the conduct of their contracted employees. On the other hand, I could have tried to counter this narrative, which risked deceptively downplaying my role as an evaluator. How should a researcher account for, as Plankey-Videla states, the ever-shifting web of power dynamics present in organizations that make our usual assumptions about informed consent problematic?

While there is no clear answer to this problem, I informed staff that my presence as an evaluator was to help improve services and conduct academic research. Further, I clarified with providers that my purpose was not to conduct an audit (a formal process in LACDMH where administrative staff report reviews of provider activities to their direct managerial staff). By engaging in this specific language, providers better understood the purpose of my presence and this allowed them to engage with me as co-constructors, particularly during interviews, where they discussed areas for improvement in AOT services. Second, I ensured that participants understood the voluntary nature of the research. As mentioned before, I remained reflexive during the consent processes, assessing whether my presence was causing any discomfort or distrust. Rarely, however, was my presence met with hesitation, partially because I never arrived at sites unannounced. I always contacted staff through email or phone first, even if my presence was confirmed at prior visits. In some cases, the staff members and I would email to schedule and confirm my presence. This process of prior and ongoing consent allowed me to continuously gauge comfort and provided participants opportunities to disengage at any point. In a few instances, providers asked that I not show up to the site for the day because they wanted to accomplish therapeutic goals without a third-party. In another instance, a residential facility permitted me to tour the facility but disengaged with the ethnography afterward. In part, these instances of declining participation indicate that I established an informed consent process where providers were able to provide consent or decline. Interestingly, some providers and clients – particularly those invited to partake in interviews – welcomed my presence and expressed that they viewed me (and other ethnographers) as potential advocates to make services better for future clients in AOT.

### ***Harm to Research Participants***

Our project posed minimal risks to research participants. Our study was observational with no interventions. Still, in this section, I discuss the potential harms and how we minimized risks. One considerable risk to participating was the possibility of emotionally difficult or distressing topics to be raised. In our observations, this was particularly true among family members and AOT clients, who frequently discussed traumatizing experiences related to physical and sexual violence, criminalization and incarceration, and, among clients, disturbing and extreme psychological experiences (such as intense emotions or hearing voices). To account for this, the researchers clarified to participants that could discontinue the interview at any time in case the topic material was too distressing or that they could decline to answer specific questions without any consequence. However, in our observations, it was rare for individuals to avoid topics and, at times, they even appreciated the opportunities to share their life experiences and stories.

**Confidentiality and Privacy.** A second major risk relates to the confidentiality and privacy of participants. To protect the data, ethnographic notes and interview data were stored on an encrypted server. Interviews were conducted on password protected and encrypted recording devices. Only members of the ethnographic research team had access to the raw notes or transcripts. Notes shared with the broader research team were de-identified by using pseudonyms of all research participants.

Two major concerns emerged regarding clients. First, we worried that collected data and analyses could be used against clients through the evaluation and data reporting process. Our procedures in handling and securing data protected against this. Further, at no point during the study did DMHLAC, the LAC Mental Health Court, or contracted OPC agencies ask the evaluation team to report on specific clients. A second consideration concerned the location of the interviews. Among clients in the outreach process or in field-based services, ethnographers infrequently had trouble locating a quiet and private location to conduct interviews in. However, residential facilities often lacked private spaces for interviews to take place in. These are busy places with many clients and staff who roam and monitor the spaces. In these instances, I discussed this limitation with clients and gauged their comfort level conducting the interview at their facility. Invariably, clients agreed to partake in the interviews at residential facilities. Then, I worked with the staff to locate the most secure space possible and asked staff on site to inform other clients to avoid the area for the length of the interview. This approach was successful, save for two interviews which were interrupted by unsuspecting clients entering the interview rooms. In these instances, the interviews were paused until the space was secure again.

**Issues of Inclusion/Exclusion.** A third issue pertains to the inclusion and exclusion of research participants. There are two major considers. First, this project examines a program that includes, by the standards of the *Belmont Report*, individuals with diminished autonomy. This poses serious questions on how researchers determine which individuals are capable of consenting to partake in research which I will explore first. The second concern regards inclusion/exclusion in regard to representation of client experiences.

***Vulnerable Populations.*** *The Belmont Report* (1979) specified that certain groups are entitled to a protected status in research. Specifically:

> Certain groups, such as racial minorities, the economically disadvantaged, the very sick, and the institutionalized may continually be sought as research subjects, owing to their ready availability in settings where research is conducted. Given their dependent status and their frequently compromised capacity for free consent, they should be protected against the danger of being involved in research solely for administrative convenience, or because they are easy to manipulate as a result of their illness or socioeconomic condition.

My research project includes a vulnerable population in two regards; however, this in itself does not bar the possibility of ethical research with this population. While individuals enrolled in AOT are labeled with a serious mental illness, which can include the presence of a single or multiple disorder diagnoses, I argue that the presence of a diagnosis does not indicate that individuals are unable to deliberate on decisions related to research participation. In recent years, bioethicists, critical psychiatrists, and mad studies scholars have challenged the assumption that people with psychotic or mood disorders share the same *types* of impaired decision-making capacities. Further, cognition is comprised of multiple domains; diminished capacities in one domain does not necessarily indicate that the more global processes of decision-making are entirely compromised. An ethical approach would not exclude based on a diagnosis alone and instead, engage with each potential participant at an individual level to assess capacity to consent.

In regard to their status as involuntarily committed to services, I argue this also does not bar this possibility for ethical research. First, OPC does not constitute the same type of restrictions on personal freedoms as prisons. Clients are able to navigate their communities, maintain regular social relationships, and make daily decisions on the activities they wish to conduct. Clients do have the capacity to walk away from research observations or interviews. Further, AOT does not have any punishments for nonadherence or declining services; its coercive element is through the *introduction* of a perceived threat (as explored in Chapter 2) which, as our analysis reveals, some participants see past. While AOT clients were restricted in the sense that they were mandated into an outpatient program, their status as AOT clients does not gravely restrict personal autonomy in the ways *The Belmont Report* describes.

Second, while clients were invited to partake in research, this population was not selected based on convenience of access. The inclusion of this population was based on the need to understand this particular population's experience with the AOT program itself. (Or, in other words, we could not have gone to non-AOT outpatient clients to understand the experiences of the program.) The inclusion of AOT clients is a necessary component of understanding how the program is experienced by individuals so that we can advocate to improve both services and the social conditions of people targeted by involuntary services. Conversely, excluding AOT clients from the project risks contributing to the ongoing erasure of the personal experiences of populations with disabilities or labeled with psychiatric diagnoses in academic literature and mental health policy. Instead, my research is driven by the assumption that vulnerable populations should be afforded equal access to social life, including platforms to voice their experiences and opinions, compared to other populations (P. Fisher, 2012). To this end, participation in qualitative research can have liberatory implications when conducted ethically. In terms of my research project, I aim to shine a light on the coercive mechanisms of the state and give voice to populations who are otherwise not provided opportunities to do so.

***Issues of Representation.*** The ethnographers exercised caution in inviting participants as to not include participants unable to give formal consent. Referred and enrolled AOT clients were not approached to partake in semi-structured interviews if the researcher had evidence to believe the client would be unable to provide informed consent, which includes being able to demonstrate that they understood the nature of the research project, their rights and responsibilities as participants, and its voluntary nature. To accomplish this, I performed participant-observations of treatment sessions in order to better understand the capacity of individuals to consent to research. As an ethnographer, I encountered clients who were non-responsive to external stimuli (i.e., were catatonic), had difficulties understanding information, or could not communicate clearly with others. Such participants were excluded from semi-structured interviews. (However, participant-observations of outreach and treatment sessions of this population were still conducted in order to understand how services are delivered across client characteristics.) If we did not have sufficient information to deduce the decision-making capacities of clients, the ethnographers discussed clients' capacity with their mental health providers. In my ethnographic experience, providers played a key role in identifying participants who would be able to provide consent for semi-structured interviews. Their assistance was particularly useful given that our research team was unable to conduct in-depth observations across the OPC agencies in order to identify research participants.

The inclusion and exclusion of particular research participants poses serious ethical questions for the representation of client experiences. While excluding severely disabled clients from interviews can protect their rights, it poses a limitation insofar that the psychological experiences of clients with limited cognitive capacities were not represented in the dataset. We cannot make inferences regarding any individual's phenomenological experience without interview data, meaning their voices were excluded for our analysis. Nonetheless, this limitation was accounted for during the data synthesis and analysis. Memos were written to consider which populations the interview data can be said to represent, and we attempted to bridge our understandings of the experiences of the most severe populations through our participant-observations.

Another major ethical concern regards the gatekeeping of clients. When clients were referred to us by providers, it inevitably raised the question of who providers were most likely to recommend. Their decisions could relate to their perceptions of (1) the decision-making capacity of clients and (2) the consequences of selecting clients who will be able to represent services. In regard to the first point, we found that providers were particularly protective of their clients, especially those with limited cognitive capacities, and referred participants who were capable of understanding the purpose and voluntary nature of the research. (This raises similar concerns regarding representation.) In regard to the second point, it may be the case that providers recommend clients who were able and likely to provide evaluations of the client that are aligned with the providers' view of the program. For example, a provider may recommend a client who has had a positive experience in AOT-LA and was able to represent their experiences with a particular provider in a positive light. This is similar to the issue of social desirability in social research. Surprisingly, in my ethnographic experience, providers recommended clients who had negative experiences with AOT. Whether this was intentional or not is unclear, though possibilities include that providers wanted to ensure that researchers were exposed to heterogeneous attitudes towards AOT; particular providers harbored negative feelings towards the AOT program and hoped that client's critiques of AOT would emerge in interviews; or providers felt indifferent towards the evaluation and, instead, wanted to give clients opportunities to partake in research and possibly gain incentives. To account for this, I similarly wrote memos on how ethnographers gained access to conduct interviews with research participants.

In my fieldwork, only a few clients declined to partake in an interview; however, other ethnographers experienced frequent declines, particularly among the ethnographers who conducted observations in the courtrooms. We found that AOT clients wished to not be bothered when visiting the Mental Health Court. Prior to hearings, clients reported wanting to focus on preparing for their hearings with judges. Afterward court hearings, clients wished to leave the courtroom and sometimes asked for the researchers to contact them at another time. At this point, researchers gave participants a business card with contact information.

Among clients interviewed in the treatment process, some were interested in sharing their experiences in services and some expressed gratitude for the opportunity to explore their experiences with medications. This posed an interesting set of questions: while this research was *not* interventionistic, interviews did provide participants opportunities to process psychological experiences. As such, these interviews make lasting impressions on how individuals relate to or experience psychiatric medications. In regard to research ethics, I believe – like other social workers and mental health advocates– that clients are entitled to discuss their experiences with psychiatric medications and that, through the interviews, they may develop new insights or language to discuss these experiences. In itself, this may indicate that clients were not being provided opportunities to discuss medications in OPC; this possibility and the implications of that will be explored in our analysis.

The issue of inclusion/exclusion extends to ethnographic participant-observations. First, our research agreed to the principle of ongoing consent. Throughout the course of ethnographic observations, we gained regular verbal consent of providers and clients to observe services. For example, in my first ethnographic observations in a treatment setting, I conducted the procedures for verbal informed consent (as described previously). At follow-up visits, I asked participants if they consent to my presence for the day and reminded them of the voluntary nature of their participation. (As described previously, if observations were consistent and regular, I conducted an informed consent process.) Similar to the interviews, I considered that not all clients were comfortable requesting privacy and was both judicious and conservative in conducting participant-observations.

## Chapter Summary

To achieve my research aims and answer my research questions, my dissertation project consisted of an imbedded team-based ethnography of an OPC program in Los Angeles County. The interpretative framework for my ethnography will be critical realism. To analyze my data, I used two conceptual frameworks: the coproduction of moral discourse and psychiatric drug effects as a social construction.

The ethnography took place in three settings: (a) courtrooms, (b) outreach and engagement, and (c) treatment. In these settings, ethnographers collected data through participant-observations and semi-structured interviews. The data collected through participant-observations represented how psychiatric drugs were negotiated, delivered, and monitored between clients and their treatment providers, legal officials, and other key actors involved in their care. The data collected through the semi-structured interviews represented the internal meanings that key actors in these scenarios give to psychiatric medications. This data was reviewed, coded, and analyzed in an interdisciplinary research team. By means of memoing, I identified major patterns in both the delivery of medications and the perceptions of psychiatric drugs effects and moral discourse of clinical decision-making.

# CHAPTER 4

# RESULTS

The purpose of this dissertation is to analyze how the management of psychiatric medications in involuntary outpatient services is undergirded by (a) provider and client interpretations of psychiatric medications effects and (b) moral discourses related to coercion and client autonomy. In doing so, I aim to explore the ethical implications of medicalized and coercive approaches to social services for vulnerable populations labeled with a serious mental illness. Further, I aim to explore how the practices of psychiatric medication use demonstrate the broader role of involuntary outpatient commitment in social welfare governance. This chapter presents the findings obtained through a team-based ethnography of an OPC program based in Los Angeles County, which included participant observations and semi-structured interviews, and was guided by critical realism. I interpreted my data through the framework of *psychiatric drug effects as a social phenomenon* and the *co-production of moral discourse.* To analyze the data, I conducted a thematic analysis with textual, analytical, and theoretical memos.

First, I will introduce an overview of how AOT-LA functions. This includes a discussion on the various administrative and frontline operations that constitute AOT-LA. Next, I introduce the prominent interpretation that psychiatric medications were a technology of control. Within this interpretation, I identified two prominent discourses: clinical and social control. The first discourse framed medications as a technology of *clinical control*; that is, medications reduced or restricted dangerous or disabling client behaviors related to their symptoms. Members of the social grid of medication management, who endorsed the concept of *clinical control*, further expressed that medications were a necessary component to AOT-LA services. I labeled this logic as *compulsory compliance.* Further, the social grid of medication management perceived clients as structurally vulnerable, especially while homeless, due to their clinical symptoms. They hoped that medications would directly reduce client vulnerability, a phenomenon I labeled *medicating vulnerability.* The second discourse framed medications as a technology of social control; that is, medications were used to control client autonomy, expression, and lifegoals.

My second set of results pertain to how psychiatric medications were delivered and the moral discourse which undergirded this. I identified three strategies of managing medications to noncompliant clients that I categorized under the umbrella of *client manipulation.* Broadly, these three strategies, which include *concealed collusion, performing coercion,* and *circumventing consent*, involved attempting to minimize client perception of autonomy in clinical decision-making. In regard to the moral discourse of coercion and client autonomy, my results indicate that manipulation was undergirded by the concept of *medicating vulnerability*, which was related to the idea of medical paternalism. Further, manipulation emerged as a provider strategy to gain compliance while minimizing the possibility of conflicts with their noncompliant clients. To end my results chapter, I present an in-depth ethnographic case of a client, named Jasmine, and her services through *Empowerment for Families*, which allows me to discuss the relationships between the primary themes in my analysis.

The findings of this ethnographic analysis address the research problem, which was to analyze how and why psychiatric medications play a role in the social governance of people with serious mental illness. The themes under the category *psychiatric medications as a technology of control* addressed the first set of research questions, which asked: *how do OPC providers and their clients interpret drug effects? How are client subjective experiences and behaviors interpreted in relation to drug effects and compliance?* Findings related to the strategies used to employ psychiatric medications answered the second set of research questions, which asked: *What techniques do OPC providers use to deliver drugs to, and monitor and enforce drug consumption by clients? How do providers respond to clients' compliance? How do providers respond to clients' non-compliance? How are client preferences incorporated into decision-making?* Findings related to the moral discourse of coercion and personal autonomy addresses the third research question, which asked: *how do providers and their clients incorporate their understandings and interpretations of drug effects into their moral reasoning in decision-making as it relates to coercive or influential techniques with their clients?*

## Overview of Treatment Services

While AOT-LA consisted of three ethnographic phases (outreach and engagement, treatment, and courtrooms), I primarily focus on the treatment phase of the notes where medications were discussed and managed between frontline providers and clients. Overall, from year 2016-2020, there were 1536 clients referred to AOT-LA. Of those, 63.9% (982) were deemed eligible for services and 48.6% (478) of them were enrolled. Of the enrollees, 86.6% (413) initially enrolled voluntarily (i.e., clients enrolled without involvement of the court). In contrast, 13.5% (65) enrolled through a settlement agreement or court order. Among the 413 who initially enrolled voluntarily, 9.92% (41) received a subsequent court order. Thus, in total, 19.2% (92) clients in total received a court-order or settlement agreement at any point during outreach or treatment.

### Divisions of Labor: Policy versus Practice

Ethnographically, our data can be divided into two categories: observations that involve (1) administrative operations, which involve policy writing and analysis, and (2) frontline activities with clients with the outreach and treatment staff. Our observations of administrative operations consisted of meetings typically with county officials from bureaus within the Department of Mental Health (DMH). These meetings provided important insights as they reveal the reasoning for specific policies and emergent problems in AOT-LA throughout the course of our observations. For historic context, the idea to implement AOT in Los Angeles County emerged in one of the central bureaus in the DMH: The Office of the Medical Director (OMD). It would take the effort of three other DMH bureaus – including Adult Systems of Care (ASC), County Resource Management (CRM), and the Emergency Outreach Bureau (EOB) – and the collaboration of a slew of county lawyers and the Los Angeles Mental Health Court system to realize the vision of AOT-LA. During administrative meetings, the issues of medications emerged frequently in relation to issues of compliance/noncompliance among clients.

In terms of frontline activities during the treatment phase, AOT-LA services were divided into FSP and ERS services. In FSP services, providers attempted to meet clients in the field on a weekly basis to conduct services. In relation to psychiatric medications, providers connected their clients to psychiatrists and delivered their medications, though providers did not conduct daily management. We noted that clients were prescribed psychiatric medications across four different classes (anti-depressants, anti-psychotics, anxiolytics, and mood stabilizers). If clients had caretakers, who were typically family members, then these caretakers were typically tasked with monitoring client medication consumption and effects. Otherwise, clients were expected to monitor and report on their own medication compliance. In ERS services, clients were housed in facilities which ranged from 4-bedroom houses in neighborhoods to large facilities with on-call medical staff. In these settings, medications were delivered daily to clients at a front desk. Out of the various actors comprising of the social grid of medication management, clients primarily discussed medications with their psychiatrists; however, clients had limited time to speak with psychiatrists and typically met with them once a month for about thirty to forty-five minutes.

At the administrative level, the division of responsibilities across governing bodies was difficult to understand. Not only did each bureau have its own assigned duties, but these bureaus intersected and depended on another for any procedure to be executed. In my training as a policy analyst at OMD, I was informed that the intent for this enmeshed design was to ensure oversight of each process by multiple parties. For example, in AOT-LA, members from the aforementioned bureaus – with addition from staff from the Patient Rights bureau – met to determine the eligibility of referred clients weekly. To determine eligibility, DMH had to determine whether it was logistically feasible to deliver services. To this end, EOB would discuss the logistics of completing outreach with the client (their duty) whereas CRM would weigh in on where the client might be assigned (their duty). Together, these two bureaus collaborated on a single process. At other points, the bureaucratic design of DMH implicated turf wars over whose responsibility it was to complete specific tasks or tensions over the quality of work conducted by one bureau. These bureaucratic conflicts represented a large portion of administrative meetings. For example, CRM staff repeatedly reported that EOB was not doing its "due diligence" in properly evaluating eligible clients for housing placements. As AOT-LA grew in its size, and novel issues emerged, the bureaus met to review and refine policies and procedures. Soon, official meetings included oversight meetings to review policies and procedures, a stakeholder meeting that compromised of community members from major advocacy groups (such as the National Alliance on Mental Illness), meetings with AOT-LA coordinators at contracted agencies, and various ad-hoc working groups to iron out emergent issues with smaller teams.

These administrative meetings not only guided our analysis of AOT-LA at a policy level, but they illuminated the difficulties of providing services on the frontline. Notably, frontline services were provided by contracted agencies. From the viewpoint of frontline providers, they had to abide by the policies set out (a) by their agency regarding AOT-LA, (b) their agency regarding mental health services more broadly, and (c) by the county, in conjunction with DMH and the Mental Health Court System. Complicating matters, providers relied on other institutions to conduct their work. Providers had to be proficient, for example, in navigating the application process for welfare programs. As AOT-LA both grew in its scope and evolved in its policies, our ethnographic notes of frontline providers revealed that staff continuously adapted their approaches to overcome gaps in policies or to meet new guidelines set out by their superiors. To this end, our observations therefore varied by both time and place and, as the program evolved, the issues we identified were modified while new ones regularly emerged. Given this, it was difficult to characterize a typical treatment process for clients across AOT-LA.

The multilayered design of AOT-LA led to fractured interpretations between bureaus, administrative staff, contracted agencies, and frontline providers on the broader purpose of the program. In the words of Dr. Rodrick Shaner, the Medical Director of LACDMH during the evaluation, AOT-LA started out as more "poetry" than an actual plan to address the various crises impacting people living with serious mental illness throughout LAC. In other words, the county had big hopes for AOT-LA, but realizing the intended purpose of the program posed serious difficulties. Administratively, LACDMH is tasked with governing serious mental illness in Los Angeles County. In part, the implementation of AOT-LA may be due to public pressure, as the county receives regular national attention for both its mass homelessness and carceral practices. (Indeed, during my time as an intern in the Office of the Medical Director, Dr. Shaner regularly discussed headlines from major news outlets, such as the *LA Times,* which criticized the county's failure to handle issues associated with mental illness.)

While service providers were united by the procedures set forth by the county, their interpretation on the role AOT-LA should play in the broader schema of mental health services, and their capacity to address the various public mental health issues the county faced, varied drastically. In part, compared to the administrative AOT-LA staff, contracted frontline providers confronted the life circumstances of clients who were noncompliant to mental health services. Some providers at agencies treated AOT-LA as an absurd project while others remained hopeful about its mission. Similarly, agencies demonstrated vast differences in their capacity to execute AOT-LA procedures. For example, some agencies had high staff turnover rates. In these cases, institutional knowledge about programs was lost; thus, even if agencies had learned to streamline specific practices in AOT-LA, often incoming staff were forced to reinvent approaches. Similarly, some providers struggled navigating the bureaucratic red tape and complicated procedures associated with AOT-LA, such as filling out and sending paperwork to the courts or securing welfare resources through the county.

Agencies were grounded in various theoretical frameworks, which they relied on to guide activities with clients. It was not uncommon for the ethnographers to hear these theoretical frameworks discussed in meetings or visually represented in posters in their offices. Terms such as "housing first," "harm reduction," or "the recovery model" evoked a specific logic, often concerned with compassionate approaches that centered client needs with flexibility. However, similar to Dr. Shaner's description of AOT-LA, these models were also more poetry than practice. First, while frameworks indicated values, the attitudes of specific providers varied. For example, an agency may have discussed the importance of the "strength-based framework," though it was not uncommon to hear providers frame their clients in terms of their deficits. Further, the broader sociopolitical and economic structures that services were embedded within often contradicted their theoretical frameworks. For example, an agency may have endorsed the "housing first model" – which posits that the first priority of any treatment plan should be securing housing for clients – however, providers and their clients experienced difficulty in locating affordable and desirable housing due to economic barriers. Thus, what providers became preoccupied with was moving clients through the flow of AOT-LA services (i.e., transitioning clients from enrollment to termination in services) while navigating the various structural barriers that complicated their work.

As previously mentioned, AOT-LA program was not only delegated by LACDMH; it also included the involvement of the Los Angeles Superior Courts, specifically their Mental Health Court Division. The outreach teams coordinated with the Mental Health Court, particularly the Office of the Public Defender, in order to deliver settlement agreements and mandates for clients who continuously declined services during the outreach phase. Once clients were enrolled in treatment services, through either of these methods, they were expected to attend court on a monthly basis for progress updates. Providers were expected to attend court hearings with their clients and, at times, deliver reports to the judges on the progress of their clients. Further complicating the frontline activities of AOT-LA providers, their clients were regularly involved in various intersecting social institutions and programs, including the criminal justice system and its various extensions, such as jails and prisons, and community-based restoration programs. Both AOT-LA providers and clients had to navigate these systems in conjunction with AOT-LA. Importantly, across client cases, providers encountered extreme variability. Some clients were mandated to treatment, while others were enthusiastic to enroll and comply. Some clients did not interface with the criminal justice system, while others had ongoing occurrences of criminalized behaviors. Some clients needed frequent hospitalization related to self-harm and suicidal behaviors, while others did not experience an acute crisis while in care. At the center of our ethnography, providers and clients were navigating the tensions between theoretical frameworks and procedural logistics - across DMH bureaus, intersecting governing institutions, and frontline providers – as well as the variability of client needs. As I discuss later, medications were often the most deliverable intervention for clients as providers had to only rely on their own agencies to secure it as a resource.

### The Flow of AOT-LA Services

In AOT-LA, the flow of services is characterized by the two stages: (1) outreach and engagement and (2) service delivery (see Appendix D for a diagram). In the outreach and engagement phase, outreach staff first met with eligible referred clients and performed a brief evaluation. (As stated previously, outreach staff are members of the Emergency Outreach Bureau in LACDMH). Next, the outreach staff collaborated with CRM to assign clients to a contracted agency. Then, outreach staff performed a "warm handoff" where they introduced clients to their assigned treatment providers. (In AOT-LA, a warm handoff specifically refers to the process whereby the outreach staff introduces the client to the assigned treatment team in hopes that the rapport that a client has with the outreach staff will transfer to the new treatment providers.) The warm handoff process varied by provider, though included a brief introduction to services and a signed consent-to-treatment process.

In her notes, Charlotte Neary-Bremer observed the outreach team activities of the only two outreach offices. At their team meetings, staff discussed their caseloads, as well as outreach activities in the field. In her observations of outreach activities, providers met with clients in various locations across LAC and included homeless shelters, jails, hospitals, and the homes of caretakers. In these meetings, outreach workers attempted to develop rapport with referred clients through discussing their life experiences and needs. Often, outreach workers delivered basic resources such as food or clothing as well. When outreach staff established rapport with clients, they extended a formal invite for referred clients to enroll in AOT-LA services. However, not all clients were willing to enroll in AOT-LA and, in these cases, outreach staff would collaborate with the Mental Health Court to deliver a settlement agreement or mandate. In regard to the role of medications, psychiatric medications were discussed with clients mostly to assess clinical symptoms and the needs of clients as well as their compliance to current treatment, if applicable. In a few instances, Charlotte observed the outreach workers enforcing medication compliance with clients who were receiving medical or mental health services, such as in nursing homes or hospitals.

The second phase, service delivery, began when clients were enrolled in treatment services, assigned to their treatment team, and providers began meeting with clients to conduct treatment services. Broadly, treatment included the following steps: (1) creating treatment goals for clients, (2) conducting treatment activities, including interpersonal and group therapy, and case management activities, and (3) preparing clients for termination from AOT-LA services.

The process of establishing treatment goals varied by providers and their clients. As previously discussed, there was large variability in the way providers approached treatment goal planning with their clients, guided by both philosophical considerations and practical constraints. In a note written by Blake Erickson (2017-07-17), an FSP provider provided an example of how treatment notes were framed by goals. In this case, the provider listed: housing, financial stability, mental health improvement, and community resource access. Within each of these goals, the provider wrote specific and measurable points of progress to track client trajectory throughout the course of the program. As Brodwin (2013) observed in *Everyday Ethics,* treatment planning acts as a technological tool to interpret client cases and create the possibility for action. At each treatment session, the provider framed each activity in the broader treatment goals. While our ethnographic research team did not access treatment planning documents, our observations and interviews with providers indicate that a common goal across clients was to reduce psychotic symptoms. Providers associated medications as a primary tool to achieve this goal. Importantly, we observed that providers had to regularly revise treatment goals based on client progress and the availability of resources. For example, while we observed that housing was a primary goal for many providers and clients, there were instances in which housing was unavailable for clients through the course of their 6-month treatment period. Thus, not every goal set out by the provider was worked on in every session and not every was goal was necessarily achievable. Still, goals gave providers a basis for action with their clients.

In relation to conducting treatment activities, treatment teams were composed of various roles that were dedicated to performing specific activities with clients. Broadly, these teams consisted of therapists, case managers, and psychiatrists. Therapists were responsible for developing treatment goals, meeting weekly with clients, performing psychosocial assessments, and, when applicable, performed medication management services. I noted that many therapists desired to conduct psychotherapy with their clients, but often did not feel clients were ready for intensive intrapersonal work. Case managers were responsible for linkages to community-based resources, such as supplementary welfare income and housing. In some services, the role of therapist and case managers overlapped or were conducted by the same individual. Lastly, psychiatrists met with clients monthly, at a maximum, performed psychiatric assessments and prescribed and adjusted medications with clients. We observed that ERS facilities had additional staff, including therapists who hosted regularly group therapy sessions or nurses who aided in medication management and addressed the health care needs to clients onsite.

Providers reported that stabilizing clients was often the first immediate treatment goal which provided the basis for a stable working relationship with their clients. To accomplish this, providers attempted to have clients consume psychiatric medications, particularly if clients were previously noncompliant to medications. In some cases, clients were already compliant to psychiatric medications prior to AOT-LA, or indicated they wanted to take medications, but were unable to secure medications due their economic situations. After stabilizing clients, if necessary, providers worked on gaining and monitoring compliance to treatment which, for noncompliant clients, was conducted through a series of manipulative techniques. Lastly, providers spent much of their time securing resources for their clients. Initially appointments included securing identification, applying for supplementary welfare income, and locating housing for clients. As a note, ERS facilities hosted more activities for clients than FPS services, given that clients were onsite 24/7, including group therapy and life skills groups.

In my observations of treatment activities, I observed that therapeutic rapport between the therapist and client was central to the success of service delivery. Therapeutic rapport refers to the interpersonal trust that a client has with their therapist. Many clients, even those who voluntarily agreed to services, were suspicious of therapists and hesitant to engage in treatment activities. At first, treatment sessions moved slowly as the therapists focused on building rapport. I noted that clients had various reactions to their providers. Some clients appeared ready and willing to work with providers, while others remained distrustful and less willing to engage. In ERS facilities, clients had the extra stressor of first adjusting to housing and the various rules and regulations that were imposed on them, such as strict sleeping and meal schedules or cleaning duties.

## Interpretations of Psychiatric Medication Effects

We identified that the topic of psychiatric medication was present throughout our ethnographic fieldnotes and semi-structured interviews. Medications emerged in relation to two aspects of AOT. First, as discussed previously, medications were discussed as a treatment goal for and expectation of AOT-LA clients, especially to achieve client stability. In our ethnographic notes, I noted short instances where medications were listed alongside treatment goals for a client, whether it was during the warm handoff process, or behind the scenes during treatment team or administrative meetings. These ethnographic moments reflected the shared assumption across treatment providers that medications were an unquestioned staple of psychiatric services. Similarly, providers regularly asked their clients questions about whether or not they were complying with their medications, and then used this information to interpret client behaviors in relation to clinical symptoms and medication effects. Further, among some providers, medication compliance served as an indicator of how willingly clients would participate across treatment goal activities. Often, clients were appraised – in treatment team meetings, for example – as being difficult or not based on their compliance to their prescribed medications.

Second, medications were discussed as a primary source of conflict between providers and their nonadherent clients. Frontline providers and their clients often disagreed about the efficacy and safety of medications. In some cases, due to these concerns, clients declined to take medications and providers worked to gain compliance from clients. However, some clients who worried about psychiatric medication effects were also compliant. While we sometimes observed these conflicts between AOT staff with clients, conflicts were usually discussed between providers in treatment team meetings or reported to us in semi-structured interviews by both providers and clients. This may relate to the fact that these conflicts were often avoided by providers and their clients and, instead, were addressed through more covert forms of manipulation. In our ethnographic analysis, these conflicts regarding psychiatric medication use were deeply informative as they often required both providers and clients to name their interpretations of psychiatric medication effects and to engage in moral discourse about coercion and consent.

### Conflicting Interpretations of Medication Effects

Broadly, psychiatric medications and their effects were interpreted as a *technology of control*, though the precise nature of what medications controlled was contested. These themes emerged from the analytical memoing of notes that were coded with the "medications" theme in the data, and intersected with codes related to violence perpetration, housing and homelessness, client outbursts, consent/coercion. In other words, these themes were not applied to the data itself, but emerged from the memoing process.

I constructed two subordinate categories to characterize the conflict of *medications as a technology of control*. First, I created the theme: medications as a technology of *clinical control*. In this theme, medications were understood to produce the necessary psychological states in clients to facilitate therapeutic and case management work. In turn, medicated clients were able to take control of their lives and meeting treatment goals including building social connections, developing life skills and goals, and identifying community-based and welfare resources. Here, medications were understood as an antidote to the disruptive and disabling nature of psychotic symptoms that robbed individuals of their personhood. Some providers interpreted that psychosis itself compromised client personhood; in this sense, medications lifted the restraints of psychosis and restored personhood. In other instances, providers believed that client autonomy should be constrained because while clients may be capable of making decisions, they did not know how to select the right treatment decisions for themselves. Among AOT-LA administrative and frontline staff, medication compliance was used to gauge client capacity to make decisions. In these instances, how willingly clients accepted medications represented to providers how compliant clients will be throughout treatment and, in cases of noncompliance to medications, indicated that clients lacked decision-making capacity. While AOT-LA administrators and frontline providers espoused the interpretation of *medications as a technology of clinical control*, we did identify clients who embraced medication use. In these cases, clients interpreted medications as a means to establish control of their own lives. Often, these interpretations by clients were accompanied by long histories of disability, incarceration, and/or homelessness that they related to states of psychosis.

Within the ethnographic data where medications were framed as a technology of *clinical control*, I constructed two smaller themes. First, I identified the pervasive and unquestioned assumption that psychiatric medications are necessary for clients to consume. I named this assumption *compulsory compliance.* Relatedly, client psychosis was understood to increase client vulnerability to structural and community-based violence. To this end, psychiatric medications were assumed to protect clients from social harms. This assumption was used to justify their compulsory use. I named this assumption *medicating vulnerability.* Similarly, in the proceeding section, I discuss the logic of medicating vulnerability and its role in the delivery and management of psychiatric medications.

I named the second subordinate category as psychiatric medications as a technology of *social control.* Through this theme, I capture how medications were interpreted to intervene on or override the personhood of clients, either through the ways in which medications were delivered and/or through their psychological effects on client mental and behavioral well-being. *Social control* extends beyond client sense of personal autonomy; clients also reported that their broader sense as persons – including their hopes, fear, and anxieties about the present and future – were disregarded for the sake of enforcing medication consumption. Largely, I noted this theme among clients who preferred to not take medications. Some clients who espoused the discourse of *social control* interpreted medications as a tool of the state to control their mental and physical wellbeing. Other clients preferred to take medications but reported that providers had disregarded, disrespected, or excluded them in medical decision-making. Often, these interpretations of medications among clients were paired with negative experiences with medication effects, including adverse subjective and physical effects, such as weight gain or fatigue. While this theme was most pronounced among AOT-LA clients, there were providers who expressed moral ambiguity about medication use and worried that both their effects and management infringed upon client personhood. These two broader themes related to control were in constant conversation with one another in the data. In the following two sections, I explore these two interpretations of medication effects (*clinical* versus *social* control) with ethnographic data.

### ***First Theme: Clinical Control***

I constructed the theme *clinical control* to capture the discourse that framed psychiatric medications as a biomedical technology capable of controlling thoughts and behaviors that were labeled as psychotic. In this theme, psychosis was broadly defined, typically capturing behaviors that were interpreted as bizarre and were related to either the client being at-risk for (1) severe disability, deterioration, and/or death and (2) violence perpetration, including threatening or physically harming others. Medications accomplished this through their sedative-like properties, which were reported to calm irritated or manic behaviors, and restored client rationality, and allowed for providers to have dialogues with their clients and make progress toward treatment goals. While psychiatric medications were understood to control psychosis, medications were also understood as insufficient for clients to reach broader treatment goals. In other words, insofar that medications and their effects were thought to intervene on psychosis, they did not replace the work of interpersonal therapy or case management services in AOT-LA. Instead, medications produced the possibility for therapeutic action.

**Compulsory Compliance.** Compulsory compliance is the first subordinate theme under *clinical control.* It refers to the pervasive belief that psychiatric medications were a necessary technology to control clinical symptoms. In my analysis, providers framed clients in relation to their psychiatric diagnoses, associated symptoms, and problems in living. For example, some clients demonstrated that they had difficulty communicating with others; through a clinical framework, providers at times interpreted this as relating to schizophrenia and its associated symptoms, such as social withdrawal or cognitive disorganization. While clinical diagnoses served for providers as a framework to interpret the clinical and social problems of their clients, the California Welfare and Institution code (5600.3) provides a narrow criterion of eligibility for community mental health services.

> (2) For the purposes of this part, “serious mental disorder” means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious

mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, “functional impairment” means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

We noted that this set of criteria was frequently used during referral and outreach team meetings to determine the eligibility and needs of clients, in conjunction with the narrower criteria for

AOT-LA. Largely, we noted that the DSM disorders that were most frequently discussed included psychotic (schizophrenia, schizoaffective, and psychosis not otherwise specific) and bipolar disorders. To determine whether a referred client's behaviors met these specific criteria, both outreach and treatment staff conducted psychological evaluations, which included both interviews with clients and securing records from previous treatment services. Largely, outreach providers relied on the information provided on the referral forms – which were completed by police officers, family members, or treatment providers of clients – and only in a few instances did we see the referral and outreach teams question or doubt the validity of diagnoses. The referral meetings, where several staff met weekly to review client eligibility, moved swiftly: at the beginning of each meeting, a list of clients was distributed to everybody and staff would go one-by-one to review the referral forms and discuss eligibility. We noted that most discussions were brief: Linda, who led the AOT-LA operations for the outreach team (housed under EOB), listed the characteristics that made each client eligible and ultimately made calls on inclusion and exclusion.

The descriptions of clients were at times paired with the shock of AOT administrative staff and demonstrated how mental illness among referred clients was interpreted, both in terms of the urgency and severity of untreated psychosis. At times, there were extreme cases where referred individuals perpetuated extreme and ongoing forms of violence towards family members or animals or were so gravely disabled the teams feared clients would die without an intervention. There were a few ethnographic observations where the clinical characteristics of a client were called into question. For example, consider this case of Christopher, an ethnographic moment that Charlotte observed. Christopher was an individual referred to AOT while hospitalized. The outreach team debated whether Christopher belonged in AOT or, alternatively, a drug treatment facility. State guidelines for mental health services do not allow Medicaid funds to be used toward people whose primary diagnosis is substance use, so this distinction stems from broader bureaucratic regulations. Further, the attending psychiatrist in the hospital believed that the client had a personality disorder and was only acting psychotic for the attention. She was adamant that the client did not need anti-psychotic medications and, in fact, simply needed to be discharged from the hospital. This moment demonstrates the boundaries of how clinical logic operates in AOT-LA: the program only treats *certain* types of behavioral issues. An individual may have a history incarceration or severe disability, but if their primary diagnosis related to substance use or a personality disorder, then they would not qualify for AOT-LA. (Conversely, an individual may have a psychotic disorder, but unless that was paired with noncompliance and the other AOT-LA criteria, they were also ruled ineligible for the program.) The case of Christopher further illuminates a relationship between this specific clinical logic and psychiatric medications: medications also only work with a specific set of problems. Here, psychiatric medication effects and their utility are intertwined with bureaucratic regulations on who also should be included in mental health services.

We noted that discussions regarding client diagnostic criteria were sidelined by discussions regarding other eligibility criteria for AOT-LA, including whether or not the person could be said to be deteriorating or would benefit from psychiatric services. Indeed, as I have demonstrated, the primary concern in regard to clinical characteristics was the relationship between diagnosis/symptoms to social problems, specifically the individual's level of disability and violence perpetration. Interestingly, while we noted that while there were not necessarily boundaries on what constituted being *too* symptomatic, there *were* limits regarding the *types* of disabled or violent behavior. Clients who are too violent, for example, put other clients and providers at risk of harm. (In fact, many ERS facilities refused to accept clients who had violent histories.) In cases where clients who were considered highly disabled, on the other hand, the referral team considered whether higher levels of care such as inpatient hospitalization or conservatorship. Here, AOT-LA was revealed to not be about controlling clinical symptoms *broadly*, but *specific* forms of clinical issues among noncompliant clients.

The interpretation of past medication effects and compliance behavior were regularly included in the review of referrals. At times, medication use indicated whether the referred client was responsive or not to specific medications in the past. If clients were responsive to medications, at times this indicated to the referral team that clients needed to be back on those medications and confirmed that mental illness was at the root of the client issues. If clients were no longer responsive, it indicated possible nonadherence or that the client needed new types of psychiatric medications. When the client was characterized as noncompliant, it indicated that their behaviors were likely disordered, psychotic, and disabled. At times, particularly in cases where clients had criminal behaviors, client noncompliance was inferred to mean that the client would pose trouble for providers. And, at other moments, noncompliance meant that the client was too disabled to manage their own medical care. We did not observe instances in which medication noncompliance or refusal were seen as an explicitly logical or rational thing for clients; rather, this was understood in relation to the diagnosis and clinical symptoms.

**Medicating Vulnerability.** Medicating vulnerability refers to the interpretation that consuming medications was necessary in order for symptomatic clients to become less vulnerable in their community settings. Across our notes, we noted that clients were characterized in relation to the profound vulnerability in community settings. Vulnerability here refers to client risk of homelessness, criminalization and police harassment, and violence victimization. Medications were thought to reduce vulnerability through an indirect effect: by reducing symptoms, clients would either be more able-bodied and capable of securing resources *or* be less symptomatic and, therefore, less stigmatized or targeted by others.

Consider a note I wrote (2017-10-24) where I observed with a social worker, Cynthia, who was a coordinator at homelessness agency. She had requested that an older Black woman, named Diane, be enrolled in an AOT-ERS program. Cynthia explained to us that Diane had showed up at her agency's doorstep one day and was displaying severe psychotic symptoms – almost entirely unable to communicate. Unfortunately, despite her efforts, Cynthia had been unable to secure mental health services for her. In the past few weeks, Cynthia tried to have Diane enrolled in a mental health programs, which disenrolled her for being "too psychotic." Cynthia was worried that Diane would never receive the resources she needed and, instead, would continue to deteriorate on the streets of Skid Row. Cynthia recently learned about AOT-LA and requested for Diane to be enrolled by an ERS facility. In my notes, I captured a moment in the ERS staff's interview of Diane:

> *Diane is incredibly calm. When she responds to questions, it's often very difficult to understand her. She clearly has a lower mouth disorder – her lower jaw looks tucked inward (a not too uncommon characteristic I've seen in this population). She mumbles when she talks, and sometimes turns her head away. She has flat affect, rarely responding. Cynthia sits right next to her, leans forward when she talks, and sometimes offers up translations to the team. Diane really wants to move into the home. She also has with her a bag that contains two pairs of pants (they both look clean and brand new). Towards the end of the interview, she mumbles something and Cynthia responds with (something to the*

> *effect of:) "No, nobody will be raping you at night. OK? They will be taking good care of you."*

One key concern for Cynthia was medications. At one point, after being hospitalized, Diane did have medications, but had trouble administering the medication to herself while on the street. At another point, Cynthia had written instructions that said: "Take one pill daily, take one pill daily", but Diane took *five* pills at once. In this instance, Cynthia's agency had Diane lie down in an extra room to sleep off the effects. There was another instance in which they got medications for her, but she lost it all within a day. Cynthia mentioned the reason that she has not been able to secure medications for her is that two of her case managers recently quit. This note reveals that *medicating vulnerability* is not simply about consuming medications, but the perceived role that AOT-LA can and should play in the context of vulnerability: to monitor clients in order to ensure ongoing medication compliance.

I identified that some clients shared the view that psychiatric medications made them less vulnerable. Broadly, these clients reported that they were compliant to their prescribed medications in order to manage their psychiatric symptoms. These clients also related psychosis to times in their life where they experienced profound psychological suffering and related to homelessness or incarceration. While these clients were compliant in services in AOT-LA, they reported that their noncompliance prior to enrollment was due to either (a) barriers in accessing voluntary medical care, particularly while homeless, or that (b) their non-compliance could be explained by their prolonged states of mental confusion or irrationality related to psychosis. In these cases, psychiatric medication effects were seen as an antidote to the psychological suffering they have experienced and a type of technology to reclaim control over their lives again. Further, these clients viewed AOT-LA as a program that provided specialized attention and helped them cut through barriers to accessing services.

Consider the case of Jack, a client who voluntarily enrolled in an FSP program. Jack was a Black man in his 30's enrolled in FSP AOT-LA through *Empowerment for Families*. He was assigned in AOT-LA as part of his discharge plan from jail. Now, Jack lived at home with his mother and sister, where I conducted my interview with him (2018-04-11). Throughout the interview, Jack described how satisfied he was with the services offered by *Empowerment for Families.* In his prior experiences with mental health services, Jack reported that he had difficulty managing his health and mental health care. Scheduling and attending appointments required a lot of work on his part but in AOT-LA, he received therapy directly in the comfort of his mother's home. Similarly, he valued the case management activities, which decreased the amount of labor he had to put into navigating his own health care needs. Jack reported taking risperidone (classified as an atypical antipsychotic) and Lithium (classified as a mood stabilizer) since beginning mental health services (i.e., before being incarcerated and discharged into AOT-LA), starting approximately fifteen years ago. His psychiatrist in AOT-LA changed Jack's risperidone prescription from the pill to injectable form.

In our discussion of medications, Jack interpreted the effects of his prescribed psychiatric medications as entirely positive with no downsides to their effects. Interestingly, Jack discussed how psychiatric medications helped restored both his rationality and critical thinking:

> *They're…good for making a person calm. Good for making him have good rationality, reason, thought…They're good…for those things, pretty much. Um…I don't know a lot about medications, I'm not a student or studying medicine growing up either…But, I'm aware it's supposed to make a person have better critical thinking and stuff like that.*

By regaining his rationality, Jack felt like he was able to work towards important life goals. For example, he wanted to discontinue smoking cigarettes. With the help of medications, Jack felt he was more able to control his urges to smoke. Notably, medications themselves did not create the more "rational" decisions in themselves; rather, medications provided Jack the rationality to make the decisions for *himself*. Similar to the provider's perception of psychiatric medications, their effects produce the possibility of therapeutic work.

Jack reported feeling total agency over his treatment decisions. Consider this moment in the interview below:

> *Oh I have full say! It's all what I say. It's what I say, that's why I watch what I say. Because I know that this may be a decision I make that could be right or wrong. But it's all what I say 'bout medicine, 'bout the program, because I'm a grown adult. I'm 36 years old. It's all about what I say, how I wanna do it. If I wanna treat myself here and there. [...] I'm the leader and ruler for myself, of all things.*

Later in the interview, Jack reported that because he had total say over his treatment plan, he had to be very careful with what he asked for. Here, empowered by both the program and his newfound rationality, Jack felt a deep sense of responsibility over his actions to "act better, look better, behave better." Surprisingly, while Jack felt supported by his providers, and that he had total control over his medications, he reported that he did not know what the specific purposes and effects of his prescribed medications were. His psychiatrist did not explain the purpose of the injectables, and his primary therapist did not discuss medications either:

> *People usually don't talk much about the medicine, unless it's about me taking it.*

Here, Jack places his trust his provider to make medical decisions on his behalf and, in the instance that he does not like the changes, listen to Jack. Notably, this particular client reported that he was taking the same medications for the past fifteen years and, perhaps, there was rarely a need for any type of changes to happen. Regardless, this interview reveals that some clients, despite being ordered to AOT-LA, can actually embrace the program, interpret medications as a useful technology for clinical control, and feel empowered by their providers. Of course, this raises some interesting questions about perceived coercion and empowerment; a question I revisit in my broader interpretation of client experiences in the proceeding chapter.

Jack's enthusiasm for the program and psychiatric medications was, for the most part, an outlier in our data. Indeed, while some participants viewed psychiatric medications as a technology of clinical control, they still weighed critiques of both medications and the AOT-LA program. For these participants, drug consumption was often about experiencing certain benefits, but at the risk of experiencing negative effects. In order to achieve the right balance, clients wanted to collaborate with their psychiatrist through reporting effects and asking questions. Consider the cases of Jose and Portia, two clients who resided in separate ERS facilitates.

Portia was a Black woman in her early 20's. I met Portia during my observations of an ERS facility located in South Central LA. When I first interviewed Portia, she was only two months into AOT-LA services. Prior to enrollment, Portia was in jail for her participation in robberies, though her sentence was transitioned to MIST, a community restoration program for people with misdemeanors. When her sentence finished, she was mandated to partake in AOT-LA and then assigned to an ERS facility. This particular ERS facility consisted of two small houses that were fenced in by a tall iron gate. The buildings were two stories with three bedrooms - shared across multiple clients - kitchens and living spaces for eating and television, and backyards that were paved with cement. Attached to the back of the houses were garages spaces outfitted for group therapy sessions, consisting of foldable card tables and chairs, locked filing cabinets, and motivational posters on the walls.

The ERS facilities ran on tight schedules with strict rules (see Appendix E for a photo of the rules). Clients had to wake, sleep, and eat at specific hours. They had limited and supervised times off the property. They were required to attend group therapy sessions throughout the week. In my observations, clients passively participated in these rules, flowing from one treatment group to the next, often without protest. During our observations, the ethnographers suspected – though could not confirm – that their compliant behavior was in part due to the strong sedating effects of antipsychotic medications. In a few moments, their adverse effects were obvious, like when I watched Portia struggle to participate in a cooking group due to her Parkinsonian-like tremors. In my note, date 2017-08-09, I wrote:

> *[An ERS therapist] comes into the room with a box of aluminum foil and asks them to cover the dishes. Portia attempts to do so, but as she can only pull the foil so far. Her hands are shaking so badly that she doesn't even have the strength to pull it all the way. It's almost impossible to watch – a task that looks so simple, but it's almost as if something else is holding back her arm and preventing her. She's nervously laughing about it. [Another therapist] steps in and pulls on the foil, then suggests that Portia pull on the foil to break it off. But once again, her hands are shaking so badly that she can't pull it off. [The therapist] decides to rip it off instead, and hands the foil over to the group to have it wrapped.*

When I spoke with the therapists on site, I asked to speak with one of their clients and I was pointed to Portia. In many ways, Portia was identified as the ideal AOT-LA client: she was active in treatment sessions, approachable and friendly, and willingly complied to her medications. In my interviews with Portia, however, she reported mixed attitudes towards both AOT-LA services and the ERS facility. In regard to the positives of the program, Portia reported that she valued the stability that the program offered. This included regular meals, individual and group therapy, and training in life skills such as budgeting.

> **Ryan**: *Um, do you feel like since you've been here you've been able to manage your life a little bit more?*
>
> **Portia**: *Yeah. Especially with money because, before I was in this program, and before I went to jail, like I would spend my money on drugs, or I would spend my money on like, well, alcohol and stuff like that, or I would give it away, you know, so…being here helped me, you know, manage my money a little different, so that I know how much a week I can spend because they help you manage your money. I've been sober for ten months now.*

Here, Portia framed the usefulness of the program through the lens of her past behaviors, where she mismanaged money and abused alcohol. It was through her experiences in jail and AOT-LA that she achieved sobriety. However, simultaneously, she resented the restrictions at the facility. In the first 30 days of the program, for example, new clients were not allowed to use their cellular devices or have contact with the outside world. Similarly, the program directly managed client finances, meaning clients were not at liberty to use any supplement welfare income they had received. Still, Portia expressed optimism about her trajectory. While AOT-LA was restrictive, it provided a path for people with serious mental illness for a new and better life. When discussing people who have graduated from the program, she stated: "*And it's good to see them go on their way, you know, to get back into life.*"

Portia reported that medications played a central role in gaining control of her life. Prior to consuming psychiatric medications, Portia described her psychotic experiences as scary and disruptive:

> *I was hearing voices and I was seeing stuff, and the stuff I was seeing was like…um, it would be like lottery balls, and um, like I would see my daughter on a, on a tricycle, or something, or I would see like my grandma and her telling me stuff, you know, stuff like that.*

While in her psychotic state, her grandmother refused to house her unless she took psychiatric medications. Looking back, Portia stated that her grandmother was right: "*I used to be trippin', I used to be going off on the edge and stuff."* During this phase, where she characterized herself as unstable and antisocial, Portia was jailed for robbery. It was while incarcerated that she was prescribed antipsychotic medications again and encouraged by one of her friends in jail to try taking them.

In describing her medications, Portia attributed each pill for a specific condition. Her Prozac was for her depression; her Lithium for bipolar; her Risperdal for schizophrenia. In describing these diagnostic criteria in relation to her psychiatric medications, Portia stated: "*they're [diagnoses] pretty much like, uh, we say…*controlled*."* However, Portia also did not relinquish clinical control to her medications entirely. She described the active strategies she took to manage her hallucinations. For example, she reported that she no longer paid attention to her voices, which prevented them from having any power over her. It was not clear where she developed these strategies, though she wondered whether if her doctor did not want her to "lean" too heavily on medications in manage her symptoms. Here, Portia interpreted medications as a tool to control her clinical symptoms, but that they were not supposed to replace the intrapersonal work in managing one's behavior and wellbeing. In other words, medications produced the possibility for Portia's own therapeutic work.

While Portia viewed medications as a technology of clinical control, this did not mean she did not have critiques of psychiatric services or medication effects. Upon entering the program, her psychiatrist immediately decreased her Risperdal prescription, which she started while in jail. By decreasing her antipsychotic medication, Portia stopped experiencing an adverse effect of lactation. However, she started to hear voices again, which terrified Portia. For Portia, she expressed frustration that her doctor did not incorporate her preferences in her decision-making:

> *Well, I know she's a doctor, but sometimes…She's like…I don't think she's hearing what I'm saying, like about my feelings sometimes, about certain things. And I know she's a doctor, so she's probably like "Well I know, I've seen patient do things like that and that and that." But it would be really cool if she could be like, "Ok Portia, how do you feel about that?" and "Okay, what do you think we should do about that?" And kinda work with me, instead of telling me. You know? Instead of "You're going to go down a dose", than just "How would you feel about going down a dose." You know, like that?*

Here, Portia fully articulated how she wanted her psychiatrist to respond. She described, in detail, the type of conversation she would prefer to have with her psychiatrist. Portia expected shared control over her treatment process. Importantly, Portia's desire for a collaborative decision-making process was not only about the implications for the immediate effects of psychiatric medications; Portia also framed the issue of control in relation to her broader life goals. Consider this moment in the interview, where I followed up regarding her critique of her psychiatrist:

> **Ryan**: *I'm curious to hear an example, just to help me understand better, in which you told Dr. Jane something, and she perhaps responded "like a doctor"?*
>
> **Portia**: *Well, uh, I told her that, I told her that…I asked her is these medications gonna stop me from getting pregnant in the future? And she was just like "You don't need to get pregnant right now. That's not cool. You won't want an unplanned pregnancy right now." And like, she went…she went doctor on me, you know? And I was like "Ok, alright." And I'm like…Wow…You know? Because if it I did want to have a kid right now?*
>
> **Ryan**: *Sure. How would you rather her responded to that sort of question?*
>
> **Portia**: *I would rather her say "Are you trying?"*

Here, the consequences of medications were framed beyond the immediate goals of treatment. Portia did not only want to manage her symptoms; she envisioned a broader trajectory for her life and wanted to know the implications of taking medications for these goals. While medications controlled her psychosis, she wanted her psychiatrist to explain to her the consequences for this type of clinical control.

Similarly, consider the case of Jose, a Latino man in his mid-40's residing at another ERS facility. This particular facility was very different from where Portia was housed. The building itself was a large brick building and whose floors felt more like hospital hallways with laminate tile flooring and fluorescent lights. There was a front check-in desk, security guard, recreational room, and dining hall. Similar to Portia's facility, however, there were strict rules in place. While some of these rules were listed on a poster on the wall I noted, during my tour of the facility on 2018-03-19, the facility had manufactured deceptive ways to enforce them:

> *[The therapist, who was serving as my tour guide, and I] then go to the back to step outside. To do so, he took a small key from his ring and unlocked the door. [He] tells me that the facility it unlocked, but that there are alarms on all the doors. He tells me that it "gives the illusion" that it's locked. They rarely have issues with people leaving.*

Even I, as an outside, felt like I was under surveillance by the staff while at the building: at no point was I allowed to wander the hallways alone unlike in Portia's facility.

This ERS facility ran weekly groups specifically for the AOT-LA program, though the clients also had the option to partake in a full range of groups and activities. During my observation of one AOT-LA group, I was introduced to Jose. His therapist informed me that unlike other clients, Jose was more talkative and was having a good week. In my interview with Jose, he discussed that his goal in the program was to transition to voluntary FSP services and secure his own place to live. Prior to the program, Jose described himself as wandering on the streets and being arrested regularly. Landing in increasingly more and more trouble, a judge sent him to the AOT-LA program so he could "get [his] life together."

Jose stated that he was thankful for being in the program: he had a roof over his head and support securing SSI and medications. The program also made him more willing to assess his problems in life – including his substance abuse and mental illnesses, bipolar and schizophrenia – and gave him the tools to confront them. One of the primary tools was his psychiatric medications which included Buspar (an anxiolytic) and Zyprexa (an atypical antipsychotic medication). He reported feeling more "normal" on medications, which he defined as going "through [his] day without any problems, without feeling depressed or anything." However, in his eyes, not all medications were created equal and none were without risk. For example, one psychiatric medication Jose tried made him feel suicidal and, at the time of the interview, Jose reported having to manage his weight gain.

Because of the possibilities for adverse effects, Jose desired a working relationship with his psychiatrist, where they would respect his reports and adjust his medications accordingly. Here, he described the way he framed medication effects to ensure that the psychiatrist did not make any changes:

> *I just let them know […] that I feel better. I feel OK […] so just leave me where I'm at with my medication. Because you don't want to lose my balance. Once you get something that works for you, you don't want to change it.*

While Jose discussed drugs in ways to influence his psychiatrist's prescribing behavior, he also discussed that in the past, the psychiatrist had changed drugs in ways that produced "messed up" effects: "*I was taking Zyprexa and that was never a problem, but they wanted to change it. I don't know why they changed.*" Jose does not necessarily distrust his psychiatrist though; on multiple occasions, he reported negative effects and his psychiatrist immediately changed his prescription.

Here, Jose sees medication as a technology of clinical control. The ERS facility, combined with these medications, have shielded him from the outside world where he was once incredibly vulnerable. Without these medications, he would not be able to functional "normally" but, in order to strike the ideal effect, he had to work with his psychiatrist. Similar to Jack and Portia, Jose also did not discuss medications with any supporting staff, including the nurse or therapists, and instead had a narrow window of time to advocate for himself. He reported that his meetings with his psychiatrist were once every two weeks and brief:

> *They're just real quick, they just ask you "Hi, how's your medication doing? How you feeling?" And stuff like that. "Do you…do you have any questions?" like and that's it. And if you don't talk to her, that's it.*

Similar to my interview with Portia, this reveals that clients who view medications as a technology of clinical control did not think that they can accomplish their goals alone. These participants desired a collaborator who specialized in medications and who knew how to properly listen to them and incorporate their preferences into decision-making processes.

Jose's initial mistrust of his ERS facility also brings up an interesting point: there were instances in which the AOT psychiatrist changed their medications, which resulted in bad effects for their clients. Yet, these clients handled these instances differently. Portia was forgiving of her psychiatrist. Consider this moment in my interview with Portia:

> *I feel like if I tell her, she will work it out, you know what I'm saying? She probably won't go up another dose, because that would be crazy, right? So, I don't know, I don't know what she's gonna do.*

Portia was at a crossroads: she experienced the negative effects of poor prescribing and, simultaneously, had no choice but to place trust in her prescriber. In the face of this unknown, she fell back on the expertise of the psychiatrist in hopes she could properly control both her symptoms and medication effects. In other moments, the psychiatrist pulled through for the client. Jose, for example, had his medications changed when entering AOT which resulted in increased suicidality. When he reported this to his psychiatrist, the psychiatrist immediately reduced his dosage again. Perhaps, as a result, Jose was willing to trust his psychiatrist more than Portia.

So far, I have presented brief moments in the ethnographic data to demonstrate properties and depict themes in relation to *clinical control.* Guided by critical realism, I argue that the interpretations of *clinical control* set the conditions to mobilize AOT-LA services and, within these, psychiatric medication use. To better demonstrate how these concepts undergirded AOT-LA treatment services, I present an analysis of my ethnographic observations that I conducted at a contracted mental health agency named *Empowerment for Families* (pseudonym).

**Ethnographic Case: Controlling Psychosis in the Field**. *Empowerment for Families* was contracted by LACDMH to deliver FSP AOT-LA services, though their broader organization delivered several types outpatient mental health and substance abuse services. Their assigned AOT clients were located throughout South Los Angeles, one of the eight service areas identified by LACDMH, that is largely compromised of racial and ethnic minorities (*Supplement to Community Health Assessment*, 2014). Their AOT-LA program was relatively small compared to other AOT-LA programs and consisted of one supervisor, three therapists, and a case manager, all of whom were assigned to the program by their administrative staff. Assigned therapists were tasked with meeting clients on a weekly basis in the field to make progress towards treatment goals. Therapists coordinated with the case manager, who assisted therapists across all cases in securing social welfare sources, such as supplement income, public housing vouchers, and food and clothing.

While DMH assigned *Empowerment for Families* clients located in South LA, the nature of the AOT-LA program took providers to areas across the county. Throughout the course of treatment, clients were hospitalized, relocated to live with family or friends, or, while homeless, found new neighborhoods or streets to live at. Providers spent the bulk of their week traveling across the county – often in the gridlock traffic characteristic of LA – to locate and meet with their clients. The team met early on Monday mornings to review their assigned clients, discuss treatment progress, and troubleshoot emergent issues. These meetings were the few instances throughout the week where the full treatment team met with one another and provided structure for a turbulent AOT-LA program characterized by difficult client cases and strained resources.

Matthew, the AOT supervisor, was a social worker in his late-30s and led the team meetings. At each meeting, he went down a list of AOT clients, one-by-one, and called on the assigned therapist to provide a brief update on their progress with the client. At times, therapists gave brief updates, though more often they discussed the strange or bizarre clinical and life circumstances of their clients. Therapists sought advice on how to proceed while, at other times, their reports were moments to commune, and even humor, over the difficulty of their work. Their caseload presented unique challenges, particularly in instances of extreme outbursts. For example, one of their assigned clients boarded a docked boat and sprayed the ship using a firehose, destroying property in the process.

Aside from reviewing cases, I observed that in their AOT-LA meetings, providers confided in one another on how to navigate the procedures set forth by both LACDMH and their own broader agency. Notably, these rules were often confusing – sometimes creating barriers in their work – and were also influx as the county reviewed and updated AOT-LA policies. In one meeting, for example, their team learned that *Empowerment for Families* merged with another mental health agency, meaning they had a new administrative body overseeing their work. This management team had new expectations for the AOT program. For example, they reported that the AOT team was too slow at uploading their clinical notes to the electronic record system, which meant that Matthew had to spend more time ensuring his team were submitting their documents in a timely fashion. At another point, the treatment team was informed that the nurse practitioner was no longer able to administer injectable medications for their AOT clients. The administrative staff at *Empowerment for Families* argued that the current nurses did not have AOT in their employment contract and, therefore, could not deliver medications to AOT clients. To overcome this, the providers had to transport clients to a mental health crisis unit in order to receive a full evaluation and medications. This process took a full 3-hours for each client. During a meeting where they debriefed their anger about this change, I wrote (2017-09-11):

> *"It feels personal," says Marisa* [a therapist]. *"What do you mean* feels personal*?" says Matthew. "I know it isn't personal, but it* feels *personal." She shrugs and says she's upset that they suddenly took away their nurse while they have clients who are actively psychotic, with little warning or information on how to actually get medications to their clients.*

Their unpredictable client cases, combined with the tedious bureaucratic oversight, made working on the AOT team particularly undesirable. Throughout meetings, staff chimed in with jokes at the expense of clients or voiced frustrations about the structural barriers that prevented them from conducting their work. In my interpretation, both their humor and rants emerged from the same source: a sense of futility due to the seeming impossibility of their work. At the end of one of my observations of their treatment team meetings, I reflected on how both frontline staff and clients were assigned to the program: "*I wonder if anybody is part of AOT by choice*."

In meetings, Matthew engaged in the provider's humor or rants, though reigned in his team by validating their feelings and discussing concrete treatment goals. Medications came into focus in these moments as they were understood as the primary tool to control clinical issues. For instance, in a team meeting Matthew brought up the case of George (2017-07-24). Matthew explained to me that George's mental well-being was cyclic and wavered between stable to severely psychotic for the past few weeks. In his report, Chad, his assigned therapist joked that

George was dating somebody. When the room laughed in disbelief, Chad raised his eyebrow and said, in a low tenor: "*Yes, he's a very* active *young man.*" In a forceful tone – perhaps one meant to subdue the laughter – Matthew interrupted the room: "He's compliant with meds?" Chad responded that George recently became compliant to medications and that, according to the psychiatrist - who remained absent at team meetings - George should not decompensate again.

This brief moment demonstrates three themes about the concept of *clinical control* in AOT-LA. First, George's status as sexually active evoked humor. This was perhaps due to the fact that this characteristic was seen as incompatible with mental instability. In other words, madness precluded the possibility of normalcy – which, here, includes sociality and sexuality. However, the possibility for therapeutic work – and even sociable citizenship – can come into focus through the lens of medication compliance. That is, with medications, the treatment team saw hope for George to become stable again. Second, there was a hierarchy involved in the interpretation of medications. While the psychiatrist was absent from AOT team meetings, their interpretation of medications was echoed by staff members and taken at face value. In other words, while psychiatric medications and their effects were seen through a clinical framework, the prescribing clinician did not need to actively present for this logic to be used. This relates to the third point: the logic of psychiatric medications did not necessarily involve an explicit working knowledge on their exact mechanisms of how or why they produce said effects. In fact, accompanying logic was absent in our observations and interviews: treatment providers rarely mentioned the presence of underlying neurological illnesses, neurotransmitters, or biopsychiatric etiology. Instead, there was a shared understand of what the goal was for clients in relation to their outward behaviors: once compliant to medications, clients would be controlled, more predictable and less volatile. Without this, conducting the therapeutic activities of AOT was seen as impossible.

In another meeting, dated 2017-09-11, I observed Matthew inquire about the status of a client whose case was ready to be close out. Marissa, the client's therapist, confirmed that she had officially disenrolled him from AOT-LA services:

> *"He's now meds only by the county." She lifts her hands up and wipes them in the air. Matthew asks: "So there's no after care for him?!" To which Marisa responds: "Meds only." "Meds only," says Chad. A beat later says, "Another success!"*

Medication compliance became the most tangible treatment goal that providers could work on. Medications were a concrete and discrete form of technology - unlike other resources that clients needed or may have benefit from (like supplement income, housing, food or clothing) that providers struggled in securing. Here, medication compliance was seen as the most realistic goal and the language of "meds only" – a phrase that these providers mockingly celebrated – symbolized how the state prioritized creating clients who consumed medications without needing further surveillance (see Floersch, 2002; Dougherty, 2019).

Insofar that medication compliance was seen as necessary to exert clinical control, particularly due to the complex labor of frontline services, medication use was seen as necessary for clients. This logic, *compulsory compliance*, implicates perceptions on the nature of AOT-LA clients and mental illness. Consider this interview excerpt from the AOT coordinator at *Empowerment for Families:*

> **Ryan**: *[W]hat are some other things you might do to keep a client engaged in the treatment process?*

**Matthew**: *Well, the therapeutic part explores whatever other areas they want to address, if that is impacting the way they are. Obviously, the psychotropic meds are another component that they need to… we need to secure for them just so they can minimize the negative symptoms, um…*

**Ryan**: *Is that universal too? Do all clients end up on—*

**Matthew**: *Meds?*

**Ryan**: *Yeah, meds.*

**Matthew**: *Because, I'm trying to think of our case load right now, because our clients…our current case load all their symptoms are…psychotic…symptoms? So, I would assume that…yes, I yet to meet a client that doesn't meet that criteria in order for them not to even be on meds. No, ya, I can't think of a specific example.*

**Ryan**: *So, housing and meds are typically—*

**Matthew**: *—yes, the key…the starter points.*

Because all clients were considered eligible for AOT through their clinical characteristics, Matthew assumed that they all will need medications. This type of reasoning emerged throughout our ethnographic observations and semi-structured interviews: the mere presence of a referral signified the necessity for medications. It is also a starting point for services: a foundation that must be secured before other activities can be conducted.

In the quote above, Matthew cites psychotic symptoms as the reason for psychiatric medications. However, symptoms were not the sole motivating factors for medications: the dangerous circumstances of clients were central in provider reasoning as well. Throughout the ethnographic data, the logic of *compulsory compliance* was intertwined with *medicating* *vulnerability*. To demonstrate this, consider a case I observed with Saqib, a therapist at *Empowerment for Families.*

Saqib was one of the assigned therapists for *Empowerment for Families.* In my observations of the team meetings, Saqib was consistently late to meetings and chastised by Matthew for his slow turnaround on case notes. Still, he was respected by the team for his friendly demeanor. Saqib invited me to observe a warm handoff with a new client, named David. David was a Black man in his 30's who was referred to AOT by his mother. After observing the warm handoff, I was invited back to observe subsequent treatment sessions, where I interviewed David and his mother on two separate occasions.

David was referred to AOT-LA due to two primary reasons related to vulnerability. First, David regularly threatened his mother and sister with violent texts. Further, David had occasional outbursts where he destroyed property. During these outbursts, his family called the police for assistance, though the family feared the criminal justice system did not understand how to handle David's needs. For example, at one point, the police drove David a few blocks from their home and dropped him off at a street corner. Here, the family wanted David to receive services to reduce his violent behaviors and reduce his exposure to policing. Lastly, David was homeless and unable to secure housing or employment for himself. David's mother offered up her garage as shelter to keep David alive, but otherwise kept her house locked to keep her and her family safe from him. Here, his family wanted David to be housed in order to reduce his proximity and reliance on his family, who felt threatened by his behaviors.

Across our observations, we noted that caretakers were often at a crossroads of wanting to have their children housed but, often to protect their own safety, unable to house them directly. Instead, many family members established work arounds, allowing children to live in their garages and backyards. In my first observation of David's case, I wrote detailed notes on his makeshift shelter in his family's garage (2017-04-05):

> *We walk towards the garage. The door itself is open, but not all the way. It's partially off the tracks that hang from the ceiling. The panels further in the garage are scrunched and broken as if somebody had been bending and folding them in anger. […] . Standing just outside the garage, I see two quilts hanging from poles. They are blocking the back of the garage, so I can't see in all the way. Tasha [an outreach worker] says it's his way of keeping out the sun. The poles that they are hanging from belong to what looks like old scaffolding that one might see for tents for outdoor events.*
>
> *When we enter the garage fully, I notice that it's disconnected entirely from the house. We walk to the back, past the two hanging quilts that are there to block out the sun, and I see a table and an old mattress on the floor. This is where [David] sleeps. Along the walls of the garage are piles of something, but I can't tell what – they're all covered in old dirty quilts. The place smells of waste too. Flies are swarming the area, flying in circles and tracing the garbage which lines the walls. I note that the central control system to the garage door has been ripped out of the ceiling. One object stands out to me in particular.  Sitting up against the back wall is a small lamp. Perhaps something you'd place on a nightstand. The body is short and white. The shade is beige and has letters written all over it. They're all different sizes, some not belonging to any alphabet I know of, and most of the symbols are upside down or sideways or intersect with others. If the bed hadn't been present, I would have never guessed somebody lived in there.*

Even in taking shelter in his family's garage, David's living condition demonstrates his profound instability and vulnerability. Here, he spent his day exposed to the intense LA heat and surrounded by feces. The mechanisms and door itself were also destroyed; here, without proper housing systems capable of supporting David, they were forced to deal with the ramifications of his behaviors.

In my observation of our first meeting, I noted that Saqib first assessed David for psychotic symptoms:

> *"Ok, so you've had some ups and some downs?" The client laughs and nods in agreement. Saqib replies with, "Ok, ok. Good. What about the voices, have you been experiencing those lately?" David turns partially away and says, "Ya man, they've been really, like…loud lately…" He raises his hands and with open palms begins to make circular motions around his head, "like…they're distracting and stuff like that…just always there." His hand motions communicate that they're coming from all angles, always talking, and always distracting him. I look to Aimee, Tasha, and Saqib. They all nod in agreement and understanding. The SHIELDS worker then asks: "So, have you been taking your medications recently?" David says, "Yes."*

Here, David's psychotic symptoms were assessed in order for Saqib to establish the needs of his client and treatment goals. Next, Saqib promised David that he will make sure all his medications were "taken care of" alongside other key case management items, such as housing and clothing. In his subsequent meetings with David, Saqib focused on case management items. They first visited the Public Social Services office to apply for welfare benefits. They discussed what housing options were available for him, including whether he would be interested in enrolling in an ERS facility. During this time, Saqib also scheduled multiple psychiatry appointments for David, though, after a month of being in the program, I learned that David continuously failed to show up. In an interview with Saqib, he framed David's absence as a characteristic of his clinical symptoms: "*You know, this is all a part of the disease. And we can't really secure housing until he's on medications*." Without medications, Saqib discussed that his work would otherwise be difficult, if not impossible. This was the logic of *compulsory compliance*.

While Saqib was adamant that David needed to be on psychiatric medications, he also discussed that he suspected David had childhood trauma at the core of his psychotic behaviors. Here, perhaps psychiatric medications became less about "curing" an illness in a biopsychiatric framework and more a tool to address disruptive behaviors that stemmed from trauma itself. While David wanted to conduct therapeutic activities to address trauma, Saqib had to first get to place with his client where he was not constantly "putting out fires" (2017-05-10):

> **Ryan:** *What sort of steps, in terms of the needs of…AOT clients that you described, what sort of steps would you take to help the client to stay engaged, or be engaged in treatment at all?*
>
> **Saqib:** *Well, first of all figuring out what their goals are. A lot of times, um…there may not be, for instance in David's case, his main goal is housing…but it would be tough to place him if he's not taking meds. Um, so yeah it's figuring out what they, what they want and seeing if we can start taking baby steps to get them to their goals.*

Here, Saqib described medications as the key factor to establishing emotional and behavioral stability in David (i.e., he interpreted medications as a technology of *clinical control*), which produced the possibility to address underlying issues and securing housing. This was the intertwined relationship between *clinical control* and *medicating vulnerability*: because provider activities were so focused on reducing client vulnerability, the work of medications were framed in relation to this.

While enrolled in AOT, David was arrested on two separate occasions by the police. The first arrest occurred in July, three months after enrollment. David threw a brick at a window and was jailed for destruction of property. During his first stay in the county jail, David was brutally attacked and hospitalized for injuries. His mother suspected that David was an easy target while in jail due to his psychosis. His second arrest occurred in September, four months after enrollment, for violence against his father. This second arrest resulted in David's disenrollment in the AOT-LA program and he was sent to federal prison. In January 2018, eight months after his enrollment in AOT, I learned the reason why his case was transferred from the mental health to the criminal court system. The judge that oversaw the case did not want David's case back in AOT-LA because they worried that he would end up back in the care of his mother where he would continue to place himself and others in danger. A brief search of the online prison system indicated that his bail was set at $150,000. He was charged with a felony and in general population, a section of jail for individuals who are not provided specialized treatment services.

Saqib expressed that David belonged in a more intensive psychiatric program for people with misdemeanors and that he needed to become more "stable" before being in AOT-LA. This was the strange programmatic irony that I noted in discussing AOT with providers: providers framed the program as intended for people with severe and untreated psychosis. However, providers were limited in their ability to address the issues that made clients eligible in the first place. In the case of David, his violent behaviors were the reasons for his referral, but Saqib had no way to address his violence other than medications. In some of these instances, providers suspected trauma as the source of psychotic behaviors, but the source could not be addressed until the client achieved behavioral and emotional stability. For providers, this created a catch-22 of medication compliance: irrationality at times meant clients rejected medications, but medications were the only source to make clients rational actors again.

While medications were interpreted to control his psychosis, not all providers viewed it as their responsibility or right to control clients themselves. The moral rationales that undergirded their approaches to medication management are explored later. However, to note, in an interview with David's mother, she shared her frustration with the program. Here, she questioned why David was granted personal autonomy in treatment decision-making at the expense of her victimization by her son (2017-10-05):

> *They, uh, first they was unable to place him because he wasn't taking medication. [...] I asked if there's anything that they could do, they said "nah" because he had to give consent. Well, how is that possible? Why are you asking for an insane person to give consent? [...] In the meantime, he threw things, fled my door, broke my windows, uh, uh, uh…tore up my whole (*She points to the garage tracks that are attached the ceiling*) This is new. [...]*
>
> *He was trying to get in a therapy that he could give David, uh, verbally, he wasn't able to…David needed medication. And he needed a stronger hand. He needed somebody to just give him…because he just… you asked a mentally ill person, you got to tell 'em.*

Here, David's mother articulated that Saqib was not forceful enough. Instead, the program leaned too heavily on David's decision-making, which she viewed as compromised due to his psychosis. As a consequence, David slipped through the cracks in the AOT program and, in the eyes of David's mother and *Empowerment for Families,* was imprisoned for his behaviors.

My ethnographic observations with *Empowerment for Families'* reveal the interworking relationships between *clinical control*, *compulsory compliance*, and *medicating vulnerability*. Combined with the difficulties involved in securing resources for clients, providers located the capacity to control psychosis through psychiatric medication effects. Often, doing so was urgent, because of the profound vulnerability of clients in being victimized by or perpetrating crime. In my analysis of David's case, his provider and mother interpreted medications as a technology to control David's clinical psychosis. While medications were understood as a compulsory component to David's services, this did not mean Saqib used explicit coercion or even mandates.

### Second Theme: Social Control

In analyzing the medication data, I noted that many clients expressed the interpretation that medications were a technology of *social control*. Participants identified that social control was exercised through (1) the ways in which medications were managed, which minimized the role of client preferences and autonomy in decision-making, and (2) their produced effects, which included adverse psychological and physical functioning that interfered with their life goals.

First, clients noted that medication management implicated a power differential between them and their treatment teams. In some instances, clients did not prefer to take medications, but expressed that they did not have a decision in the manner otherwise. These clients reported that they anticipated various punishments for noncompliance; however, not all clients were able to name *specific* consequences. Even in cases where clients *did* prefer to take medications, clients expressed that their preferences in terms of types and dosages of medications were not appropriately considered in decision-making. In these cases, clients reported that they were seeking an ideal medication effect but, as I noted earlier, were limited by the time and resource constraints of AOT-LA. In many instances, treatment teams were not willing to discuss with clients their interpretations of medications. (As I demonstrated in previous interviews, clients did not talk to their therapists or case managers about the medications.) In some cases, psychiatrist made decisions about client medications without their input at all. The reasons for this varied. In some instances, providers interpreted clients as too psychotic to be able to have meaningful communications regarding medication effects. In other cases, providers, particularly among frontline providers such as therapists or case managers, reported that the topic of medication was outside their expertise and, instead, their duty was to monitor and enforce compliance. Relatedly, psychiatrist availability was limited. While psychiatrists were responsible for prescribing and adjusting medication dosages, clients were limited to monthly meetings. Our team noted instances in which clients went periods longer than one month without a psychiatrist reviewing their medications. Here, the interpretation of *social control* was inferred from the forms of medication management that restrained clients' ability to express and realize their preferences with medications.

Second, some clients reported experiencing adverse effects from consuming prescribed psychiatric medications and that these effects intervened upon an aspect of their personhood. As I described earlier, adverse effects ranged from psychological to physical effects. Broadly, some clients connected these harmful effects to current and future barriers to living fulfilling lives or achieving life goals, such as performing an occupational role, starting families, or being accepted in society. When clients identified adverse effects, these were typically in relation to prescribed antipsychotic medications. Psychological adverse effects included lethargy, drowsiness, and mental fogginess. Physical adverse effects included weight gain. Further, some clients worried about the long-term physical impact of consuming antipsychotic medications, particularly their liver.

In my analysis, I noted an overlap between these two interpretations of medication as a technology of social control. Reconsider the case of Portia. She preferred to consume psychiatric medications to help control her hallucinations that she associated with psychosis, but also experienced negative effects. In order to produce the ideal psychiatric medication effect, Portia desired a provider who would listen to her concerns, though unfortunately, felt that her psychiatrist sometimes acted too much “like a doctor” and minimized her experience. Here, Portia espoused the two interpretations of psychiatric medication effects: while she wanted to have clinical control, she acknowledged that she lacked social power to learn about and determine her medications with her psychiatrist.

While I identified that interpretation of *social control* was reported mostly with clients, there were moments in the ethnography where providers revealed that they saw psychiatric medications as a useful tool outside of strict clinical management. For example, during an observation I conducted of an outreach worker at an inpatient hospital, dated 2017-10-24, I wrote:

> *Rick [the outreach worker] turns to Georgia [the hospital worker] and asks […]:” Is he being given Ativan because he needs to be calmed down, or because he’s actually agitated?” In essence, [George] is being asked: is this so he’s easy to manage or because he’s actually anxious? There is a knowing grin to both Rick and Georgia. Georgia responds, saying that all the medications here are prescribed based on the client’s request. But then she pauses, shrugs and smirks: “Yeah but I mean, you never know…”*

This moment reveals a shared but unspoken assumption that managing client behaviors was not just about clinical symptoms related to psychiatric diagnosis. At times, clients may need to be "calmed down" – which, for Rick and Georgie here, did not necessarily have to deal with clinical symptoms – and psychiatric medications might accomplish this. In other words, some providers acknowledged that medications were a useful technology for managing individuals in social settings and institutions. At other points, some providers suggested that they were uneasy with the way medications were managed among clients. One particular therapist named Emma, whose services I describe in-depth later, described that she did not approve of treatment teams pressuring a client who preferred to not take medications (acknowledging their exercise of *social control*), but was simultaneously impressed with how her client improved after being compliant to antipsychotic medications (acknowledging their capacity for *clinical control*). It was difficult, otherwise, to infer whether providers reflected on medications as a technology of *social control* as their day-to-day tasks related to addressing client problems emerging from both clinical and social factors.

In my client interviews, some clients explicitly critiqued the AOT-LA program and reported that psychiatric medications were intentionally employed to manipulate clients. Consider my interview of Robert, a client enrolled in the same ERS facility as Portia. I first was introduced to Robert during a group therapy session that I observed at the facility. Robert was a white man in his mid-30s. I had two opportunities to interview Robert: the first interview was conducted in his first month of the program and my second interview was three months later, where we discussed at length his experiences with psychiatric medications in AOT-LA.

Robert's tone was markedly different between the two interviews. He was enrolled in AOT-LA due his involvement in criminal activity and, in the first interview, expressed hope that the program would offer in-depth one-on-one therapy so he could confront his past. However, in the second interview, Robert looked defeated. He was disappointed in the program. He reported that his liberties had been revoked, that the services were poor, and he was constantly being monitored. During this interview, his eyes shifted left and right, and he constantly looked over his shoulder. I wondered whether he was making sure his therapists were not listening in on the interview and, at the end of the interview, Robert thanked me for the opportunity to express his critiques: he sincerely hoped the AOT-LA evaluation team would make needed changes to the program.

Like other clients, when I asked Robert about the medications he took, he listed them off in relation to their associated conditions. His Depakote, a mood stabilizer, was for bipolar. His Remeron, an anti-depressant, was for depression. While he also listed Olanzapine, he contested his schizophrenia diagnosis for which it was prescribed. Robert was first diagnosed with schizophrenia and prescribed the antipsychotic medications by his jail psychiatrist which occurred, as he described it, during a brief "five-minute" meeting. His schizophrenia diagnosis and antipsychotic prescription followed him to AOT-LA which he tried to have revoked:

> *The doctor, um, kept me on the medication that I was on coming out of jail…I explained to the doctor that…that the psychiatrist in jail hadn't spent any time with me. I hadn't…I was never on these medications…I'm on medications for side effects that I never had. And I'm on just…on a bunch of medication I'm taking all of a sudden. So, I gained 40 pounds. Uh, and I'm trying to now wean myself…not wean myself, but have them taper to find out what my baseline is, and what…It's like pulling teeth to get this done though.*

Here, Robert discussed his role in treatment similar to that of a clinician and scientist: he was invested in finding out what he would be like without his medications (his "baseline"). He was given a series of medications while in jail without a proper evaluation and believed AOT-LA would be an opportunity for more supportive mental health services. But in trying to conduct his self-work in the ERS facility – in particular, attempting to understand what medications he did or did not need – Robert experienced resistance from his treatment team. Providers did not always listen to him and, even when they did, any changes were slow to take effect. At multiple occasions Robert asked to be taken off the antipsychotic medication, which his psychiatrist refused, even after he cited his concerns for adverse effects.

Not only were his attempts to assert agency restrained by his psychiatrist, but Robert indicated that the limited staff, physical infrastructure, and routines of the ERS facility denied him opportunities to find new providers or counteract the drug-induced weight gain. For example, while his psychiatrist encouraged him to diet and exercise to counter his weight gain from his antipsychotic use, Robert argued that he had no choice but to eat what was fed to him and to stay on the premises of his boarding care facility. Robert had nobody else in the facility to turn to either. He acknowledged that everybody was positioned in a power structure: at the bottom was him, the staff were in the middle, and, at the top, the psychiatrist: everybody "falls under the doctor." Ironically, while the psychiatrist had the highest authority to determine what medications Robert would consume, the psychiatrist was the most concealed and least accessible for clients. Their daily interactions with treatment staff around medications did not concern their effects either; rather, these interactions were centered around enforcing compliance. And for Robert, refusing drugs was not an option. He reported that his compliance was his way of not "rock[ing] the boat" in hopes to be transferred to a lower (non-compulsory) level of care.

Robert reported that the medications were a method in themselves to make clients more manageable in the facility. (And, as I noted, our ethnographic research team noted that clients exhibited many adverse effects of atypical antipsychotics at ERS facility.) Consider this quote by Robert: "I feel like I'm being…I feel like I'm being…uh…warehoused sort of. Like my body has been warehoused…or…I'm angry about it." Here, Robert evokes the analogy of his body being warehoused – not as a person who must be cared for or engaged with, but rather another client who they needed to see through his six-month treatment period with as little issues as possible.

Robert's case reveals how the interpretation of *social control* frames medication and medication management as a means to deny individuals agency to pursue their own goals and interests. For Robert, he aspired for a new life marked by spiritual principles, sobriety, self-work. In a sense, Robert's disappointment may be because he initially believed AOT-LA was a program that aided him on this journey, but instead he felt warehoused in a small house, with little one-on-one therapy, and was coerced to take medications.

I identified the concept of *social control* when medications were used reactively in relation to client experiences and behaviors. This particularly occurred in cases where client violence perpetration was in question. Some clients expressed that the reported instances of violence were rational responses to abusive living situations at home or as a means to protect themselves. In these instances, the rationality of client violence was scrutinized by AOT-LA providers, who viewed violence perpetration from clients as an extension of psychosis.

To demonstrate this, consider the case of Darian, an AOT-LA client I observed in a group therapy session in the same ERS facility as Jose. I asked the main therapist if I could talk to Darian. In my observations of group therapy, I became interested in interviewing him because he was one of the younger AOT-LA clients I encountered in my ethnography and, in the group, he mentioned that he wanted to go to college. After his group therapy session, I asked the therapist if I could interview Darian, to which she immediately said: “No.” She then explained that Darian was violent and particularly non-compliant to treatment. In this instance, the therapist felt protective of me, as an ethnographer, and felt liability over my own safety. I pressed a little more, informing the therapist that it was important I captured everybody’s experiences including clients who are non-compliant. She agreed to it but informed me that I could only perform the interview with security immediately outside the door.

The therapist escorted Darian and me to a separate room. Darian was a Latino man, age 19, who wore a grey hoodie, baggy red basketball shorts and red sneakers. His hair was cut short, except for in the back, which was held up in a small ponytail. Darian approached me with a warm and curious demeanor. Before we even began the consent form process, he asked me all sorts of questions about college: *What’s it like to go to college? Am I in a dorm? Is it difficult?* I could tell by his voice, which was later confirmed in the interview, that he admired me for having gone to college. Darian had a clear life goal set before him and was excited to gain any insight to the world that awaited him when he finished AOT-LA.

In the interview I learned that prior to AOT-LA Darian was incarcerated in a juvenile detention center. His original charges – which were later lowered - were attempted murder, kidnapping, and carjacking. He was transitioned from juvenile detention to AOT-LA for, as Darian phrased it, “mental health reasons.” Specifically, his lawyer sought an evaluation by a psychiatrist whose report allowed him to “beat the charges” by the criminal court system. While his schizophrenia diagnosis diverted him from more serious charges, he expressed ambivalence towards the label. He described having hallucinations – moments where he would see a dog following him or the Devil appearing everywhere – and even reflected on how others used to describe his behaviors as delusional and bizarre. Darian almost reflected on his past with a sense of humor, laughing about his strange experiences. It was his psychiatrist in jail who finally convinced him to start medications. Darian recounted his words: "*Just take 'em bro, you're going to feel better, 'cause like, what you're telling me isn't normal*." And while Darian wanted to become more normal, he did not believe he was not *normal* due to psychosis. Instead, he was missing out on normalcy because he was not like other people his age: instead of living in the community and attending college, he was in juvenile detention and now an intensive mental health services program.

When I asked about his goals for AOT-LA, Darian described the program through the words of his therapist: to start medication and "go on with [his] life." While medications were a primary component of the program, he reported mixed experiences with them. His anti-anxiety medication made him feel more "clear-headed"; it was a prescription he valued and wanted to continue after AOT-LA. However, if he had a choice, he would discontinue his anti-psychotic medications. Darian had cycled through so many in the past few years – Seroquel, Zyprexa, Abilify, and Latuda – that he had trouble remembering the order he took them and needed time to remember their particular effects.

The threat of punishment from the ERS facility was one of many factors that made the use of psychiatric medications feel oppressive. Noncompliant clients were placed on "restriction," which was a 7 day hold where clients were not allowed to leave the facility for group outings. Darian first tested this rule when arriving at the facility by refusing his antipsychotic drug and ended up on restriction. Darian reported that this restriction "got" him because afterward, he became compliant: "I want to have the privileges that other people have here."

Like other clients, Darian also felt that his psychiatrist did not consider his needs or preferences with medications seriously enough. For example, his ERS psychiatrist switched him to Seroquel, where he felt immediate adverse effects: "*The first day, I just felt heavy…I felt so sleepy. I just couldn't do nothing. I just wanted to sleep all day. You just have no thoughts, like a zombie, you get me?"* In response, Darian attempted to advocate for himself to his psychiatrist: "*I had to tell her a couple of times, you get me, 'cause they really don't listen…'cause she's like "you're a bunch of kids," you get me? She saw us a bunch of kids, you get me?*" Here, Darian identified that his psychiatrist had paternalistic attitude towards him: his opinions regarding medications were not taken seriously unless he was persistent. In another instance, Darian drew a parallel of how clients were treated as "puppies" in training. In this analogy, the ERS providers conditioned clients to follow orders through their use of rewards and punishments. Indeed, in the ERS facility, Darian was under constant supervision. He had daily group therapy sessions and weekly meetings with an interpersonal therapist. Despite how enmeshed he was with the treatment operations, he was granted one opportunity once a month to advocate for medication changes with psychiatrist. Otherwise, the only role his treatment team played in regard to medication was to serve as an enforcer. Consider this conversation Darian recounted with his therapist:

> *They were just like "What aren't you taking your medications?" And I told her why – like, they doubled it, you get me, from what I was taking. And they're saying like, they say, well I mean, "I can't control that, you get me? That's not part of like, there's nothing that I can do. That's between you and uh, the psychiatrist here."*

Here, the psychiatrist played the role of managing psychosis through prescribing medications. The other actors on the treatment team took up the responsibilities of monitoring and enforcing consumption.

Darian's interview also reveals how violence perpetration was interpreted through the lens of biopsychiatry and the role of antipsychotic medications in managing client behaviors. Consider this moment in our interview where Darian reflected on how his psychiatrist raised the dosage of his antipsychotic upon entering the ERS facility.

> **Ryan**: *So when you entered AOT, they said they were going to raise you from 20 to 40…*
>
> **Darian**: *Oh no, she just did that. The…the psychiatrist here did that. Not even the team.*
>
> **Ryan**: *Do you know what reason why? Did she give you a specific reason?*
>
> **Darian**: *Yeah, she said that I was acting up, that I was being very aggressive…horse-playing, not following staff instructions…*
>
> **Ryan**: *How do you feel about that? Do you feel like –*
>
> **Darian**: *Uh, I kinda was doing that…But, uh, I don't know, like for me I was just…in my mind, I was like gonna be in a place where there were gonna be…pretty grown men…I was sure that one of 'em were gonna try and punk me, you hear me? So I gotta show 'em, nobody gonna punk me, y'know? So I…*
>
> **Ryan**: *So you were…you sorta had to prove yourself…in a way?*
>
> **Darian**: *Yeah. But now it's like…dumb, 'cause these people are like nice people.*

Here, Darian connected his violence perpetration in the ERS facility to feeling vulnerable and insecure in a new and unknown institutional setting. In his past experiences in juvenile detention and the "most hated gangs in the world," he had to be prepared to defend himself at all times: "*I had to fight all the time*." Darian explained the rationality of his violent behaviors as an extension of his personal life experiences – marked by trauma and vulnerability. But this expression of feeling of unsafe was viewed through a clinical lens by his psychiatrist, who was likely concerned with the impact of his violence on the operations and client safety in the ERS facility. And while doubling of his medications may have sedated Darian, the treatment team did not connect his current behaviors to his past experiences. At the crux of whether medications were seen as a technology of *clinical* or *social control* was a more implicit understanding of whether client behaviors can be understood as rational or psychotic.

The interpretation of psychiatric medications as a technology of *social control* often produced ideological conflict. These conflicts were, at times, expressed – like in the case of Darian – or, in other cases, clients did their best to comply and move on in the program. In some cases that we observed, however, clients had ongoing noncompliance to psychiatric medications – especially when they viewed medications as a form of social control.

### Moral Discourses and Medication Management

So far, I reported my analysis on the interpretations of psychiatric medication effects. When these interpretations were congruent between providers and their clients, medication management services proceeded as providers intended. In these case, psychiatric medications were delivered to receptive clients who compliantly consumed the medications. As I noted, instances of client compliance did not necessarily mean clients did not seek changes to their prescriptions or provider medication management approaches. Some clients briefly discontinued medications or sought adjustments based on emergent negative effects in the course of services. However, when interpretations were incongruent – namely, when providers viewed medications as a technology of *clinical control,* but clients viewed medications as a technology of *social control* – conflict emerged in the therapeutic dynamic. This posed several problems for providers. First and foremost, some clients who viewed medications as a technology of *social control* preferred to decline psychiatric medications, which was barrier to providers achieving compliance with their clients. Second, some of these clients reportedly did not trust their providers. In turn, providers had to navigate mistrust and tension in relation to managing psychiatric medications. This tension spilled over into other key areas of work, such as psychotherapy or case management activities. In response, providers relied on a range of covert and manipulative techniques to achieve their aims for client medication compliance.

Manipulation is one of many types of coercive and influential techniques discussed in the clinical and bioethics literature. I intentionally chose this term to provide a framework to capture providers medication management techniques in AOT-LA and based on the working definitions of this term in extant bioethics literature. Broadly, manipulation refers to an influential tactic whereby an individual attempts to bypass another's reasoning, often through influencing the perceptions of an agent through deception (Blumenthal-Barby & Burroughs, 2012). In some definitions of manipulation, the manipulator guides the agent in such a way that the individual thinks that they are acting of their own freewill but would have chosen otherwise without the influence of the manipulator. In other definitions, manipulation refers to when an agent's decision-making process is shaped by an external party who distorts the agent's interpretation of their choices and their associated consequences.

While I had expected to capture an explicit moral discourse regarding coercion and client autonomy in our ethnographic observations, rarely were ethics at the forefront of discussions. There were brief moments where administrative staff considered ethical questions, though often these were often born from when staff noted gaps in services. For example, Rachel Parks observed, during in a referral team (2017-07-11), a debate on whether there should be a limit on

AOT-LA extensions or whether, theoretically, a client could be in AOT-LA forever. One staff member spoke up to explore the moral implications of their work: “What does it mean for people to *think* they’re court-ordered to take meds?” While the table considered asking a staff member from the Patient Right’s bureau on the ethics of this, the conversation halted and the team moved on to their referral review. At first, these moments appeared to be an opening where the moral ambiguity of services might fully be confronted but, more than not, staff defaulted to the importance of reducing client vulnerability through enrollment and medication consumption. Similarly, some treatment staff reflected on the ethics that supported their work, but mostly their reasoning was not brought into question, even at staff meetings, where providers instead focused on the various day-to-day duties of delivering services and, as Saqib stated, “putting out fires.”

What can we infer about the moral discourse upon which such pervasive forms of institutionalized and interpersonal forms of client manipulation emerged? The first type of discourse I identified in the data relates to the medical paternalism of *medicating vulnerability.* Here, providers morally rationalized the practice of coercion and influence – broadly defined – as a way to protect clients from other adverse outcomes that they would otherwise face in their communities. Consider this interaction that I had with a psychiatrist, dated 2018-01-25:

> [*Dr. Reed*] *discloses he thinks AOT is a compassionate policy approach to the issue of severe mental illness. He tells me that compared to prisons, it’s a much better option. He tells me he used to work in the Bay Area in the prison system as a psychiatrist. Dr. Reed says this is the basis for his evaluation of AOT – sure, it may not be perfect but it’s nowhere near as detrimental to clients as prison is. I nod my head. He tells me that the “libertarian types” are very opposed to AOT. These types of people exist in the world of FSP services and they think commitment is a “bad word” but that it shouldn’t be –*

> *service providers should be open to the idea of committing somebody to treatment. Many of these providers, he argues, usually don't understand the damage that prison can do.*

This logic is strikingly similar to the broader rhetoric to support coercion in AOT-LA and of course, also undergirds the theme of *medicating vulnerability*. It is important to note, however, the AOT-LA does not restrict individual freedoms through physical force or punishment either. AOT-LA restricts individual liberties through a specific form of coercion and influence – what I have termed *client manipulation* – so the remaining question is not why coercion itself is justified through moral discourse, but rather what are the moral imperatives for this particular *form* of coercion?

The social grid of medication management demonstrated a wide range of moral attitudes towards the use of coercion, influence, and manipulation in mental health services. On one end, there were AOT-LA staff who did not consider client autonomy in treatment and, instead, believed that addressing clinical symptoms should always be a primary goal for clients. Indeed, we observed this type of medical paternalism most prominently in the mental health court with the judges and public defender. On the other end, we observed providers who were hesitant about compelling medication consumption. Treatment providers sought less influential techniques to encourage medications, such continuous suggestions. This may be because, as opposed to the mental health court, the treatment providers needed to work towards a long-term rapport with clients in order to conduct their services. Consider this moment I had an interview with Saqib (2017-05-10):

> **Saqib***: So, I guess there's…AOT is sort of a grey area because…we're saying, we're strongly suggesting they do it, but there's no legal recourse. You know so, I mean*

> *it's…it's…mandated in name, right? Do I think it's "fair"? (*sighs*) I mean…that's just such a complicated question –*
>
> **Ryan***: It is, it's a difficult one –*
>
> **Saqib***: --because it's not just the client, we have to consider the family they're living with, or the community that they live in. So when we have people who are sick, in the community, it's…it's a community issue. So, was it fair for the, for the neighborhood to be there somebody who is hostile…potentially violent? That wouldn't be fair. But, but giving them the treatment with dignity…you know…uh, which I think AOT, from my brief experience does, you know we're not…strapping anyone down and making them get injected either, you know, and we're doing a lot of safety planning…and – and -- and being involved with the family, and – and trying to reduce any potential harm that could happen…we're trying to walk a fine line. And we do the best we can.*

Here, Saqib echoes the sentiment of *medicating vulnerability* and medical paternalism. He also demonstrates that "in between" may not entirely have to do with a moral discourse itself and, rather, be a product of the forced therapist-client relationship, where the provider must work with the client and thus is dissuaded from using techniques that would make that work difficult or impossible. Said more plainly: it was in the providers best interest to use manipulation with their clients because overt tactics would offend the client and, conversely, relinquishing control meant that clients slipped through the cracks of services. Similarly, providers and family members alike expressed hope that once clients began to comply, they would "naturally" see the benefits from taking medications and then prefer to consume them. For example, in observing a warm handoff with a client and their mother, Blake noted (2017-07-17) a mother said to a provider: "*Once he [the client] sees that being compliant gets him somewhere, he will be better.*" Here, manipulation was rationalized through the expressed hope that the client will come around to their rationality and ultimately come to agree with the decisions that were made on their behalf.

The specific moral behaviors that emerged can also be understood through the peculiar position that providers were in. AOT-LA policy defined what was *not* acceptable (i.e., both force and leaving clients vulnerable), but also did not outline how services *should* be delivered to noncompliant clients. This left providers in this realm of extreme moral ambiguity, forcing them to test various ways to gain client compliance, while calculating how their actions may impact their working relationships to clients. Indeed, many providers resented the fact that they had to enforce medication consumption and not the judges directly. In an AOT-LA meeting with providers and administrative staff (2018-01-2016), a DMH staff member stated that they were considering creating new protocols for AOT that would permit incorporating "Riese hearings" in the program. Riese hearings refers to special procedures to enforce medication consumption among individuals who (1) are committed to hospitals for three or more days and (2) are declining psychiatric medications. At the time of this project, Riese hearings were not incorporated in AOT-LA; however, the suggestion of adding them was met with a sigh of relief from the providers in the room: providers wanted the courts to take on the task of pressuring clients to take medications.

### The Three Practices of Client Manipulation

To create and name the category of "manipulation," I first characterized techniques I noted regarding psychiatric medication management in the data. Next, I considered how to best characterize these methods in relation to existing categories in the literature (methodologically, this is called theoretical sensitivity; Charmaz, 2014). I noted that while providers used various tactics to gain client compliance, these techniques did not involve total physical force or coercion (i.e., use of threats) in the way Nozick (1969) defined. Conversely, providers did not rely on argumentation, persuasion, or other rational-based discussions with their clients. Instead, providers relied on a series of techniques which I have named as *concealed collusion, performing coercion,* and *circumventing consent.* I noted that these techniques were used in conjunction or succession with one another in instances of noncompliance, which suggested these techniques can be best understood as belonging the framework of *client manipulation* which, alongside medical paternalism, undergirded AOT-LA services.

Before I define the various forms of *client manipulation*, I will make a few points of clarification regarding the concept of client manipulation. First, these three strategies were not present in every ethnographic case, of course, as providers only relied on strategies until they gained psychiatric medication compliance. Further, these strategies are not meant to capture all the types of *specific* ways of interacting with clients but, as I demonstrate in my findings, represent broader approaches. In other words, there were many ways in which the category *performing coercion* was identifiable in my data and no two instances were identical. My goal of the proceeding section is to not only demonstrate how these categories operated in the data, but also demonstrate their breadth, properties, and nuance across cases. Lastly, these techniques do not encompass cases where providers did *not* enforce compliance with their noncompliance clients. As I demonstrated in the case of David, some providers believed that medications were a necessary component to recovery (i.e., they espoused the logics of *compulsory compliance*), but had trouble implementing services due to logistical barriers like a lack of resources or personal factors such as disinterest in performing their assigned labor.

### ***Concealed Collusion***

The first category is concealed collusion. Concealed collusion was a process where the social grid of medication management strategized together, often without the knowledge or input of clients, to make clients feel compelled to take medications. In the data, this phenomenon was more than merely dividing the responsibilities of medication management across the social grid; rather, members of the social grid collaborated to play different roles to enforce medications. Through this, clients became entrapped in a network of individuals where they became restricted in their behaviors due to constant surveillance or behavioral enforcement. In a sense, concealed collusions may be compared to the concept of peer pressure, though the individuals exerting pressure had significant institutional power over client behaviors. I am presenting the concept of concealed collusion first because it was present through the two other forms of manipulation, *performing coercion* and *circumventing consent*.

### ***Performing Coercion***

The second category is *performing coercion.* Performing coercion was the intentional effort by the social grid of medication management to make clients believe that (a) medications were a mandatory part of the program and (b) there were programmatic consequences if clients failed to comply. I named this effort as a performance because providers sought to create this understanding with their clients while simultaneously aware that (a) medications legally cannot be mandated and that (b) there were no consequences for client noncompliance alone, outside the restrictions that ERS facilitates may choose to exercise. I classified performing coercion as a form of client manipulation because the intent, by the social grid of medication management, was to change client deliberation on whether to consume psychiatric medications or not through deceit: that is, by making reality appear differently from how it actually operates.

**Courts: The Main Stage for Performing Coercion.** In this section, I demonstrate the theme of *performing coercion* in AOT-LA services. In particularly, I demonstrate how the function of the courtroom in AOT-LA can be best understood as fulfilling the role of *performing coercion*. Further, these ethnographic examples will simultaneously demonstrate the concept of *concealed collusion.* To do this, I first briefly give an overview of the setting of the mental health court and its regular proceedings. Then I provide a few specific ethnographic case examples to demonstrate my themes.

The Mental Health Division was located on the fourth floor of one of the Los Angeles Court Houses located in South LA. On this floor, there are four courtrooms - each assigned to one judge. Every Friday was dedicated to AOT cases. Otherwise, the judges ruled on cases related to mental health competency, civil commitment, and other community-based restoration programs for people with serious mental illness. The courtrooms themselves were like wooden boxes: the walls, ceiling, benches, and stands are constructed light wood stained with the same golden bronze stain. The United States, California, and Los Angeles County flags were draped on stands in the back. A chalkboard in the back right of each courtroom outlined basic rules for audience members: no talking, no cellular devices. To my surprise, it appeared any one can simply enter the courtrooms to sit in the audience and observe court proceedings. One simply needed to push past the double doors and sit in the wooden benches. Overall, the organization of AOT-LA hearings were disorderly. Some days, AOT-LA hearings were canceled or pushed back a few hours. Judges worked through case after case until they reached their allotted time, which meant that providers and clients could sit for hours waiting for a case to be heard, only to find out that the case would not be heard at all.

The judges ruled over two types of hearings for AOT-LA. The first type of hearing was to mandate individuals to partake in the program. In these hearings, the judges would call upon outreach and engagement staff, particularly licensed professionals on their team, to hear their evaluation of a referred client. Here, the judge would ask questions about client symptoms, history of noncompliance and associated disability, and their ability to benefit from the program. Then, the judge would rule that the client must partake in AOT-LA services. The second type of hearing was a progress report. In these meetings, clients would sit before the judge and the two would discuss the client's progress towards treatment goals. The judge relied on reports submitted by treatment providers in these meetings as well. Here, the judges engaged in a dialogue with clients. At times, judges complimented clients who were actively participating and, conversely, pressured noncompliant clients to partake in services. Notably, I did not note any substantial conversation about the drugs in themselves between judges and clients. There was no discussion on client experiences with psychiatric medications effects, the specifics of the prescriptions, or how often they were taking them. Judges moved quickly through their questioning, simply seeking a quick verbal affirmation from clients that they were being compliant.

The courtrooms were a site for judges to interact with clients but, in our observations, one of the primary actors in the space was the public defender. In AOT-LA, specifically, their job was to mediate discussions between judges and the various clients. In my first observation of the mental health court, I was immediately clued into the role that the public defender plays in relation to psychiatric medications. In a note dated 2017-02-03, I wrote:

> *A small divisor, made of the same material [wood] materials, cuts the room in half: the audience (who are lightly dispersed across the rows of seats), and a space dedicated to the*

> *judge and lawyer's [benches]. [Outreach and Engagement] staff have arrived in the room, along with a few clients who sit in the audience's first row. I see a woman at the lawyer's table move to speak to one of the clients. She is the public defender. She leans across the divisor, using her hands to steady herself, and asked one of the men: "Have you taken your medication?" He confirms with an urgent "Yes!" and proceeds to stand up. But she quickly interrupts him in a raised voice: "Good, now sit down! Sit down!" She returns to her seat.*

Here, the public defender was Clara, a middle-aged white woman whose presence felt omnipresent in the courts. At some moments, she was whispering to the judge behind the stand while, at other points, she presented cases on behalf of clients, and still, at other moments, she rushed into the hallway to deliberate with outreach and treatment staff. Like in the passage above, Clara often checked to make sure outreach and treatment staff and clients were all prepared to present in front of judges in order to move the court hearings along as smoothly as possible. When she met with outreach and treatment staff, she instructed them on the specific wording they should use to describe clients while with judges. And, when she spoke to clients, she asked questions about their compliance and echoed judges orders. In some moments, Clara also spoke up during court mandates and progress reports, acting as a translator between judges and clients.

Consider the case, Diamond. In a note, dated 2016-11-18, Joel observed a formal consent process to voluntarily enroll in AOT services while at the courthouse. This specific client refused to sign AOT voluntary papers outside of the court room setting. The outreach staff were able to convince her to show up to the mental health court to sign the paper. During the consent process, medications were explicitly stated as a part of the program. They mention that they'll be monitoring her to make sure she's taking them, and that she should follow all the recommendations. The court will be there to "make sure everything goes well."

Here, Joel noted how various AOT-LA providers and administrative staff had different effects on Diamond, presumably due to their interpersonal styles. Ricky, one of the AOT-LA outreach staff, had "unremitting humor and general levity" – an observation confirmed by Charlotte's observations of the outreach process. In a similar sense, the public defender Clara was able to affirm the client's concerns while moving the process of consent forward, swiftly moving through moments of potential conflict and landing towards resolutions. On the other hand, Keisha, the staff psychiatrist, complained that she could not win Diamond over: "*I'm upsetting everyone today, first my kids and now her.*" Here, the social arrangement was present as the providers strategized with one another who could best sway Diamond to enroll in services. Later, Joel (2020-09-04) noted:

> *The [outreach team] expresses some concern about Diamond being in the courtroom for discussion of this case because essentially this other patient has continually failed to comply with the treatment plans to which she has prescribed and subsequently "decompensated" and ended up being hospitalized—they are concerned Diamond could learn from this example that there is nothing officially stopping her from not taking the medications.*

Here, the social grid of medication management wanted to keep a client ignorant of the policy regarding mandated medications. If Diamond learned there were no ramifications for noncompliance, it would risk breaking the illusion of mandated mediations. That is, the illusion of coercion in the court was the pin that held medication compliance in place.

The public defender also worked behind the scenes. For example, Charlotte observed in a meeting, dated 02-07-2017, the types of collaboration that took place between the public defender and the outreach team. During this meeting, they strategized exactly how to present the client characteristics to the court in order for clients to be mandated. Clara explained that the judge would consider not how well the client was doing at the moment of the referral but whether without the program, the client might be considered a risk for deterioration and *becoming* dangerous to self or others. Linda, who ran the outreach program for AOT-LA, was excited by this insight as it allowed them strategically frame cases in order to achieve the outcome of a mandate. Here, *concealed collusion* operates between institutions within AOT-LA.

While Clara collaborated with the outreach teams and treatment providers to advance the production of *performing coercion*, her insistence on medication use in services seemed to also embolden judges. Consider a note (dated 2017-06-03) in the courtroom where a judge had encouraged a client to partake in a mental health evaluation with their provider. The ethnographers wrote:

> *With that settled, it seemed like everything was about to wrap up, so Clara jumped in.*
>
> *"So the court's recommending medication?"*

The judge responded by stating the court is *ordering* the client to comply with medication and that is part of the program. The performance of coercion was escalated by the public defender who demanded more explicit language from the judge for the client. While we were unable to secure details on the specific background of the client, it may be the case that Clara and the judge believed that certain clients need a more convincing performance that medications were mandated in order to gain their compliance. Still, there was no means to actually enforce medication consumption by the court system itself and no legal repercussions (e.g., hospitalization, fees, or incarceration) and the actual monitoring of medication compliance was delegated to the client's provider. In other words, the judge's demand was a performance – an order without substance.

I noted that the logic of *performing coercion* extended outside the courtroom though and was repeated to providers throughout the course of our observations. In a meeting on 2017-08-07 at *Empowerment for Families*, two county administrators visit the team meetings to clarify the policies and procedures of AOT. In this meeting, I wrote:

> *Marisa* [therapist] *asks, "What is a petition?" I'm surprised that she doesn't know, and how late in the meeting it is for her to be asking such a basic question. Nicole* [DMH official] *responds that the client sits in front of a judge and [the judge] orders them to participate. Marisa asks a clarification question, wondering if this would involve taking medication. Nicole says no and that by law medication cannot be mandated in AOT. Robert* [DMH official] *leans forward, holding his finger up: "Ya, but there's a catch…" He seems smug about what he is about to say. He smirks and says the judge tells the client to follow the treatment order and to follow the program. "So, if you guys say medications are part of the program…"*
>
> *Matthew wants to know "what's hanging over their head."*
>
> *Marisa responds: "Possible jail time."*
>
> *Robert quickly corrects her: "Not for AOT."*

Here, the administrative officials encouraged the use of *performing coercion* as a tool to gain medication compliance for clients. Interestingly, the providers still want to know what the actual repercussions for noncompliance were. After Robert corrected Marisa, another DMH administrator lamented that the mental health court system needs more "teeth" to punish noncompliance. The language of “teeth” was common in our observations - the perception that coercion should not involve a performance, but actual ramifications that could be exercised.

In my interviews with clients, this performance appeared to be effective. Consider the case of Robert, who discussed why he was compliant with medications despite his concerns regarding their safety:

> *I’m forced to take the medication. If I don’t take the medication, I have to go back…uh…there’s been a report in court that affects my…uh, life…where I’m going from here…and I feel like a victim…and I don’t feel empowered [...]*

Here, he connected his medication behavior to a broader system of surveillance; however, note that while Robert was placed in AOT-LA by a judge, he did not name a specific consequence for noncompliance. The general sense of being monitored by a court system itself can produce compliance.

### ***Circumventing Consent***

The third category is circumventing consent. This theme refers to when providers avoid deliberating on treatment decisions with their clients and, instead, make decisions on their behalf. This also emerged as informed consent processes that providers conducted without (a) supplying clients with full information regarding services or its components (omission) and (b) providing time for clients to deliberate on the information provided to them. This can be interpreted under the broader theme of circumventing consent because it creates the appearance, for clients, that there is no space for informed decision-making process in AOT-LA services.

I noted that the theme of *circumventing consent* was present in the both the outreach and treatment processes. During the outreach phase, I noted the pattern of circumventing consent in the beginning stages of treatment where providers sought consent to treatment from services.

During the treatment phase, I noted the pattern of circumventing consent throughout the course of treatment services when providers sought to implement treatment services. In my analysis, I identified that providers circumvented consent in order to minimize opportunities for interpersonal conflict with their client, particularly if they believed clients would decline treatment interventions.

As it relates to the outreach phase, I noted that the consent-to-treatment processes in AOT-LA were exercised in ways that actual circumvented client autonomy. The consent-to-treatment process refers to when clients, who have voluntarily agreed to services, officially sign the paperwork which marks their enrollment in AOT-LA. These ethnographic moments were often wrapped up in the question of medications, particularly whether and how providers disclosed the use of psychiatric medications. Consider the consent process for David, the client with *Empowerment for Families,* dated on 2017-04-05. During the initial moments of outreach meeting, Saqib discussed that AOT-LA would involve therapy and medications. Once David seemed open to the idea, Saqib had to gain David's signature. To do so, Saqib reviewed a packet of materials that outlined the specifics participating in AOT-LA. I wrote:

> *It's excruciating: page after page after page after page. The client is trying read everything he's signing. He uses the pen in hand as a pointer to follow the lines of text, somewhat in an abrupt and arrhythmic manner. I think Saqib misinterprets this as the client being confused as where he should sign. He continues to point on the piece of paper to indicate where he should sign. It's like an awkward dance. The client even tries to brush his hand away so he can read, to which Saqib says something to the effect of, in a reassuring tone: "I already told you what it's about" and "You've already initialed this*

> *item before, this paper is just a copy that you need to sign again." While he's signing paperwork, the [outreach workers] stand off quietly to the side and observe.*

Here, Saqib pressured David to sign the documents as quickly as possible. Whether this was intentional or not is an interesting point of interpretation. It is possible that Saqib did not want to engage in any questions from David, or provide him sufficient time to review the documents, because he felt that David already had sufficient information on the program. Still, David was indicating he wanted more time to review the documents he was signing on to by reading the document line-by-line with his pen. It is possible, as well, that Saqib did not even consider the fact that David would want to or can deliberate on what he was signing on to. Note that as David reads through the document, Saqib directed David to the signature line, and seemingly attempts to clear David's supposed confusion about the document. Here, Saqib may be underestimating David's capacity to interpret and deliberate on information. Lastly, it is important to note that David did not have a meaningful say on whether he would like to participate in the program or not. If David declined participation, then the outreach team would seek a court order or settlement agreement. To this end, it may be the case that Saqib saw through the performance of the consent-to-treatment process: whether David understood the materials or not did not change his inevitable enrollment in the program. Regardless of the reason, while Saqib followed the institutional procedures to gain a consent, this process did not meaningfully engage in David's own preferences or interpretations of the program.

This was a common theme in the notes that involved consent-to-treatment. In some instances, providers did not mention medications and instead stressed the physical resources clients would gain by participating. At other points, the consent-to-treatment process was conducted with clients who may have lacked the psychological capacity to consent. For example, in another observation by Charlotte (dated 2017-03-21), the outreach team meet a referred client in a hospital and were informed, by the attending nurse, that that particular client was heavily sedated on drugs. These instances reveal not only how a consent process can be abused by providers, but also begs the question of what this consent process actually does for AOT-LA. Is the consent process merely a façade to protect the AOT program's “ethical integrity”? Is it a relic of voluntary services, grafted onto AOT-LA? Or is the signature not even truly about consent, but having a legally binding document that can later be leveraged against clients if they were to become noncompliant in services? Regardless of the reason, throughout these notes, providers avoided the issue of client autonomy throughout the consent process and, ironically, end up circumventing proper consent. These instances, of course, do represent every single instance of the consent-to-treatment process, of course. There were ethnographic examples where providers discuss more fully the specifics of AOT-LA.

As it relates to the treatment phase, and psychiatric medication management, I first identified this theme in the semi-structured interviews I conducted with clients regarding their experiences with medications, which I introduced in the data regarding interpretations of psychiatric medication effects. Regardless of their specific interpretations of psychiatric medications, many clients discussed how decisions regarding their prescriptions were conducted without consideration to their past experiences or preferences with medications. Here, clients identified ways in which providers were circumventing a collaboration and consensual working relationship with them to determine medication use. Interestingly, while I had asked whether they discussed medications with any providers other than their psychiatrists, clients indicated that their other treatment providers only monitored medication compliance.

### An Ethnographic Case of Manipulation: The Story of Jasmine

This ethnographic case is related to Jasmine, a Black woman in her early 20's who was diagnosed with schizophrenia and voluntarily enrolled in AOT services. I first met Jasmine in October 2017 through *Empowerment with Families,* the FSP AOT program whose treatment team meetings I attended. I participated in observations of Jasmine's treatment with the FSP agency until October 2018 and maintained contact with her primary therapist afterward. I made an effort to attend her treatment sessions weekly, though my attendance was inconsistence as her treatment team ran into difficulties scheduling regular sessions with her. Through the course of my observations, I took notes on her treatment sessions, and conducted interviews with Jasmine, her primary caretaker (her mother, Ximone), and several members of her treatment team. I quickly established rapport, after my first observations, and received a warm welcome from Ximone and Jasmine when I entered their home. This was a particularly rare opportunity to deepen my understanding of AOT-LA given my welcomed presence: each member saw my presence as the opportunity to give voice to their experiences and improve aspects of mental health services, though from their different perspectives. As such, I portray the different perspectives of each individual related to psychiatric medications and moral discourses of consent/coercion.

To do so, I present Jasmine's case with the following manner. First, I introduce Jasmine and her social grid of medication management. This includes exploring Jasmine and her history with the mental health system as well as the initial areas of concern that set forth the motion of Jasmine's AOT treatment. Second, I trace how the case evolved after her enrollment, including the role of medications, whose use involved implicated her assigned treatment goals and evoked tensions regarding different interpretations of their effects. Woven throughout, I discuss Jasmine's experience with housing and homelessness, which exacerbated her structural vulnerability to community-based violence, which became a primary consideration in the social gird of medication management's pursuit for medication compliance. Throughout and at the end of this section, I demonstrate where I identified my thematic categories (medications as a technology of control and clinical manipulation) and their relationships to one another in shaping the course of Jasmine's case and medication use.

### *Introducing the Key Actors*

For the first few weeks of my meetings with Jasmine and her treatment team, we met at her mother's house in south LA, situated on a thin stretch of land and sandwiched between a major freeway and a busy 4-lane road. This particularly area consisted of one-story adobe-like structures gated by black iron fences – stylistic for this part of the city – though more modern condominiums were sprinkled throughout, marking an inevitable wave of gentrification. Her mother called the area "the ghetto" and diligently locked her driveway, iron screen door, and front door every time I visited. While I took her word for it, I noted that through my time in the neighborhood, the area was often quiet and calm. The streets were lined with tall palm trees and around the corners were several automotive repair shops, often gated in with tall iron sheets that are decorated with vibrant graffiti.

During my first visit, Halloween was just around the corner and the yards were alive with decorations - some playful and cheeky, others darker and more gruesome. Browned leaves were scattered across the yard and baking in intense Southern Californian heat. As I parked my car, I received a call from the therapist, Emma, who told me she will arrive soon. Then, in a measured voice, told me that I should be careful around this client: Jasmine can be irritable and was prone to outbursts. Emma's tone lightened up and she added: "I've been trying to connect with her through art." Throughout my observations, I found that Emma would consult with me by taking time to explain the new strategies she wanted to try to connect with Jasmine. Shortly afterward, I saw her pull up in her car and exit.

Emma was an Asian woman in her early 20's, new to *Empowerment for Families*, and had recently completed her MSW. She sported a white blouse and grey pants with navy pin stripes. She carried a large purse that held documents, a clipboard, and her laptop. During this first encounter, I noted that Emma was different compared to the other therapists that I met during my ethnographic observations. While some therapists viewed their roles as tiresome, full of laborious obligations, Emma was passionate about her role and extended a warm welcome to include me in her treatment sessions with Jasmine.

When I first walked into the home, my eyes took time to adjust to contrasting darkness. There were three sets of windows in the room, though they were all covered by navy curtains. The floor was lined with navy blue carpet, the walls were bare white, and a single light fixture sat flushed against the ceiling. The room was crowded with random object: bright pink play toys, belonging to Jasmine's niece, were scattered against the far wall. A small TV sat on a stand, connected to an old PC laptop with a glitched screen, across from a sectional couch where Jasmine sat. Over the following weeks, I came to understand this front living room as a representation of Ximone's family situation. Initially, Ximone, her two daughters, and her granddaughter shared the few living spaces, though only a few weeks in, Ximone's grandmother, brother and sister-in-law moved in too, creating more and more clutter and less and less space. Ximone hosted everyone under her roof, serving as a caretaker against the harsh economic realities that her immediate and extended family faced. I described my first encounter meeting Jasmine in my ethnographic note (2017-10-25):

> *Ximone pulls up two foldable chairs by the couch, where I notice a woman sitting. Or, rather, she's lying down on her side. Ximone snaps at her to sit up. Suddenly, I realize that it's Jasmine - the client we've come to talk to. Jasmine is likely in her early 20's. She's wearing a t-shirt and sweat shorts. Her hair is natural and cut short - at the moment, it's sticking up and messy. While she sits up for a moment, now she's leaning her head forward, cradling her face in her hands and lap, and she anxiously bounces her feet up and down. I sit directly across from her, introduce myself, and shake her hand. She smiles at me briefly, though her handshake consists of only a finger. After our handshake, she retreats back into her fetal-like position.*

Jasmine was closed off from the world - both physically and psychologically. Indeed, in the first few meetings, she was folded over into her lap or sunk back into the couch. When she looked up to speak with Emma or me, it was only momentary, and she often avoided direct eye contact. – Her social grid of medication management interpreted this as a clinical symptom of schizophrenia. Indeed, these behaviors could be categorized under "negative symptoms," a set of symptoms related to flat emotional affect, apathy, and general withdraw from the world. In part, this was the first set of clinical issues her team was motivated to address. However, there were moments where Jasmine was more interactive and expressive. At times this was because Emma and she talked about something she was passionate about, like art or music. For example, later in our first meeting, Jasmine performed spoken word for us, and she shared a moment of laughter and applause with Emma afterward.

In the first initial observations of Jasmine's treatment, I noted the prominent role that Ximone plays in directing her daughter's life. First and foremost, Ximone made the official referral for Jasmine in AOT. This was because Jasmine had gotten into verbal fights with

Ximone's boyfriend, which were escalating so rapidly that Ximone worried Jasmine would lash out. During treatment sessions, Ximone intentionally spent her time in the adjacent kitchen, finding busy work with cooking and cleaning, in order to monitor Jasmine's behavior in treatment sessions. At some points, she entered the living room to interrupt sessions to give Emma information on Jasmine or instruct her daughter on how to properly behave around her therapist. Lastly, after each treatment session, Emma consulted with Ximone about Jasmine's progress in treatment and any emergent issues.

After observing Jasmine's second treatment session, I conducted an interview with Ximone to understand more about her hopes and fears related to Jasmine and her AOT-LA services with *Empowerment for Families*. She described Jasmine's first psychotic episode and experiences with psychiatric medications:

> *I just know somewhere in 2013, she had a mental…she had a real breakdown, and I just didn't understand. I thought somebody had given her some kind of drug or something. So, I called the police because she was out of control and the police called the paramedics. The paramedics took her to [a local hospital]…and had a…for a mental evaluation.*
>
> *So the psychiatrist there put her on a 72-hour hold and they sent her to a locked down facility […]. So they had the groups and the whole nine yards and everything. And then we had this big family caucus to see if she was ready to come out. And she was like, "Mom, I'm ready to come home." She didn't like being locked down and, y'know, being told what to do: when to eat, when to sleep, and all that stuff. So, to me, she displayed that she was ready and gave her…they prescribed some meds. She took the meds.*

> *Once the meds were over, I tried to reup the meds. And they told me at the pharmacy that the doctor had to prescribe them and when I called there, y'know, of course, I got sent to five different people. And therefore no meds were, y'know, were issued again. So now we're going through the rest of 2013, 2014, just, "Okay, what is she gonna do today?" "How is she gonna act today?"*

In Ximone's eyes, Jasmine's psychosis was a sudden and mysterious fall from sociability and brilliance. In fact, throughout the interview, her mother emphasized how intelligent her daughter was, but that Jasmine's ability to express this was now buried under the weight of her clinical symptoms. For Ximone, Jasmine's first psychotic episode warranted an immediate emergency intervention but, after her 72-hour commitment, two things occurred. First, she became well enough for the hospital to discharge her and, secondly, Jasmine desired her freedom and became compliant to rejoin her family.

Maintaining Jasmine's wellness in a community setting presented its own challenges for Ximone, however. First, Ximone encountered structural barriers in accessing medications for her daughter. Indeed, this was a common occurrence across research participants: upon being discharged from hospital and jails, both clients and family members experienced insurmountable barriers to sustain medication regiments. These barriers included long waiting lists for appointments, being excluded from certain social programs for not meeting the criteria or suddenly becoming ineligible, and financial issues related to their affordability, including costs associated with transportation to appointments and pharmacies. Ironically, for a system that emphasizes the importance of medication compliance, securing medications in community settings is difficult. And without medications, Ximone described Jasmine's behaviors as unpredictable.

While there were many barriers to accessing medications, another issue for Ximone was her daughter's willingness to take psychiatric medications. Still, even in AOT-LA, I noted that throughout my observations that Jasmine's willingness to take medications was frequently low. At some points, Jasmine did not like her negative experiences with their effects. At other points, she rejected them based on the pressure she experienced to take them. Interestingly, Jasmine's case, however, entailed broader anti-psychiatry rhetoric. Early in my observations, I am clued into one possible reason for Jasmine declining medications. She visited a museum in Hollywood, one funded by the Church of Scientology, that portrayed psychiatry as a profit-driven and deadly industry. While Jasmine did not want to speak about the museum in our meetings, in my interview with Ximone I decide to revisit the topic:

> *I believe then she was trying to diagnose herself because she told me, she said um…She asked me, she said: "Mom, do you…have you had any mental problems in your family? Anybody have mental problems?"*

While Ximone admits she has not seen the contents of the DVD herself, she interpreted Jasmine's engagement in the materials as evidence of her inquisitive nature rather than a reason for Jasmine declining medications. I follow up her response later:

> **Ryan***: In what ways do you think that [the Museum of Death] affected her willingness to receive help or not?*
>
> **Ximone***: I don't think it affected her like that. I think she said that…a lot of the stuff with um…the psych…psychological stuff like the meds and stuff, she said, she said 'Mom, those are not federal regulated medicines, you know, the FATC, or whoever it is. FHA, FDA, whoever it is.' She said, "Those are clinical trial medicines. They're just practicing on me. I'm not taking that stuff."*

**Ryan***: Oh, so she's been fairly resistant to taking medications.*

**Ximone***: Yeah, because what she does is she'll say, 'Well, what kind of medicine is this? Let me see the name.' And she'll type it in. Google it. And then she's gonna read. If Google doesn't give her, she's gonna go Wikipedia, and if she doesn't get what she need in Wikipedia, then she's looking…she's searchin'. She's gonna search until she finds it.*

Again, Ximone's interprets Jasmine's refusal to take medications as part of Jasmine's capacity to search, evaluate, and act on information related to medications and their safety. While neither Ximone nor Emma questioned the consent of the museum or the DVD, it may also be the case that Jasmine visited the museum to learn more about psychiatrics medications, which may have created or confirmed suspicions towards psychiatric treatment.

Ximone's perception of Jasmine's attitudes towards medications clued me in to the moral reasoning of how she directed Jasmine's treatment. For Ximone, Jasmine's attitudes towards psychiatry were a product of her critical nature. Further, neither Emma nor Ximone suspected any explicit hostility towards psychiatric medications from Jasmine – even after learning she had visited an anti-psychiatry museum– though believed that Jasmine *did* have the capacity to grow hostile towards others. Thus, they preferred to avoid rationale argumentation in order to avoid conflict with Jasmine and, in order for the treatment team to gain Jasmine's medication compliance, chose as strategy of wining over her trust. For example, Ximone discussed how when Jasmine was first introduced to AOT-LA services by outreach staff, she "shut all the way down" to the strong persuasive techniques they attempted. The outreach team may have been successful in gaining Jasmine's consent to begin services, but Ximone reported that gaining ongoing treatment compliance will be more complicated. Emma, in Ximone's view, understood how to achieve this with her daughter: *"[Emma] is a little bit more—well she's consistent, but also something about her approach is much more sort of calm and careful*."

When I ask about Ximone's hope for AOT and what it can do for her daughter, her hope was rooted in a longing for the past:

> **Ximone**: *I hope that…she'll be able to function as…as a responsible adult. And that she will have, um, less anger. Um. She's very angry. She gravitates towards the anger, versus her…'cause she's got a good heart. She's a good person. Um. She…she really has a good heart and I want…my kid to come back. I want my kid. She was my good baby. She was biggest baby. She was my smartest baby. She was the one that walked at seven months. Giving full sentences at nine months. Reading books at two years old. She was five, she read Catcher and the Rye, and told me exactly what it was about. […] Have I ever shown you her senior pictures?*
>
> **Ryan**: *No!*
>
> **Ximone**: *Oh I got the proof over here because the picture's packed.* [Ximone rushes across the room and, from a box, pulls out a framed portrait of Jasmine. Holding the frame to myself, she shakes it back and forth.] *I want this girl back. I want her back. I want her back. I want her back.*

Ximone held the frame up for me a few second longer. In this moment, I understood that she wanted me to see *past* Jasmine in her current state and, instead, see that there was another version of her daughter there. Treatment was beyond recovery but saving her daughter: she wanted me to see the humanity, her potential. Indeed, Jasmine almost looked like an entirely different person in the photo. I was alarmed by her direct, yet soft, gaze into the camera, which was so different from the adverted gaze I was often met with, and she had a beaming smile, something I had not seen. There was not only hope for what the program could do for her daughter, but a terror of losing her daughter. When I inquired what would happen if AOT failed – if they are unable to convince Jasmine to partake in psychiatric treatment –she responded with the following:

> *I think that um…I'll lose her. And that's what I'm afraid of. She…she wouldn't last a month in the streets. She wouldn't last a month in Skid Row. They would kill my kid. Um. And if I lose her…She would be dead.*

My interview with Ximone highlights dynamics of hope and desperation, a longingness for her daughter to return to the self that she raised and nourished. Underneath it all, Ximone identified the parts of Jasmine that remained - her inquisitive nature, her independence, her desire to be with people who see and understand her. And Ximone wanted these traits to be the elements through which Emma should conduct her work.

As Emma had disclosed in our first meeting, a primary component for Ximone's referral to AOT-LA was Jasmine's supposed dangerousness. I observed that concerns about her violence were omnipresent throughout the treatment sessions. For example, Emma and Ximone had a safe word. If Emma were to ever feel unsafe due to Jasmine's behavior, she could ask Ximone for a glass of water. This would be Ximone's signal to come in and defuse the situation. Further, a few days after our first treatment session, Emma and I learned that Jasmine only spends the daytime at her mother house, but at night, sleeps in her car (see Appendix E for photograph, taken with Jasmine's permission). I am told that Jasmine was not allowed to sleep at either of her parent's home because they both worried about their own safety. Further, her parents refused to send Jasmine to a shelter or board-and-care facility because they worried about her *own* safety. Like in David's case, the unconditional love of her family motivated their involvement in her life, but the perceived dangerousness created a "caring from a distance." Parents did not want to leave their children without shelter but felt similarly obligated to protect themselves and others from the potential violent outbursts.

In experiencing homelessness at night, Jasmine confronted frequent victimization. In our first meeting, we learned that her skateboard – a primary form of transportation for her – had been stolen. This theft was so upsetting for Jasmine that Ximone encouraged we not to talk about it with her. Further, the police regularly disturbed her at night to tell her she cannot sleep in her car. In one instance, this escalated into verbal confrontations. At one point, Jasmine awoke to the police knocking on her window. According to her father, Jasmine became "belligerent" toward the police and, by the time her dad heard what was going on and went downstairs, the police had left. Another incident happened two months into my observations: Jasmine was tackled while jaywalking across the street by a police officer. She resisted was then promptly 5150'd. These raised difficult moments in Jasmine's treatment. While Emma hoped to be a resource to process her trauma, Jasmine often stopped talking when Emma raised the topics, no matter how gently she went about it. Emma suspected that Jasmine felt humiliated by her experiences and abandoned by her family in light of her vulnerability.

These were the conditions that set motion for Jasmine's case in AOT: economic precarity and a housing shortage crisis met with a mother who, due to a fragmented mental health system, could not secure regular treatment for her daughter, who herself had become distrustful of social systems that surveilled her life. However, Ximone reported great optimism for her daughter to be "restored" to her former self through AOT, particularly through the power of psychiatric medications. Here, psychiatric medications were seen as the central technology for *clinical control* and, without them, treatment would not be successful (*compulsory compliance*). Through managing her symptoms, Ximone believed AOT-LA could secure independent housing for Jasmine, which would decrease her vulnerability while homeless (*medicating vulnerability*). While Ximone – aligned with her treatment team – promoted the use of medications, Jasmine saw their use as a form of *social control.* In our early meetings, the social grid of medication management saw the potential for conflict – emergent from clashing ideologies – which itself set the stage for manipulative strategies to gain her compliance.

### ***Strategies to Gain Jasmine's Medication Compliance***

While the social grid of medication management had the treatment goal for medications – even before services themselves began – there was uncertainty among them regarding how exactly they would gain Jasmine's compliance. First, Emma had to focus on building a relationship with Jasmine. Emma's approach could be best characterized as gentle yet responsive to Jasmine's state. At times, she spoke in a soft tone with many pauses, providing space for Jasmine to think and respond. At other moments, Emma leans forward and provides firm instructions to Jasmine. In my notes from 2017-10-25, I observe:

> *Emma doesn't move too quickly in the conversation. She tries a few things here and there - see if Jasmine will engage. Jasmine is cut-off though, in her both her body language and her words. When Jasmine doesn't "take the bait" from Emma, Emma gently backs away. She doesn't press, rather, she follows her client. When Jasmine is done talking about it, so is Emma. Emma will pause, then try something new.*

I surmised that Emma's technique may have reflected both her social work training, where social workers are sometimes taught to mirror their clients, as well as her natural social disposition. Indeed, Emma was in a difficult position as a therapist. She was acutely aware that her client did not want to engage in the services she was assigned to offer but had to be present and work towards building rapport. For Emma – perhaps guided by Ximone's suggestions – winning trust began with the fundamentals of social interactions: not making her feel pressured by imposing on or taking up too much space, taking the lead from her client and demonstrating she wanted to hear what Jasmine had to say.

In the first meeting, Emma brought a laptop to show a spoken word performance on YouTube. She asked questions about Jasmine's interests in sports, fashion, and art. These moments were weaved throughout their discussions on securing welfare benefits, locating housing, and treatment goals. Even in her attempts to connect with her, however, Jasmine was hesitant to engage, shying away from the opportunities to share her art or spoken word with Emma. During our meetings, I observed small points of tension surface between Emma and Jasmine, which perhaps revealed Jasmine's underlying distrust. For example, Emma inquired about her interests in Barnes and Nobles to which Jasmine asked: *"Do I not look like the kind of person that goes there? Do I not fit the type?"* Despite these moments, Emma waded through Jasmine's uncertainty and trusted that, with time, their rapport would increase. Her patience paid off too as Jasmine slowly opened up more and more about herself. Near the end of the first visit, she shared with us that she plays the French Horn and drums. She also raps and, in this first meeting, rapped to a rhythm she created by clapping her hands and stomping her feet. The three of us laughed and clapped when she finished. A few weeks into our meetings, Jasmine shared with us her favorite pieces of artwork she created with markers.

In this initial meeting, the case manager also stopped to briefly to discuss how to secure housing for Jasmine. (At this moment, we believed that Jasmine was living at her mother's house and that her mother was anxious for her to live independently.) The process to secure housing was very complicated. First, they must secure Social Security, which involves paperwork, a telephone interview, and medical evaluation. Social Security would entail about $800 monthly which, in Los Angeles, does not go very far. Jasmine's treatment team told her that she must be prepared to rent out a room and live with roommates, something that Jasmine was not happy about. After they discussed housing, the session was over.

Like the treatments sessions that followed, Emma and Ximone stepped outside after the first meeting discuss the session. These moments provided a rare opportunity for the therapist to triangulate what the client reported in the session, gain a better sense of the dynamics of the client’s day-to-day life, and develop a strategy with Ximone – perhaps the most influential member in the social grid of medication management – to gain compliance. In the first meeting, outside and away from Jasmine, I noted Emma asking Ximone: “How’s she been doing in the past week?” This opened the floodgates of a conversation about everything that had been impacting her family in the past few weeks. Mostly, Ximone was surprised by Jasmine. For the first time, Jasmine brought up the possibility of finding housing. Ximone also reported that Jasmine’s mood was better though, she urged Emma to connect her daughter with the psychiatrist. When Ximone stated her desire for medication, she said it in a hushed and staccato tone, both emphasizing its importance but also secrecy from Jasmine. Gaining medication compliance, Ximone reported in this meeting, would be very difficult because her daughter can be easily irritated at others. Ximone stated that that is what *she* was there for, as a mother. In other words, if Jasmine gets mad at *her,* it would not be a problem, because Jasmine would eventually forgive her mother. But if Jasmine gets mad at a therapist, Ximone reported that Jasmine will never engage in treatment again.

These meetings were the operations of *concealed collusion.* The treatment sessions themselves were only the tip of the iceberg of what was otherwise a complicated social process that converged around Jasmine without her involvement. They allowed members of the social grid of medication management to strategize how they would work together to have the client behave in ways she would not otherwise. They strategized how they would allocate medication management responsibilities. Emma would transfer some of the responsibilities to the mother, who could serve as a scapegoat for Jasmine's treatment frustrations. This was a strategic decision to preserve therapeutic rapport and increase the likelihood of gaining Jasmine's willing engagement.

Finally, in the second treatment session, medications were mentioned to Jasmine. Emma went through a checklist of items with Jasmine. She told her that in the next treatment session, the case manager would be present so they can get her on SSI. Then, quickly, she listed to Jasmine that she had a psychiatry appointment coming up. While it was clear Emma wanted to move the topic along, Jasmine looked hurt and said: "Why? There something wrong with me?" Emma looked alarmed by this, though recovered quickly. She responded by saying that they are interested in receiving a second, and medical, opinion. Jasmine shrugged and did not pursue the topic anymore. While they quickly move onto the next topic and wrapped up the session, I was struck with how Emma glossed over the topic of medications. While the issue was given emphasis in their meetings without Jasmine, here the topic was introduced and moved through swiftly.

The psychiatrist with *Empowerment with Families*, Dr. Reed was a controversial figure, with both the treatment team and Jasmine's family. Emma and the case manager told me that he was decidedly "hands off" with clients; he kept his engagements brief, refused to discuss medications at length, or discuss broader treatment goals. From my discussions with him, I inferred that he saw his rule as a supplier of medications but did not want to consider their relationship to client treatment itself. While Dr. Reed believed in the importance of mandated services (as evidence by his prior quote comparing it to jail), he also did not see it as his role to pressure clients to take medications. The case manager mocked his approach to me – “Ok, that's your choice” – and clapped her hands off as if he absolved himself from client noncompliance. His interactions with staff were also off-putting for them. At a later meeting, Emma reported that she felt like she “overstepped” her bounds with Dr. Reed during a psychiatry meeting with one of her clients. She tried to facilitate a discussion on medications and their effects, which he did not appreciate. While I was unable to attend Jasmine’s psychiatry appointment, which took place between Emma, Jasmine, and her mother, Emma reported to me that Jasmine started an atypical antipsychotic medication, risperidone.

As Ximone and Emma strategized, Ximone delivered Jasmine's pills daily, in the morning, though only when Jasmine was receptive to taking them. Similarly, Emma did not raise the topic of medications to Jasmine during their regular sessions and noted that any mention of medications made Jasmine uncomfortable and, at times, upset. However, the topic of medications could not be avoided entirely. First, medications were entangled in the process of securing welfare benefits. In order to qualify for SSI, for example, Jasmine had to demonstrate she had a disability. In my note, dated 2018-01-17, Jasmine met with her case manager to call into Social Services to secure welfare benefits. During the phone call, the SSI officer asked Jasmine on whether she was taking medications. Jasmine confirmed that she was but then began to discuss how she did not like their effects on her. To minimize Jasmine’s upset, and focus her on the phone call, Emma interrupted Jasmine and told her that they could talk about it later. Second, medication negative effects began to interfere with treatment sessions, which were a persistent issue in the year of observations I conducted. At times, Jasmine looked drugged, barely able to raise her head from her slouch position, and had difficulties completing sentences. In one note, 2018-02-02, I reflected on how Emma attempted to show Jasmine how to properly cook meals and maintain a kitchen space:

> *Emma says, "Yeah, I can tell you're really tired today." Jasmine lowers her head, rubs her eyes, "Ya, I'm really not about doing anything today." Emma nods her head in sympathy, but then presses slightly – she says she understands but really wants to make sure Jasmine is prepared to live on her own. Jasmine then dramatically sprawls out on the couch in defeat. "Is it the medications?" Emma asks. Jasmine says yes, they make her tired. She doesn't like the way they make her feel. They've been giving her a bad stomachache.*

In multiple instances, Emma had to rework her session plans to accommodate for the medication effects and at times end meetings early.

As the psychiatric medication effects set in for Jasmine, tensions grew between her and her mother, who delivered the pills on a daily basis. In my observations, these tensions cut across her treatment meetings and even interrupted moments where Jasmine had begun to open up to us. In a note, dated 2018-01-18, I described an instance where Jasmine was finally debuting her artwork:

> *We slowly flip through her two art pads. They are full of colorful and abstract drawings. Emma and I are delighted by her creativity – her use of colors and shapes are unique, interesting, and strange. Emma asks if we can take pictures, which she says yes. (They're attached below) We chat about some of the ones that stick out to us. I ask her what her inspiration is. "I don't know. Smoking!" She says, referring to marijuana. Emma asks about some of the deeper meanings behind some of the drawings – "What does this one mean?" "Who's this in this drawing?" "Why did you decide to use black here?" – which*

> *also delights Jasmine that her therapist is taking such interest in her work. Jasmine's answers are often short and witty, which make both of them laugh out loud. For example, there is a larger scribble of man who has a rectangular body. "What's his name?" Emma asks. "Oh…uhh, that's cell phone man!" There's another image of a fish and above it, in big block letters, reads: "MR. FISH FILET."*
>
> *In between all the laughter and discussion, I think that it's the most I've ever seen out of Jasmine. From outside, I hear Ximone yell: "By the way, this is her on meds!" I'm assuming Ximone is talking about her daughter's happy demeanor. Jasmine squints her eyes and looks annoyed, "Wha – what are you talking about?" It does come across [as] a jab from her mother.*

Here, Ximone's interpretation of medication effects were revealed - with medications, her daughter emerged from her psychosis to become sociable again. But more than this, these moments reveal how conflicting interpretations of medication between the social grid of medication management and a client reinforce a power dynamic. Ximone asserted her interpretation of Jasmine's behavior towards Emma and me, over her daughter, as if she were not present nor able to give her own interpretation, almost as if to passively address the issue without confronting it directly.

Three months into Ximone delivering Jasmine's pill, Dr. Reed recommended injectable antipsychotic medications at a treatment meeting. According to him, injectable medications would be preferrable for a few reasons. First, Jasmine would not have to deal with the daily side-effects associated with pill. Second, Ximone and Emma would no longer have to monitor or enforce Jasmine's compliance to the pills, which would reduce the tensions between them and

Jasmine. The only caveat, however, was that in order to transition Jasmine on to injections, she needed to be on a consistent dose of the pills. Up until this point, Ximone had only delivered medications when Jasmine was receptive to it.

For the social grid of medication management, the idea of injectable medications was preferable. Growing desperate to achieve Jasmine's compliance to pills, Ximone reported to Emma that she started using a new "trick": keeping Jasmine distracted while delivering her meds in the morning. In a note from 2018-02-02, I wrote:

> *Emma asks why she thinks Jasmine is so out of it today. Ximone tells us it's the medications. "So, has she been taking it every day?" Ximone says yes, and that she's figured out how to get her to take it. Instead of making it a whole ritual, she gets Jasmine her breakfast and hands her the pills but doesn't even talk about it. She keeps Jasmine distracted – almost as if she's got Jasmine in an auto-pilot routine to take the meds without even thinking about it. "That's the trick I've been doing."*

While Ximone worked to gain Jasmine's medication compliance through distraction, Emma began to persuade her to consider the injectable medications. Emma raised the topic of medications in sessions, though only briefly, to discuss some of their benefits. However, she was met with resistance from Jasmine who said she did not like the idea of needles. A month later, with little success, I observed this interaction between Emma and Ximone in their one-on-one meeting (2018-03-16):

> *Emma asks how Jasmine's been doing. Ximone says good and that Jasmine has been taking her pills. She laughs and says "I know this is gonna sound ghetto..." then proceeds to tell us she's been mashing up Jasmine's pills, slipping them in Kool-Aid – only because the red coating on the pills floats to the top – in order to get the meds in Jasmine's system. She'll*

> *mix together all different flavors – red, purple, orange – to hide it. Without missing a beat, she then tells us that she will have to take us to a Soul Food place sometime and she wants to see the waiter's face when Emma and I order red Kool-Aid: "How do you two know about red Kool-Aid?" She says, imitating this hypothetical waiter. Emma is nodding, laughing, but I can tell by her wide-eyes that what she just heard about Jasmine's mother drugging her was not okay – though she stays silent. A second later, Jasmine bursts through the front door holding a basketball, "Alright, let's go!" She says. She seems awake and ready to play to me.*

After Emma conducted her session with Jasmine - which, that day, consisted of playing basketball with Jasmine to build interpersonal rapport - I debriefed what Ximone disclosed to us. Emma told me she was deeply troubled. She reported that drugging Jasmine was unethical. If Jasmine found out she was being drugged, she could try to leave the program altogether. Further, how was Emma – an outsider to this family – supposed to tell a mother – who was desperate to save her daughter – that her actions were unethical?

In a follow up meeting, Emma debriefed the medication delivery issue with Ximone, where they come to a new understanding of how medications should be delivered. Ximone switched back to delivering pills with Jasmine's explicit awareness. Meanwhile, Emma continued to ask Jasmine about transitioning to injections and, after a few weeks of asking, Jasmine agreed to injections. From the standpoint of the social grid of medication management, they had successfully controlled Jasmine's clinical symptoms through her medication compliance.

### ***Jasmine's Perspective***

While Jasmine had welcomed my presence in the treatment sessions, it was only until a year into her treatment that she felt ready to discuss her experiences with psychiatric medications to me. (To note, her treatment team petitioned to have her enrollment extended by another 6 months as they reported she was still not ready to be transitioned to voluntary services.) This interview was conducted at a park after her new therapist, Chad, conducted a session with Jasmine. Unfortunately, to even Jasmine's dismay, Emma had accepted a job with a new mental health agency. This interview was quite remarkable for me as it was one of the first times Jasmine had opened up about her experiences.

The first thing Jasmine communicated to me was that, overall, she noticed changes in herself due to the program. She felt less aggressive towards others and was more invested in her health. In fact, one of the reasons we were at a park was because Jasmine and Chad played basketball during their sessions to promote her engagement in community spaces. However, she felt the program itself was unfair. First, while she admitted that she had been aggressive towards her mother's boyfriend, she felt that he had instigated arguments and that she was defending herself. Instead of her family dealing with their own internal issues, Jasmine felt like she had been scapegoated for the problems that existed within her family dynamics. Second, Jasmine found the process of medication delivery demoralizing (2018-09-21):

**Ryan:** *What was it like having, like, your family help with you taking those medications?*

**Jasmine:** *It was degrading.*

**Ryan:** *What do you mean by degrading?*

**Jasmine:** *Because I don't feel like I needed those pills and that they wasn't working and I didn't really, you know, look forward to taking them. And I...I told them that the pills were making me uncomfortable, but you know, they don't really care.* […]

**Ryan:** *Did you feel degraded when your mom also was trying to give you the medication?*

**Jasmine:** *Yeah…*

**Ryan:** *Has that sense of, like, being degraded changed since being on the shots now?*

**Jasmine:** *Nah, it make me feel like less of a human.*

**Ryan:** *In what kinda way does it make you feel less of a human?*

**Jasmine:** *Just how they had me at the hospital. How they had me in jail. It was really horrible. I didn't feel like I was, you know, humanized. I felt like an animal.*

**Ryan:** *Yeah…How do you think things might change, in the future?*

**Jasmine:** *I mean, it's only getting worse.*

Previously, Jasmine may have appeared to be a passive in relation to the strategies of her social grid of medication management, but here she revealed that she was critical of the process the entire time and felt demoralized. And while Jasmine may have felt that the program changed her, she believed that things were going to get worse: she was still without housing and still dealing with the effects of psychiatric medications. Another key component of Jasmine's demoralization was that the program had neglected to meaningfully engage her at all around her experience of depression. While she rejected her diagnosis of schizophrenia and did not want to consume the antipsychotic, she did want her depression to be the focus of treatment sessions. For Jasmine, her psychiatrist, Dr. Reed, was guilty of prioritizing medication management over meaningful interactions:

**Jasmine:** *He don't really say anything, really, every time we go there, the meetings are pretty much to the point.*

**Ryan:** *Yeah.*

**Jasmine:** *Kinda like a 10 minute meeting. I mean, I get that he has other patients.*

**Ryan:** *If you had to change something about those interactions with Dr. Reed, what would it be?*

**Jasmine:** *Um, him just, you know, digging in deeper. I don't think he dives in deep enough.*

**Ryan:** *What kind of questions would he ask if he were kinda "diving in deeper"?*

**Jasmine:** *"Oh, how was your week?" Like, regular questions, like, how am I doing and is the medicine working. Regular questions. He doesn't really ask out-of-the-box questions like, "What happened to you as a kid?" Like, he doesn't really…really… "Why you – why you acting like that?" He doesn't really dig in deeper.*

Similarly, Chad – her new AOT-LA therapist – seemed to be only engaged in monitoring Jasmine's medications for Dr. Reed. Otherwise, Chad was unable to improve her life circumstances: he could not make housing appear out of thin air or secure for her a job or income. Here, a year into treatment, the program had clearly succeeded in gaining Jasmine's compliance but – in the face of Jasmine's poverty and an otherwise unaccepting world – she felt the program had failed her.

**Ryan:** *If you had to, like, make the program worthwhile and…like, useful for you, like…what would you change?*

**Jasmine:** (Pause) *Talk…talk about my depression more.*

**Ryan:** *(*Pause*) How often do you talk about your depression with Chad?*

**Jasmine:** *I mean, I don't talk about my depression with Chad. Ever.*

**Ryan:** *Yeah. (*Pause*) Is that something you do want to do though*?

**Jasmine:** *Yeah.*

**Ryan:** *What do you think it would take to start talking about that with him?* (There is a very long pause. I notice Jasmine is visibly upset she anxiously bounces her foot and stares at the ground below her.) *We can end the interview now if you would like*. (She nods her head. I end the interview.)

### *Interpreting the Story of Jasmine*

Jasmine's case illustrates the how the themes related to the interpretations of psychiatric medications and moral discourses related to coercion and client autonomy undergirded the ways psychiatric medications were managed. Her social grid of medication management –consisting of her mother and father, therapist, and psychiatrist – employed various tactics to establish her compliance and control her clinical symptoms. At the very onset, the social grid interpreted the need for medications and this assumption set the broader goal for Jasmine's compliance from the onset. This attitude, *compulsory compliance,* set forth medication delivery. While her treatment team saw medications as a technology of *clinical control* – specifically, as a means to reign in both her withdrawn social behavior and dangerousness – Jasmine interpreted their use as a technology of *social control.* Here, she believed the ways her family delt with their broader issues was by making her take medications against her will. Throughout the course of the treatment, Jasmine and her social grid of medication management sought to avoid a direct confrontation with this underlying ideological conflict of *clinical* versus *social control.*

Like many AOT-LA clients, Jasmine was at the intersection of multiple forms of structural vulnerability. While AOT-LA clients were diverse in their identities, experiences, and vulnerabilities, the shared factors of economic and housing instability, police surveillance and brutality, and violence victimization and perceived dangerousness emerged throughout her treatment trajectory. Jasmine's social grid of medication management persistently expressed worry about her vulnerability. Ximone herself was limited in her ability to care for her daughter too. She provided the care that she was comfortable with while having to set boundaries to protect herself and other family members. Here, Ximone's method to secretly drug Jasmine should not be viewed as malicious, but a desperate attempt by a mother – who had been repeatedly failed by social welfare policy – to do what she could to save her daughter. Through the lens of *medicating vulnerability,* we can identify how the structural factors that rendered Jasmine and her family vulnerable became intertwined in both the interpretations of medication effects and moral discourses of coercion and client autonomy. In other words, through a social constructionist lens, psychiatric medications were an interpretive site to locate solutions to the structural problems that Jasmine and her family navigated. This point was evident throughout the treatment ethnographic fieldnotes: medications were thought to play a role in governance by saving people with serious mental illness from various social structural harms. In the face of structural vulnerabilities, *medicating vulnerability* emerged in psychiatric services, even in ways that rationalized unethical modes of medicine, such as covertly drugging a client.

The social grid of medication management utilized client manipulation to gain Jasmine's compliance. Here, manipulation refers to how the social grid attempted to minimized Jasmine's perception of her own personal autonomy in treatment decision-making. Ximone and Emma strategized how they could most effectively gain her compliance without causing conflict. They divided up responsibilities, traded notes on her behaviors, and strategized new forms of managing medications through a phenomenon I labeled *concealed collusion.* Further, Ximone, Emma, and Dr. Reed all circumvented the issue of Jasmine's consent (*circumventing consent*). These initial interactions with Jasmine regarding medications treated her as a passive recipient of services who was otherwise too irritable or psychotic to make decisions for her own well-being.

For Emma, medications could not be talked about directly because she worried it would irritate Jasmine and compromise their therapeutic relationship. The process of gaining trust, as Ximone implied in her interview, was framed as a careful in-between where they pushed Jasmine along, but not enough for her to become resentful. Further, Ximone was operating from the assumptions that medications were necessary, but that anything too forceful or, conversely, that provides too much freedom, would end in disaster. Instead, the social grid of medication management worked towards Jasmine's medication compliance through employing various techniques which circumvented the issue of client preferences.

The social grid sought to gain compliance, but there was an attempt to walk a moral middle ground between force and freedom. In this case, Emma served the role of enforcing ethical norms in clinical services by intervening on Ximone’s technique of drugging. On one hand, Emma felt committed to a set of ethical principles and drugging clients violated this. However, drugging was also undesirable because it worked against the treatment logic of AOT-LA, which was to have clients become individuals who would consume medications without the need for further intervention or supervision. While medications were not mandated in this case, Jasmine’s autonomy was denied through entrapping her in the social grid, whereby declining medication simply meant that this grid formed new strategies to ensure her compliance again. This was motivated by the logic that medications were necessary and also addressed her vulnerability in the community. By minimizing her own sense of autonomy over her body, the social grid of medication management was able to succeed in their goals. However, it came at the cost of Jasmine’s sense of humiliation and defeat.

## Chapter Summary

In this chapter, I introduced the analytic results of my ethnography. First, I explored the interpretations of psychiatric medication effects. Broadly, medications were interpreted as a technology of control. There were two types of interpretations of the type of control they exerted: clinical or social control. In the theme of *clinical control*, I demonstrated how providers and some clients believed that medications were the primary tool to reduce problematic clinical symptoms. I further identified the theme of *compulsory compliance*, which was the belief that medication compliance was essential in order for clients to benefit from services at all, and *medicating vulnerability*, which was the belief that medications were the primary tool to reduce client risk of victimization and violence in community settings. In contrast, I identified the theme of *social control* among clients who felt that their autonomy was not respected in medication decision-making processes and/or that medication effects directly infringed upon their well-being and life goals.

Primarily, medications are delivered through client manipulation; that is, providers use various influential tactics - including *concealed collusion, performing coercion,* and *circumventing consent* - to gain medication adherence. Through these methods, administrative and frontline staff attempted to minimize client perception of their own autonomy and preferences in treatment decision-making processes. These practices were guided by medical paternalism – that is, the belief that psychiatric providers could override personal preferences out of the principle of *beneficence* – as well as practical considerations regarding how to gain compliance while maintaining therapeutic rapport with clients.

# CHAPTER 5

# DISCUSSION AND CONCLUSIONS

The purpose of this dissertation is to analyze how the management of psychiatric medications in involuntary outpatient services is undergirded by (a) provider and client interpretations of psychiatric medications effects and (b) moral discourses related to coercion and client autonomy. In doing so, I aim to explore the ethical implications of medicalized and coercive approaches to social services for vulnerable populations labeled with a serious mental illness. Further, I aim to explore how the practices of psychiatric medication use demonstrate the broader role of involuntary outpatient commitment in social welfare governance. To do so, I conducted a team-based ethnography of an OPC program based in Los Angeles County, including participant observations and semi-structured interviews, which was guided by critical realism. I interpreted my data through the framework of *psychiatric drug effects as a social phenomenon* and the *coproduction of moral discourse.* To analyze the data, I conducted a thematic analysis and produced textual, analytical, and theoretical memos.

In my results chapter, I presented my analysis in four parts. First, I provided an overview of AOT-LA services. Second, I presented my findings on the interpretations of psychiatric medication effects. Third, I presented my findings on moral discourses related to coercion and client autonomy in the management of psychiatric medications. For sections two and three, I presented several thematic categories to explain the data. For each thematic category, I provided definitions, summarized observations, and illustrated their properties with ethnographic examples. Fourth, I presented an extended ethnographic case to further demonstrate the relationship between these themes.

To summarize, I demonstrated that participants interpreted psychiatric medications as a technology of *clinical control* and/or *social control.* Within the construct of *clinical control,* I identified the themes of *compulsory compliance* and *mediating vulnerability.* Together, these subcategories highlight the ways social grids of management across treatment believed medications were a necessary component to services and addressed client vulnerability in community settings. I identified three primary techniques of gaining client compliance to psychiatric medications. I placed these techniques under the umbrella of *client manipulation* and then explored them. These techniques include: (a) *concealed collusion*, (b) *performing coercion*, and (c) *circumventing consent*. Broadly, these techniques were used by client social grids of medication management in order to gain compliance by changing how clients understood and perceived their own autonomy. Further, I identified that *medicating vulnerability*, alongside medical paternalism, was used to rationalize manipulation. In the extended ethnographic case, I discussed Jasmine and her social grid of medication management, which included her mother and staff with *Empowerment for Families*, who manipulated her to become compliant to medications in order to reduce her risk of violence victimization and perpetration.

I accomplished this ethnographic analysis through the philosophy of science, critical realism (CR). In CR, the goal of scientific research is to identify conditions that allow specific observable phenomena to manifest (Bhaskar, 2013). In this case, I identified the role of psychological interpretations that set forth the conditions for both the use of psychiatric medications (i.e., *clinical control*) and the rejection of psychiatric medications by some clients and subsequent conflicts (i.e., *social control*). Further, I identified how moral discourses regarding coercion and client autonomy undergirded client manipulation in AOT-LA (i.e., *medicating vulnerability*).

What do these findings mean in relation to my questions regarding bioethics in mental health services and the broader project of governing madness? In this chapter, I interpret my results in relation to these theoretical topic areas that I explored in Chapter 1.

## Prescribing Ethics to Psychiatric Medications

While the purpose of this chapter is to relate my results to the broader theoretical questions in my dissertation, I must first discuss my interpretations related to thematic categories I constructed. Specifically, I consider the nature of my findings, including what my data can and cannot be said to represent, and clarify the limitations of my data in drawing broader interpretations. Further, I consider how my categories align or challenge existing findings in the literature regarding psychiatric medication effects and their management in services. By exploring my data and thematic categories in these ways, I conducted a more robust analysis of the relationship between my findings, bioethics in state psychiatry, and social welfare governance.

First, I highlighted the local interpretations that frame psychiatric medications as a technology of *clinical* and/or *social control*. An important clarification is that I do not intend to suggest that *individuals* themselves can be categorized into either the two interpretative schemas of clinical or social control, nor were these the *only* interpretations of psychiatric medication effects in the data. Rather, these categories represent discourses that best demonstrate the ideological conflicts which gave rise to noncompliance and manipulation, which was the main interest of this dissertation project. Further, participants did not explicitly use the phrasing that medications were a form of clinical or social control. Instead, I constructed these categories to characterize interpretations of psychiatric medication effects and perform analytical work. For example, Portia did not name psychiatric medications as a form of *social control*, however, in her interview, one can identify that she felt controlled by her psychiatrist in ways that violated her sense of personhood.

Within the concept of *clinical control,* I introduced the concepts of *compulsory compliance* and *medicating vulnerability.* These categories were key constructs for my analysis because the concept of *clinical control* does not, in itself, indicate the priority medications were given by providers in relation to other treatment goals. Neither does *clinical control* necessarily highlight the perceived relationship between medication effects and client vulnerability in AOT-LA. By creating these subordinate thematic categories, I was able to move beyond the concept of controlling clinical symptoms.

The findings on *clinical control* highlight the longstanding and well-documented biopsychiatric discourse that pervades mental health services (Kirk et al., 2013). Further, through this pervasive framework, expressions of madness and disability were linked to disruptions in individual biology. Surprisingly, in our notes, specific diagnostic criteria were rarely discussed – only features of psychotic symptoms – though, at times, diagnoses emerged when attempting to differentiate from primary substance abuse or personality disorders. These diagnostic labels of biopsychiatry were perhaps unspoken because biopsychiatric logic itself was the assumed foundation that supported provider activities (Brodwin, 2013; Gomory et al., 2011). This logic never had to be confronted or interrogated explicitly, except in instances in which individual client criteria was questioned. This was particularly true in instances in which the question and issue of substance abuse arose, an overlapping issue with serious mental illness and homelessness, though one that was outside the scope of practice for providers in AOT-LA. Further, referred individuals often had a record with psychiatric services in the past, which indicated the presence of a serious mental illness, and thus eliminated the need for a thorough psychiatric evaluation.

Instead of diligently asking questions related to diagnostic criteria for mental illness, questions at referral team meetings considered: does the client have multiple incarcerations within the time window, and would AOT-LA reduce their dangerous behaviors? Is the client deteriorating and likely to benefit from services? The primary focus of discussion at referral meetings, as well as in treatment goal setting by providers, suggests to me that the primary *clinical* concerns of AOT-LA were not necessarily to treat an underlying illness. Rather, the social grid of medication management was concerned with managing clinical symptoms in relation to their impacts on client community living. Indeed, the primary purpose of community mental health services was to facilitate the integration of people with serious mental illnesses into their community settings (see Floersch, 2002), which would seem to imply living in a community setting without causing disruptions to day-to-day life.

To this end, medication effects were not about clinical symptoms alone, but were related to addressing client vulnerability. In other words, on the flipside of compelling medication consumption was the persistent fear that clients are vulnerable in their community settings. This could be accomplished by addressing symptoms, but the goal of “meds only” further extends the analysis by Floersch (2002) and my previous analysis on neoliberalism and neuroleptics (Dougherty, 2019): medication compliance is not just about creating self-governing clients in community settings, but medications are thought to shield clients and their communities against the violence associated with serious mental illness. As I demonstrated through my ethnographic case examples, and confirmed by previous research, people with mental illness are extraordinarily structurally vulnerable, and particularly experience compounded forms of oppression when individuals sit at multiple marginalized intersections related to race, gender, class and disability (Padgett, Hawkins, Abrams, & Davis, 2006; Pahwa et al., 2020). Through a lens of structurally vulnerability (Bourgois, Holmes, Sue, & Quesada, 2017), we can understand the health and mental health care needs of these individuals in relation to their positionality on multiple axes of oppression, which produced health problems and barriers to services, though perhaps made them also vulnerable to interventions by state psychiatry.

In this analysis, I did not specifically examine the intersecting roles of race and racism, gender/sex and sexism, and class and classism, though these identities and their associated systems of oppression clearly informed the experiences of participants in the study. Many clients existed at multiple intersections of oppression and lived in high-density communities that were over-policed and lacked affordable housing and resources. The relationship of these phenomena to social systems of oppression were at times clear, even named by participants in the study themselves who, for example, critiqued the ways they were racially profiled by police or felt abandoned by the government due to their status as working class or poor. However, a deeper examination of these issues is warranted. Previous analyses, particularly ones guided by critical race theory, have highlighted the ways in which welfare reforms, racial segregation and redlining, and mass incarceration have systematically upended communities of color (Abramovitz, 2006; DeParle, 2004; Soss, Fording, & Schram, 2011). Their specific roles in shaping the experiences of people targeted by involuntary treatment programs and the design of such programs is currently understudied. These explorations should not be limited to quantitative analyses to only examine *who* is enrolled in what types of programs (see Swanson et al., 2009) but must also include a qualitative examination of how rationales for coercion are uniquely shaped by racism, sexism, and classism. For example, it may be the case that people of color, particularly those in impoverished communities, are enrolled in involuntary outpatient programs as a means to reduce their vulnerability in relation to *particular* types of settings and social issues. This type of analysis was outside the scope of this analysis, but certainly possible with the current data and, with the foundation I developed to think about the moral rationales for coercion, a future direction for research can include highlighting the intertwined roles of race, gender, and class.

In regard to *social control*, clients reported feeling that their interpretations and preferences regarding medications were minimized or ignored. At times, this was related to interpersonal conflicts with specific providers, who outright ignored client requests, or broader structural issues that barred access to regular communication, such as the limited time psychiatrists have to speak with clients in the public sector (Torrey, Griesemer, & Carpenter-Song, 2017). Medication effects themselves were not always the source of tension but rather the modes in which medications were managed with clients. In other words, it was not necessarily the pill itself and its produced effects, but whether clients felt dignified in the management process. As I previously noted, there was a relationship between these two aspects: clients who identified negative effects preferred to have providers who engaged them in decision-making. The findings regarding *social control* confirm what other ethnographers have found (Estroff, 1985): clients recognize the power that psychiatric services wield over their lives and medications can come to symbolize this.

Furthermore, some clients wanted to decline medications because they viewed their use as non-rational. That is, they argued that either the medications were prescribed for a diagnosis they did not identify with or that the medication was producing negative effects that interfered their life goals. Interestingly, in the psychiatric literature, noncompliance is typically framed around client lack of insight and cognitive capacity; that is, people with serious mental illness and their relationships to psychiatric medications are viewed through a deficit lens (see Sacchetti, Vita, Siracusano, & Fleischhacker, 2014). However, my findings highlight a clear counter-narrative from clients – among people who are considered to be the most chronically ill – who discussed the pros and cons of medications and its relationship to their life stories. Here, both rejection and non-compliance can be seen as a deeply rational response. My results reveal that clients evaluated whether or not services were aligned with their own values. If clients felt psychiatric services related to them in ways incongruent with how they saw *themselves*, then medications became a focal point for this perceived ideological conflict.

## The Diversity of Interpretations

I discovered that members of the social grid of medication management (providers, family members and caretakers, and the court system) endorsed medications as a technology of clinical control. Conversely, clients expressed a more diverse set of beliefs around medication effects, particularly in demonstrating the different ways medications were a form of social control. We might consider that these discourses stem from the historical narratives of biopsychiatry in community mental health services as well as the counter-narrative advanced by clients, ex-patients, survivors of psychiatry. At the same time, I argue that the interpretations of *clinical control* can also be understood a response to the unpredictable or scary scenarios related to madness and disability in the context of structural vulnerability. Similarly, we can consider client responses as rational responses to feeling that one does not have full control over what chemicals are entering one's body. This conflict over control is where moral distress emerged, both within individuals and in the therapist-client relationship.

If ideological conflicts regarding medication effects were the basis from which client manipulation emerged, then it would be useful to examine *why* some clients preferred medications while others did not. Does respecting client autonomy lead to positive interpretations of medication effects, or do positive medication effects make clients feel supported by the program? And how might one explain the relationship between interpretations of psychiatric medication effects and whether or not clients consumed medications? To explore these questions, I compared my participant interviews.

First, I considered that even while Portia and Robert were housed in the same ERS facility, they had strikingly different interpretations of psychiatric medications. For Portia, medications helped control her psychosis, and while she was able to work with her treatment providers, she felt that her preferences were met in a paternalistic fashion. Conversely, Robert felt that medications were a strategy to make clients sedated and compliant. He discussed the ways his treatment team dismissed his concerns regarding psychiatric medications and were uninterested in helping him achieve his life goals. Here, for Robert, the approach of providers was not necessarily paternalistic as it was oppressive. What can account for this? In part, Portia reported the relief she felt from medications. She may have had concerns regarding their long-term effects, but largely she felt thankful that she no longer was psychotic and homeless. Robert did not make this connection. In fact, Robert refused his diagnosis as psychotic altogether. This may be one piece to the puzzle: whether or not clients identified past or present behaviors as psychotic shapes their willingness to consume psychiatric medications. Notably, I do not mean to argue whether or not a client has *insight*, but rather whether their interpretation of themselves is congruent with the narrative provided by biopsychiatry.

Another possible explanation may pertain to the fact that clients do not have static attitudes towards their diagnoses or psychiatric medications. Their interpretations were bound by time and place, colored by their particular life circumstances, and the goals they have laid out for themselves. Portia, for example, discussed how she thought pills would make her a zombie but, now that she had taken them and experienced their positive effect, she no longer felt this way. Thus, taking medications and directly experiencing their effects *may* make clients re-think their attitudes towards biopsychiatry. As I explored, this was the belief prevalent across social grids of medication management: clients will only resist medications up until they consume them and experience their positive effects. In another example, Darian refuted his current diagnosis of psychosis but, in admitting his hallucinations went away after taking antipsychotics, he considered the possibility that he *was* psychotic in the past. Similar to Portia, Darian's interpretation of his own behaviors was transformed through taking psychiatric medications. Further, because medications transformed his own psychological experiences and behaviors, he no longer felt as if he could be psychotic. The fact that these interpretations were in flux demonstrates how clients have a dynamic relationship to their own experiences and medications. Clients actively work to understand their own experiences, consider whether biopsychiatric discourse can help them make sense of their own suffering or not, and infer meaning from the medication effects that they experience. In other words, the variation I noted in the data may reflect where clients are in their trajectory of recovery and disability, and life experiences with madness and medications.

Another key component to understanding the variation in client interpretations relates to how clients discussed their relationship to psychiatric medications in specific social settings. I noted that clients most often discussed medication experiences in two types of settings: while experiencing homelessness or incarcerated. In regard to homelessness, Jose and Portia characterized their mental states while homeless as confused, paranoid, and disorganized. Jose discussed that while homeless and refusing psychiatric medications, he was “depressed and down all the time” and not “with it.” Now, in security of the ERS facility, Jose had a new narrative surrounding his own needs: there was something wrong with him, which could lead him back to his state of vulnerability, but medications fixed that. Jose’s interpretation of his mental state was tied up with his experiences of housing instability. In another example, Portia refused medications while homeless, and described this point in her life as terrifying. However, now within an ERS facility, she had access to medications. Combined with the broader structure of housing and interpersonal therapy, Portia crystalized her interpretation of AOT-LA: it was a beneficial program that, for the most part, was concerned with her wellbeing. In these instances, medications were embedded in personal narratives of both recovery and newfound safety in the face of terrifying vulnerability.

In regard to jail settings, clients reported meeting with a psychiatrist only once to receive their prescription and then never meeting with a mental health professional afterward to evaluate their prescription. There was also a general attitude that jail prescribing had a standard routine. Jose, for example, learned that he would not be prescribed Buspar in jail, to which he dismissively shrugged and said: “It was jail.” Here, the meanings of medication – and the evolving client interpretations of medications – were wrapped up in the institutional practices which delivered medications. Specifically, because clients lacked any sort of freedoms (e.g., to take drugs or not) and/or regular medical care (e.g., having your meds evaluated), they felt they had to resign to what was being prescribed. For some clients, like Portia or Darian, AOT-LA was preferable to jail because of the comparative freedoms ERS facilities provide. Other clients, however, compared jail prescription to that of AOT-LA providers. Robert, for example, felt that medications were used as a means to "warehouse" him. It did not matter that the facility was a mental health program. In his view, the services were not seriously invested in his personal growth, similar to jail. To this end, the AOT-LA ERS facility offered more freedoms, but medications were used as a similar technology of *social control* in jails.

While there was a clear relationship between client attitudes towards psychiatric *medication* and *the prescribing institutions,* at other points it was more complicated. Darian, for example, enjoyed taking his Xanax – he even reported that he would consume them in the future - but resented the perception that he was *mandated* to take them. Similarly, Jose reported that his drugs were life saving for him, yet he reported that his providers were not supporting him enough and wanted his psychiatrist to be more available. Thus, it appears that the relationship between the client and psychiatrist can be central to interpretations of *social control*: whether the psychiatrist will be responsive and engaged, or simply prescribe and urge consumption, indicated to clients the broader purpose of medications in the AOT-LA.

To this end, the diversity of client interpretations of psychiatric medications can be explained by how individuals related medication effects to the personal life circumstances and the stories that they told to make sense of their lives: are they following a trajectory of recovery, having come to embrace the benefits of medications (even if this means bearing through their negative effects or subpar provider practices)? Or, does AOT-LA mark another low point on their journey, where their agency is constrained, and the compulsory uses of medications signify their lack of freedom? Do they want to be active participants in figuring out what medications work best for them, or will they relinquish control and trust in the prescribing patterns of their providers? These findings suggest that the social construction of medications extend far beyond biopsychiatric discourse or immediate subjective effects of medications.

## The Moral Management of Medications

My analysis demonstrated that providers implemented a series of manipulative techniques in their medication management (Blumenthal-Barby, 2012). These techniques were accomplished by the social grid of medication management who strategized with one another to pressure clients to take medications. I called this phenomenon *concealed collusion.* Importantly, collusion did not just implicate individuals, but also characterized how various *institutions* worked together toward this goal. For example, our notes demonstrated the Office of the Public Defender's collaboration with the outreach and treatment teams. As clients moved through the flow of AOT-LA, various administrative arenas oversaw the development and termination of the provider-patient relationship. At the referral and outreach stages, the teams strategized how to gain their enrollment in services and were prepared to deliver court-mandates to those who declined. If clients were mandated, they were monitored by the court system where judges exert the black robe effect, and the public defender colluded with the outreach and treatment teams to ensure this process went as smoothly as possible. During treatment, the treatment teams also discussed clients and their progress behind closed doors. At times, providers discussed clients with caretakers and family, all expressing the goal of gaining total compliance with clients and troubleshooting issues that interrupted service delivery. Along every step of the way, people who wielded significant institutional power over AOT-LA clients worked together to guide clients toward medication compliance. Clients become entrapped in a web of social and institutional arrangements where their preferences and personal autonomy were marginalized.

According to Welfare and Institutions Code for AOT-LA, medications cannot be formally mandated. This led to my assumption that the primary place where medications would be managed would be outside the courtroom, within the interpersonal interactions between treatment staff and their clients. Throughout these ethnographic observations, various ethnographers revealed in their writing their curiosity - and at times their shock - at the prominent role that judges and public defenders played in *performing coercion*. While the concept of *performance* is vague, I intend for it to capture the many techniques used by providers to construct, maintain, and reify this illusion. The social grid of medication management hoped that this illusion would motivate clients to become and stay compliant to all aspects of treatment. In many instances, this illusion worked. At other points, clients realized that the possibility of negative consequences was an illusion. Importantly, while I term this a *performance*, I do not intend to undermine the ways that AOT-LA did place serious limitations on client freedom. Clients were monitored by providers, especially in ERS facilities. Sometimes, these facilities were locked, and clients had little choice but to partake in treatment.

Whether or not an introduced threat is *real* was irrelevant to Nozick: the perception of threat actually becomes the cause for an action to be taken and, without this perception, the action would not be taken. In this case, why do I not consider this to be plain coercion then? The specific reason I am employing the concept of “performing” is to emphasize the fact that (a) providers are knowingly performing coercion but do not typically name a threat to clients and know that there are no real consequences for client noncompliance and (b) it is an explicit strategy that is deliberated “behind the scenes” – that is, the providers strategized a script and then performed it before clients to manipulate them.

While I identified client manipulation in AOT-LA, do these techniques really emerge from a moral discourse regarding coercion and client autonomy? Perhaps other factors allowed manipulation to emerge. First, AOT policy does not stipulate how medications should be managed – only that they cannot be court mandated – which may have given rise to ethically ambiguous workarounds. In this case, providers may be navigating the everyday ethics of treatment (Brodwin, 2013). Second, the middle ground between "coercion" and "autonomy" might be sought for practical considerations. For example, if clients became too nonadherent, they could discover the illusory boundaries of coercion. Thus, progressively adopting coercive approaches runs the risk of showing the bluff of *performing coercion*. Second, as I demonstrated in the case of Jasmine, providers might also use manipulation to avoid direct decision-making processes with their clients, which might bring the conflict of *clinical* versus *social control* to the forefront. Lastly, the presence of *clinical control* does not necessarily guarantee that manipulation or coercion will be used. Manipulation also relied on provider capacity to effectively organize social systems to pull off deceit in the first place. For example, in the case of David and Saqib in *Empowerment for Families,* Saqib did not successfully gain David's medication compliance.

My findings highlighted the undergirding role that *medicating vulnerability* played in *client manipulation*. Related to medical paternalism, *medication vulnerability* served to justify overriding client autonomy, though instead it emphasized the relationship between medications and client vulnerability (Beauchamp & Childress, 2009). This moral discourse may be co-produced (Brodwin, 2008). At a policy level, administrators who were not engaged in daily frontline work, like public defender and judge, were more focused on ensuring medication compliance from across clients. In this sense, AOT-LA can be understood as driven by a concern for beneficence which might explain why the issue of client autonomy was not raised in these spaces. On the ground, as I suggested earlier, moral reasoning was shaped by local problems: providers could not lean on full force or coercion in the name of beneficence because they had to deal with ramifications of conflicts with their clients. In other instances, the institutional policies set forth by administrators to guide ethical conduct were misused by providers like, for example, the so-called treatment-to-consent form (Beauchamp, 2011). It may be the case that client manipulation emerged where the ethical concerns of administrators (beneficence) and everyday ethics of frontline providers (Brodwin, 2013) intersected, giving rise to an understanding that they could work around the mandate and rely on manipulation and deceit to achieve their goals.

Importantly, client attitudes towards medications did not indicate whether or not they would be compliant while in AOT-LA or after disenrollment. Some clients performed compliance in order to graduate from the program and be able to deliberate on their own medical preferences, like Robert. While clients named various ways in which they felt their autonomy was undermined in AOT-LA, the interview with Jack posed difficult questions about the nature of manipulation: how can a client feel *empowered* by an otherwise mandated program? How could a client feel like they had total say about the program, when other client cases demonstrated that noncompliance was unacceptable? First, it was evident that his preferences aligned with the goal of clinical control. Therefore, there may have been no tension regarding psychiatric medication use and thus no reason for the question of Jack's autonomy to be raised or undermined. His interpretation could also be a product of manipulation. Nowhere in the interview did Jack indicate that he was aware the program *could* mandate him to partake in services if he decided to become noncompliant. This could be considered a form of omission (Blumenthal-Barby, 2012). Or, perhaps Jack knew that the program lacked any consequences (or, as some providers called it, "teeth") and did not incorporate the possible threat of court mandates in his decision-making process. Still, the reasons clients invoked to comply or not did not just implicate their interpretation of psychiatric medication effects. Instead, clients evaluated the amount of freedom they had and the consequences for their compliance or noncompliance.

A major question that I considered was where were the prescribers in the ethnography? The research ethnographic team had trouble accessing prescribers, often due to their limited time and resources, in an overworked public mental health system. This was not unlike the experiences for both the clients, who had few and brief meetings with their providers, and providers, who did not even have access to the prescribing psychiatrists during AOT-LA team meetings. Their concealed role demonstrates the logic of how AOT-LA functions: while medicine was prescribed to create the possibility for therapeutic action, it is up to the frontline providers (including therapists and case managers) to actualize this action – both through ensuring compliance and conducting treatment goal activities.

With these considerations in mind, I now explore how these findings can guide our understanding (a) whether OPC itself is an inherently coercive program and (b) what role does OPC play in the broader project of governance.

## Bioethics Beyond the Interpersonal: Institutional Coercion

While my analysis revealed the broader construct of client manipulation in AOT-LA, does this mean that OPC is an inherently coercive program? What are the ethical implications for its use, especially as it relates to client autonomy and the use of psychiatric medications? I set out to gain conceptual clarity on the concept of coercion in psychiatric services (Hem, Gjerberg, Husum, and Pederson, 2018) and weigh the ethical considerations of various techniques (Blumenthal-Barby & Burroughs, 2021). I focused on coercion as it became a central focus related to OPC services in the literature, and community member health services more broadly (Gomory, Cohen, & Kirk, 2013; O'Brien & Golding, 2003; Wynn, 2006), however, as I explore, my concern regarding client autonomy had expanded beyond the concept of coercion.

To consider whether AOT-LA is coercive, we first would consider whether coercion refers to the specific interpersonal tactic as described by Nozick (1969), where the coercer introduces a threat and the coercee acts differently due to the threat. Next, we would need to assess whether AOT-LA relies on this interpersonal strategy consistently enough to accomplish its aims. On the basis of Nozick's definition, our ethnographic and quantitative data indicated that AOT-LA does not rely on (a) court mandates for the majority of enrolled clients and (b) providers do not rely on interpersonal threats in order to gain client compliance. This does not necessarily exclude the possibility for coercion in AOT-LA as (a) voluntary enrollments may have been achieved through the introduction of a possible court-mandate which, as I previously argued, could constitute coercion if the client perceives this as a threat, and (b) moments where interpersonal coercion was used may have gone unobserved or unreported by the ethnographers. Indeed, there were clients who reported that they complied because they worried that noncompliance would be reported to the courts. However, largely, our ethnographic observations and semi-structured interviews captured that AOT-LA relied on various non-coercive yet influential techniques, which I have characterized as client manipulation.

Does this mean that coercion is not an issue in OPC? First, it is important to note that Nozick (1969) does not think that coercion is the only form of restricting individual liberties, nor do other bioethicists (Lovell, 1996; Szmukler & Appelbaum, 2008). I identified many forms in which client autonomy was undermined in services, namely manipulation. Yet, another difficult observation to interpret regards how client manipulation took on the performances of ethical process (the signing of treatment forms, for example). These practices may have emerged because providers believed that abandoning them would violate important norms. This is how bioethical principles were not only co-produced in the frontline, but also risked being appropriated: when the policy for a consent process is "passed" from policy to practice, its undergirding moral purpose becomes reinterpreted. The issues take new life as providers incorporate their interpretations of these debates into the everyday tasks they must perform (Brodwin, 2013). In my observation, ethics took on a new life, becoming a broader backdrop but never front and center; a performance for its cultural value but never quite realized and real; plundered for its language (consent to treatment) only to be appropriated in the pursuit of other moralized social and political goals (such as protecting communities from harm).

Does this mean that Nozick's technical definition of coercion in services is relevant only in specific instances and, otherwise, we should use another framework to describe issues of power and autonomy in services? Here, I must agree with Diamond (1996): we can debate over whether incentivization constitutes coercion or not, as Guinart & Kane (2020) do, and perhaps having a narrow definition can be useful, but we might also consider the broader purpose in which these strategies are being employed. Strategies to gain medication compliance do not exist in isolation – as a discreet interpersonal action – but, in the data, clearly emerged from undergirding moral discourses regarding coercion and client autonomy. Here, that moral discourse pertains to *medicating vulnerability.*

Instead of coercion, I selected the term *manipulation* based on the definition provided by Blumenthal-Barby (2012): manipulation entails changing how people reason through changing the perceived consequences (without leveraging threats) or appealing to emotional states. On the scales introduced by Lovell (1996; see page 27 of dissertation) and Szmukler & Appelbaum

(2008; see 28 of dissertation), we can think of this manipulation as sitting in the middle of their scales, which ranged from total coercion to appealing to client rationale. Interestingly, Szmukler & Appelbaum (2008) suggested providers use increasing forms of pressure. Institutionally, this is what we see in AOT-LA: first clients are invited, then there is a petition and settlement agreement, and lastly, there is a court mandate. But practically, in the day-to-day work of frontline providers, this was not really the strategy we identified. Rather, I noted a series of manipulative techniques used and selected by social grids of medication management based on their beliefs of what would be most effective (through *concealed collusion*).

The problem of manipulation presents an interesting situation. While we may experience ourselves as rational beings who, more often than not, neutrally deliberate and decide among our options, our decision-making is constantly shaped by non-rational factors (Buss, 2005). In a sense, one could identify all the ways our decisions, at any given moment, are *not* based on our reasoning alone. One might raise the question: if clients are always under influence of some sort, are providers truly *violating* client autonomy through manipulation? My concern, however, is not that client autonomy is being undermined in itself, but regards the intentional effort of providers to undermine said autonomy and the ramifications of this in relation to client experiences as well as our implications for understanding social governance.

While I named these techniques *client manipulation,* I argue it would not be too much of a deviation from Nozick's definition to name OPC itself as a coercive program. As I argued previously, if court mandates are also able to be leveraged as threats against clients, then the program itself relies on coercion to change client behaviors. Perhaps this does not implicate *interpersonal* coercion, but the policy itself relies on the power of coercion to shape human behavior. Second, we noted that the manipulative techniques were related to the same concerns that clinical ethicists raise about Nozick's coercion. Specifically, client manipulation impacted the way clients relate to their own autonomy and psychiatric services more broadly in similar ways that coercion does (Nyttingnes, Ruud & Rugkåsa, 2016). Perhaps then it would be useful to distinguish between Nozick's coercion as *interpersonal coercion* and the coercion of OPC as a form of *institutional coercion.*

Through the framework of *institutional coercion*, social theorists can explore the broader strategies aimed at restraining human freedom or directing clients' behavioral by various rational and non-rational means. In this analysis, institutional coercion can make sense of how every staff member, including public defenders, were implicated in client manipulation. To this end, institutional coercion became permissible – in fact, the main organizing logic – as the entire program of OPC constitutes people in positions of power whose shared interests can be promoted without institutional checks. (At times, pushed past the limit, as when the public defender and judge escalated their demands to a client.)

The second set of implications relate to social welfare practice. First, in relation to psychiatric medications, I raise the same concerns of Barnes and Badre (2016) regarding the use of anti-psychotic medications in OPC. Through the lens of institutional coercion*,* it is misleading, and perhaps entirely disingenuous, to suggest that medication use is solely at the discretion of providers and their clients (Sharfstein, Lieberman, and Talbott, 2016). The use of psychiatric medications in OPC involved a set of strategies, combined with the limited time of psychiatrists in the public sector, that erased client preferences and autonomy entirely. This placed clients in dangerous positions, where adverse medication effects emerged more quickly than the programs were capable of dealing with, which further made clients feel disenfranchised by OPC.

Further, the presence of institutional coercion begs the question whether it would be possible to envision a role dedicated to protecting client autonomy in treatment services. During our ethnography, we asked who was the public defender "defending? Here, it was not the client's autonomy, but rather – as demonstrated by *medicating vulnerability* – clients and their communities from harm. There is an evident need for an individual who can defend the personal autonomy and liberty of clients in OPC, so special consideration can be given to each and every client. Further, it is not enough to set policy parameters for clinical interactions. As revealed through the lens of the coproduction of moral discourse (Brodwin, 2008), and demonstrated through the performance of both coercion and consent, policies themselves can be misappropriated and abused for the purposes of institutional coercion. Social welfare and bioethics scholars must consider how to safeguard ethical principles in ways that preserve their meaning at the local level.

## Governing Madness in the Post-Welfare State

Chapter 1 introduced the framework of governance which refers to the methods societies use to effectively manage social issues. Guided by Foucault (2009), who encouraged us to examine how societies rationalize forms of governance, I also created the framework to analyze forms of governance: "Targeted at *whom*, by *what means*, and for *what ends*?" (see page 3) As I noted in Chapter 2, major scholars of governance and medicine have charged psychiatry as an extension of the state tasked with managing populations who display bizarre or socially unacceptable thoughts and behaviors (Conrad & Schneider, 2010; Szasz, 1961). Through a medical framework, psychiatry is thought to locate the source of such problems within individual biology and modify such behaviors through treatment. Historically, in psychiatry, these forms of treatment have ranged from psychological (psychotherapy) and biological (medications) interventions (Scull, 2015). Further, state psychiatry, compared to other public health institutions, is unique in that it is endowed with special privileges to restrain the individual liberties of individuals too through procedures such as civil commitments or conservatorships (Burstow, 2015). Often, these powers intersect with other state mechanisms, such as court systems or mental health bureaus, to operate. This is what "state psychiatry" refers to. Where does involuntary outpatient commitment fall within the broader project of social governance? What special tasks is it thought to accomplish? What logics about citizens, madness, and governance undergird its operations?

By examining OPC, we see that biopsychiatric discourse is not the only logic that undergirded services. It would be erroneous to assume that OPC served as an extension of biopsychiatry alone, operating only to drug mad behaviors (Whitaker, 2005). As I have demonstrated, AOT-LA was concerned with addressing the vulnerability of clients through gaining medication compliance. There was an understanding that the broader landscape of services and resources to meet basic human needs, such as housing or income, was increasingly scarce and inaccessible. This relates to the fact that the United States is considered by social welfare scholars to be a post-welfare state (Gilbert, 2002), where the public has seceded responsibility in supporting people living in poverty. Historically, these attitudes have seriously undermined the funding of community mental health centers as the United States deinstitutionalized patients with serious mental illness (Mechanic et al., 2014). As demonstrated in my finding, clients had trouble accessing even voluntary services or welfare due to their disability, which perpetrated their enrollment in AOT-LA. It is then ironic to note that in order for some of these clients to have benefited from the welfare state, they needed a higher level of able-bodiedness in the first place. Overall, the deterioration of the welfare state has posed a problem for people with serious mental illnesses whose vulnerability to health issues continue to exacerbate while homeless, jailed, or institutionalized, which in turn increases their barriers to accessing welfare goods and services.

In recognizing the extraordinary vulnerable position these individuals are in, OPC sought to make individuals compliant to treatment, up until the point where they could be transitioned to lower levels of care (i.e., voluntary services) and be considered "meds only." In other words, individuals were retained in AOT-LA until they demonstrated that they know how to participate and benefit from mental health services. Some clients sought to take advantage of this fact too. For example, Robert knew that by being compliant, he would be seen as a "good patient" ready for voluntary services. To this end, I argue that OPC is a program of social governance that seeks to reform mad and disabled people to behave in ways that fall "in line" with the recovery narrative that pervades mental health services and our understandings of psychiatric medications (Braslow, 2013; Dougherty, 2019).

My analysis is not meant to condemn practitioners or advocates of mental health as coconspirators in a broader scheme to harm mad and disabled people, however. In the case of AOT-LA, I witnessed many clients who were on the verge of severe danger or death. Some clients, like Diane, had wandered the streets for unknown periods of time, barely able to maintain their hygiene and health, and were so withdrawn from the world that providers had difficulty learning their identity. The project of governing madness was not necessarily about intentional oppression (that is, the unjust restriction of individual liberties of specific populations), but oppressive mechanisms did emerge and to many appeared as natural or humane responses to greater horrors. Further, clients themselves took up the logic of *clinical control*, and became motivated to be self-governing individuals in the eyes of biopsychiatry (Foucault, 2009). In other words, AOT-LA was not always a narrative of an oppressive institution and its victims as anti-psychiatrists might posit.

Returning to Floersch (2002), psychiatric services were part of the broader project of creating independence citizen. So, what of those who do not follow this narrative? What does the state do when there is a break down in governmentality? Here, institutional coercion in psychiatric services may be best understood as a neoliberal reaction to (a) the breakdown of client governmentality (i.e., clients who stopped behaving as "good" patients in recovery) and (b) the dissembling of a social safety net (i.e., clients who cannot secure medications or resources for themselves anymore; Foucault, 2009; GIlbert, 2002; Soss, Fording, & Schram, 2011). Institutional coercion in state psychiatry becomes perpetrated by the erosion of the welfare state under neoliberalism.

Indeed, if anything, at the heart of this ethnography, was a confrontation of the bureaucratic and fractured nature of social welfare policies in the United States. Each social issue – whether homelessness, criminal activity, or psychotic behaviors - had a dedicated governing body to addressing it, though often in competition or at odds with one another in securing clients. While AOT-LA sought to solve this by forging new relationships to support people in community settings, policymakers, providers, and clients still were forced to navigate a complex field of institutions and rules, which at moments still contradicted the purpose of AOT-LA. Here, our ethnographic observations depict the tragic consequences of a deeply mismanaged set of systems that led to a sense of futility among policymakers and providers, and adverse outcomes for clients.

Why did I investigate the role of psychiatric medications to demonstrate this point? First, by examining psychiatric medications, I revealed the specific role of *medicalized* logic in OPC services, and its relationships to the other discourses that emerge in intensive mental health services like welfare, recovery, and compliance. This is not to say that medications were the only intervention in OPC services, but their consumption by clients was an observable and universal service provided to all the clients in our observations. Second, I was able to examine the underlying tensions regarding governance and compliance, that I then identified to be at the heart of clinical interactions. Medications were a contested site in services: providers thought medications would make clients *more governable*, while clients thought their use represented *social control* over their lives. These tensions, while at the individual level, are remarkably similar to the broader debate in mental health service, psychiatric ethics, and governance scholarship.

Is this the result of a compromise between two opposing ideologies of coercion and liberty? Perhaps, but it can also be understood as the manifestation of a *particular logic* regarding personal liberties. OPC is not just a restriction of freedoms, but a *particular* way in which freedoms were restricted through the coordination of complex social institutions and bureaucracies, which all worked together to reform certain citizens through manipulation. In OPC, providers want to *cultivate* compliant behaviors among particularly problematic populations, but this cannot be done by *forcing* people to take medications. The optimal outcome, then, is to provide services in a less restrictive environment (community-based services) and in ways that do not *overtly* restrain liberties, but still compel compliance in the hopes that clients eventually come to comply to services through their own deliberation.

One of the problems with critiquing institutional coercion in OPC is that advocates see, on the flip side, the profound vulnerability of mad and disabled people. I argue we need to reframe our conversations away from *coercion* or *abandonment.* Instead, we must work towards broader structural change that would eliminate the seeming necessity or inevitability of these paths in the first place. To start, we must dare to see the rationality of people who have rejected psychiatry – perhaps not as an ultimate truth, but as a personal truth rooted in trauma, and feeling marginalized and through their negative experiences with the institution of state psychiatry. A program that can subvert coercive and neoliberal logic would instead seek to reforge relationships with individuals who have walked away from state services and demonstrate the potential for medicine to improve their lives.

This brings me to my last series of points. OPC locates the issues of vulnerability in the individual yet, ironically, providers struggled to address these issues directly. The housing facilities were often overbooked and, in fact, ERS providers contested the enrollment of various AOT clients due to their histories of violence. There were no intensive services for trauma. Providers did not take medication histories with their clients. The OPC program was founded on the same logic as voluntary programs in hopes that *more* of the same will accomplish the goals of the lesser; it assumes the *only* difference in this population is that they simply must be more coercively told to do otherwise. I argue that we should wean ourselves off of OPC and offer real solutions targeted at the specific problems through a framework that acknowledges structural vulnerability (Bourgois et al., 2017): anti-violence training for families, desirable housing and support for individuals, closer working relationships with experts that allow people to determine whether if and which medications are appropriate.

Importantly, my aims here are not to suggest specific revisions to OPC; rather, my analysis suggests that OPC has become a reactionary band-aid to the broader problems produced by both neoliberalism and unchecked state psychiatric power. To do so, I revealed the conditions for which policymakers and social grids of management have viewed it as crucial to coerce individuals to take psychiatric medications. Many changes need to happen, from social institutions to our broader interpretations of madness and disability. While this might seem like a tall or even impossible task, I would argue that at many points in history we have had dramatic shifts in our understandings of citizenship, the nature of mental experiences and normalcy, and the role of the state in supporting those who need it. Such dramatic revisions may have seemed impossible at times, but they were sparked by diligent activists, artists, journalists, and researchers who brought to light human rights abuses and voiced the urgent need for dramatic social change. My hope is that this research joins the voices of many who have called for a paradigm shift.

# Appendix A: Interview Protocols

## Family Interviews (During program involvement)

- Please tell me in your own words how your family member became an AOT participant.
- What previous treatment programs had s/he been in? What were the benefits? If no benefit, why do you think these programs did not help?
- Had there been failed attempts at treatment? Why did these fail?
- Does s/he take medications regularly now? *(If no)* Why do you think s/he is not taking meds?
- Have you been able to talk to the treatment team about how your family member is doing as much as you would have liked to? *(if no)* Why do you think that is?
- What is your relationship with him/her? Do you think you are able to help him/her deal with his/her illness?
- How often does/did s/he see or talk with the AOT-FSP treatment team?
- Do you think it would be helpful for the team to be in touch more often?
- What do you hope the AOT program will be able to do for your family member? Do you think it will be more helpful to him/her than past treatment programs? If so, why?
- If not, what do you think would be a better alternative?
- What do you expect will happen if your family member refuses to participate in AOT? How do you feel about that?
- What do you think will happen after your family member's assignment to the program ends?

## Family Interviews (After program completion)

- Please tell me in your own words what changed for your family member because s/he participated in LA County's AOT program.
- Was the program helpful to him/her? If so, how and why?
- If not, what would have been more helpful? What would you change?
- How often does/did s/he see or talk with the AOT-FSP treatment team?
- Do you think it would be helpful for the team to be in touch more often?
- Do you feel that s/he is more able to manage your thoughts and behavior than when s/he started the program?
- Do you feel that s/he is more able to participate in family life than when s/he started the program?
- What is your relationship with him/her now?
- What is s/he doing now? Is s/he engaged in treatment? Does s/he have future plans?
- Have you been able to talk to the treatment team about how your family member is doing as much as you would have liked to? *(if no)* Why do you think that is?
- Has his/her willingness to take psychiatric medications changed since s/he started the program?

- Does s/he take medications regularly now? *(If no)* Why do you think s/he is not taking meds?
- In general, how would you characterize the AOT program: as helpful? As necessary to ensuring the best care for some people? As coercive?

**Provider Interviews**

- What is your role on the treatment team? What is your level of training?
- How would you characterize your AOT clients compared with the other clients you provide services to?
- What kind of treatment goals do your AOT clients have? Who sets the goal?
- What steps do you take to help the client stay engaged in treatment?
- Do you believe the program is helpful to all clients? To some clients but not to others? Which ones? How does it help these individuals?
- If not helpful for all, what would be a better alternative? What would you change?
- How would you define "non-compliance" – what exactly happens that defines that a client is not complying with the mandated treatment?
- What do you do when a client does not comply? What do you think are the reasons for non-compliance?
- Were any family members involved with the development of the treatment plan?
- When the family wants to be involved in the treatment, how do you work with them? Do you meet/talk with them as part of the treatment plan? Do you meet/talk with them at other times? About how often?
- How do you assess if the client has improved and is ready to move on to voluntary treatment?
- Are most clients able to move on after the initial period? Some but not all? Which ones are not able to move on and why not?
- In general, how would you characterize the AOT program: as helpful? As necessary to ensure the best care for people? As coercive?
- Do you think the program is fair to use with mental health clients? How?
- Does the involuntary aspect of the program bother you in any way?

**Law Enforcement and Court Staff**

- How long have you been involved in the AOT program? What is your role?
- How many participants/prospective participants have you worked with?
- Please tell me in your own words what you think is/are the main objective(s) of the program.
- Do you think the program has achieved these objectives? If so, how and why does it work?
- If not, what would you change about the program? What problems have you observed?
- What kinds of mental health clients do you think are appropriate for the AOT program?
- Are there clients you think are not appropriate?
- Do you think the program is beneficial for clients? How?
- Do you think the program is fair to use with mental health clients? How?
- Does the involuntary aspect of the program bother you in any way?
- What do you think might be a better alternative, if any?

**Client Interview: in outreach**

- Hi, how are you? Can I ask you a few questions?
- Why do you think the DMH team is reaching out to you? Can you give me a little background?
- What are they offering you? What will happen if you agree to participate in the program they are recommending to you?
- Do you think it would be helpful to you to be part of the program they are offering? Why or why not?
- If not, what would be more helpful?
- What would happen if you decided on your own not to participate?
- Do you feel that you might be forced to participate regardless of what you want to do?
- What is your current goal for your life? How have you been trying to achieve this goal?
- Do you think participation in this program might help you achieve your goal? Why or why not?
- What kinds of things are you doing now to keep yourself healthy?
- What kinds of things are you doing now to help yourself feel better? (*if client may be a substance abuser, use this question to open up that topic a little)*
- Do you take medications now? Do you think medications might be helpful to you? Why or why not?
- Do you think it is ever fair or right to make people participate in a treatment program if they do not want to?

**Client Interview: in treatment**

- Please tell me in your own words what you have been doing as a participant in this program.
- Do you know what the program is called?
- Do you think this program has been helpful to you so far? If so, how?
- If not, what would have been more helpful? What would you change?
- Do you feel that you are more able to manage your life than you were when you started the program?
    - *If respondent seems unclear about how to answer, be more specific: are you more able to manage your thoughts? Your behavior?*
- Do you feel that you are more able to be a member of your community than you were when you started the program? How? *If respondent seems unclear about "community," try to help elucidate what "community" means to the individual.*
- How would you describe your relationship with the treatment team? How do they help you?
- Do you feel that you are being forced to participate in this program regardless of what you want to do? How do you feel about that?
- Was there ever a point when you did not want to participate any more? What did you do?
- What is your current goal for your life? How have you been trying to achieve this goal?
- Do you think participation in this program will help you achieve your goal? Why or why not?
- What kinds of things are you doing now to keep yourself healthy?

- What kinds of things are you doing now to help yourself feel better?
- Are you taking any medications now? Do you think the medications are helpful to you? Why or why not?
- What do you think will happen after your assignment to the program ends? What will you do?
- Do you think it is ever fair or right to make people participate in a treatment program if they do not want to?

**Client Interview: after program graduation**

- Please tell me in your own words what changed in your life because you participated in this program.
- Do you know what the program is called?
- Was the program helpful to you? If so, how?
- If not, what would have been more helpful? What would you change?
- Do you feel that you are more able to manage your life than you were when you started the program?
    - *If respondent seems unclear about how to answer, be more specific: are you more able to manage your thoughts? Your behavior?*
- Do you feel that you are more able to be a member of your community than you were when you started the program? *If respondent seems unclear about "community," try to help elucidate what "community" means to the individual.*
- Do you feel you would be doing better now if you had chosen to participate in treatment voluntarily? If so, how?
- Do you feel that you would be doing better now if you had not participated in treatment at all? If so, how?
- Do you feel that you were forced to participate in the AOT program? How did you feel about that?
- What is your current goal for your life? How have you been trying to achieve this goal?
- Do you think participation in this program has helped you to achieve your goal? Why or why not?
- What kinds of things are you doing now to keep yourself healthy?
- What kinds of things are you doing now to help yourself feel better?
- Have you been taking medications? *If so,* do you think you will you continue to take them? Why or why not?
- Do you think it is ever fair or right to make people participate in a treatment program if they do not want to?

**Client Interview: medication interview**

- *Details on medications*: I'm interested in hearing about the medications you were prescribed. Can you tell me more about them?
    - Follow up: When did you start taking these medications?
    - Follow up: How often do you receive or take them?
    - Follow up: Who helps you obtain/who delivers your medications?
    - Follow up: Before being enrolled in AOT, what are some other times you've taken similar medications?

- *The meanings of medications:* What is your understanding about the purpose of these medications?
    - Follow up: What sources did you use to learn about these medications?
    - Follow up: How long do you think you will need to be taking these medications?
- *Medication effects:* Can you describe what changed when you began to take these medications?
    - Follow up: Can you give me an example of something that has changed in your day-to-day life since taking these medications?
    - Follow up: How has their impact on you changed over time?
- *Social effects:* In what ways do you feel your medication has changed the way others view you?
    - Follow up: Can you provide an everyday example?
    - Follow up: How has medications changed the way you view yourself?
    - Follow up: Can you provide an everyday example?
- *Unpacking positive effects:* Out of the all the different ways you've told me the medications have impacted you, which ones stand out as especially *positive* or *helpful* to you?
    - Follow up: How often do you experience these sorts of effects?
    - Follow up: Do you feel like the positive effects have changed how you feel about taking medications?
- *Unpacking negative effects:* Out of the all the different ways you've told me medications have impacted you, can you now tell me which ones have been especially *negative* or *unhelpful* for you?
    - Follow up: How often do you experience these sorts of effects?
    - Follow up: How do these effects impact your day-to-day life? Can you give an example to help me understand better?
    - Follow up: Describe to me what you do to help deal with some of these negative effects.
    - Follow up: Do you feel like the negative effects have changed how you feel about taking medications?
- *The social processes in care:* What is it like to talk to your doctor or therapist about your medications?
    - Follow up: What are some things that your psychiatrist or therapist could do differently to better support you in dealing with these negative effects?
    - Follow up: Are there any other people, even outside of your treatment team, that support you in taking or dealing with the medications and their effects on you?
- *Coercion in care.* How much say do you feel you have in terms of taking medications?
    - Follow up: What are some of the reasons [*you've decided to/you are*] follow the treatment plan given to you?
    - Follow up: How do you feel others would react if you told them you decided to reduce or stop taking your medications? How so?
        - Follow up: How do you think the judge would react?
- *If they've taken medications before:*
- Follow up: How is taking medications different in this program compared to other therapists/psychiatrists you've been in before?

# Appendix B: Division of Ethnographic Methods

| **Name** | **Affiliation/Background** | **Contributions** |
|---|---|---|
| Ryan Dougherty | Current: PhD Candidate in Social Welfare (UCLA)<br>Previous: MSW (UCLA), Bachelors in Biopsychology (Michigan) | Participant-observations: Treatment settings (Full-Service Partnerships, Enriched-Residential Facilities)<br>Interviews: Enrolled clients, treatment providers, family members |
| Charlotte Neary-Bremer | Current: PhD Student in Anthropology (UCLA)<br>Previous: Bachelor of Medicine and Bachelor of Surgery (UK), Masters in Medical Anthropology (Harvard) | Participant-observations: Outreach and Engagement<br>Interviews: Referred clients, outreach providers, family members |
| Ron Calderon | Current: MSW (UCLA)<br>Previous: BS in Biology | Participant-observations: Court rooms<br>Interviews: Family members, enrolled clients |
| Blake Erickson | Current: PhD candidate in Anthropology (UCLA)<br>Previous: M.D. (University of Minnesota) | Participant-observations: Outreach and Engagement, Treatment (Full-Service Partnerships) |
| Victoria Lewis | Current: Masters in Public Policy (UCLA)<br>Previous: Bachelors in Public Health (Berkeley) | Participant-observations: Courtrooms, Outreach and Engagement |

| | | |
|---|---|---|
| Rachel Parks | Current: MD/PhD candidate in the Medical Scientist Training Program (UCLA) | Participant-observations: Administrative meetings, courtrooms |

## Appendix C: Qualitative Authorship Guidelines

### Purpose

Broadly, the purpose of these guidelines is to encourage productive collaboration among members of the AOT evaluation team. Specifically, these guidelines are to ensure that (1) proper credit is given to collaborators when due, (2) data is accurately interpreted and represented, and (3) there is consistency in findings across publications.

### Guidelines

Broadly, authorship will be given when an individual contributes substantially to the conception, analysis, and writing of an article; and provides a final approval of the final submission and any subsequent re-submissions.

In regard to the use of ethnographic notes, authorship will be considered when a substantial portion of an individual's ethnographic notes are used. This may include, though is not limited to when:

- The article relies on multiple events written in one or multiple notes to inform their analysis.
- A direct quote or theoretical interpretation from notes are included in the article.

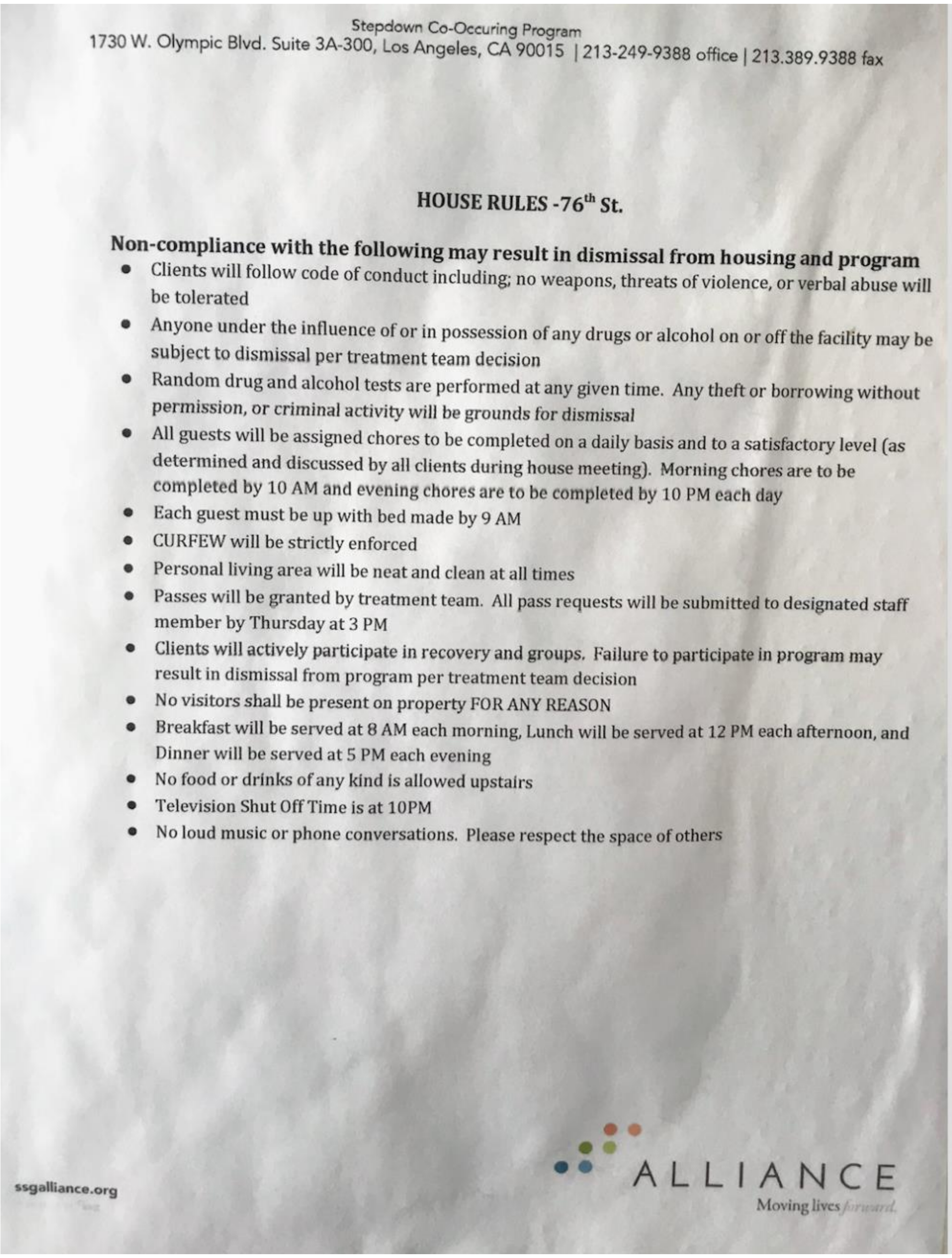
### Procedures

When an author intends to use an ethnographer's note, the following procedures will be followed:

- When *any* portion of an interview or ethnographic note is used, the ethnographer should be approached to ensure the note is being accurately interpreted. When disagreement arises regarding the interpretation of a note, preference should be given to the interpretation of the note's author.
- When authorship should be considered, as outlined in the above guidelines, the author will invite them to participate in the writing and/or editing process. Order of authors should reflect the portion of work contributed in the article.
- Any submitted or published articles should be listed on the Box Excel Sheet, which will include the topic of the article, place of submission of publication, and list of authors.

## Appendix D: The Flow of AOT-LA Services

## Appendix E: Photographs



Stepdown Co-Occuring Program
1730 W. Olympic Blvd. Suite 3A-300, Los Angeles, CA 90015 | 213-249-9388 office | 213.389.9388 fax

### HOUSE RULES -76th St.

**Non-compliance with the following may result in dismissal from housing and program**

- Clients will follow code of conduct including; no weapons, threats of violence, or verbal abuse will be tolerated
- Anyone under the influence of or in possession of any drugs or alcohol on or off the facility may be subject to dismissal per treatment team decision
- Random drug and alcohol tests are performed at any given time. Any theft or borrowing without permission, or criminal activity will be grounds for dismissal
- All guests will be assigned chores to be completed on a daily basis and to a satisfactory level (as determined and discussed by all clients during house meeting). Morning chores are to be completed by 10 AM and evening chores are to be completed by 10 PM each day
- Each guest must be up with bed made by 9 AM
- CURFEW will be strictly enforced
- Personal living area will be neat and clean at all times
- Passes will be granted by treatment team. All pass requests will be submitted to designated staff member by Thursday at 3 PM
- Clients will actively participate in recovery and groups. Failure to participate in program may result in dismissal from program per treatment team decision
- No visitors shall be present on property FOR ANY REASON
- Breakfast will be served at 8 AM each morning, Lunch will be served at 12 PM each afternoon, and Dinner will be served at 5 PM each evening
- No food or drinks of any kind is allowed upstairs
- Television Shut Off Time is at 10PM
- No loud music or phone conversations. Please respect the space of others

ssgalliance.org

ALLIANCE
Moving lives forward.

The rules at Portia and Robert's ERS facility


The group treatment center room at Portia and Robert's facility


A makeshift shelter and belongings of a referred AOT-LA client

Jasmine’s shelter at night

# References

Abramovitz, M. (2006). Welfare reform in the United States: gender, race and class matter. *Critical Social Policy*, *26*(2), 336–364. https://doi.org/10.1177/0261018306062589

Anderson, S. (2011). Coercion.

Angell, B., Mahoney, C. A., & Martinez, N. I. (2006). Promoting treatment adherence in assertive community treatment. *Social Service Review*, *80*(3), 485–526.

Barnes, S. S., & Badre, N. (2016). Is the evidence strong enough to warrant long-term antipsychotic use in compulsory outpatient treatment? *Psychiatric Services*, *67*(7), 784–786. https://doi.org/10.1176/appi.ps.201500408

Beauchamp, T. L. (2011). Informed consent: Its history, meaning, and present challenges. *Cambridge Quarterly of Healthcare Ethics*, *20*(4), 515–523.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (Sixth). New York, New York: Oxford University Press.

Beecher, B. (2009). The medical model, mental health practitioners, and individuals with schizophrenia and their families. *Journal of Social Work Practice*, *23*(1), 9–20. https://doi.org/10.1080/02650530902723282

Berger, P. L., & Luckman, T. (1967). *The social construction of reality: a treatise in the sociology of knowledge*. Garden City, New York: Anchor Books.

Bhaskar, R. (2013). *A realist theory of science*. Routledge.

Blumenthal-Barby, J. S. (2012). Between reason and coercion: Ethically permissible influence in health care and health policy contexts. *Kennedy Institute of Ethics Journal*, *22*(4), 345–366. https://doi.org/10.1353/ken.2012.0018

Blumenthal-Barby, J. S., & Burroughs, H. (2012). Seeking better health care outcomes: The ethics of using the “nudge.” *American Journal of Bioethics*, *12*(2), 1–10. https://doi.org/10.1080/15265161.2011.634481

Bourgois, P. (2002). Ethnography’s troubles and the reproduction of academic habitus. *International Journal of Qualitative Studies in Education*, *15*(4), 417–420. https://doi.org/10.1080/09518390210145471

Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017, March 1). Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Academic Medicine*. Lippincott Williams and Wilkins. https://doi.org/10.1097/ACM.0000000000001294

Braslow, J., Starks, S., Kelly, E., Meldrum, M., & Bourgois, P. (2020). *Assisted Outpatient Treatment Evaluation: Final Report*. Los Angeles, California.

Braslow, J. T. (2013). The manufacture of recovery. *Annual Review of Clinical Psychology*, *9*, 781–809. https://doi.org/10.1146/annurev-clinpsy-050212-185642

Brodwin, P. (2008). The coproduction of moral discourse in U.S. community psychiatry. *Medical Anthropology Quarterly*, *22*(2), 127–147. https://doi.org/10.1111/j.1548-1387.2008.00011.x

Brodwin, P. E. (2013). *Everyday ethics: voices from the front line of community psychiatry*. University of California Press.

Burstow, B. (2015). *Psychiatry and the business of madness: an ethical and epistemological accounting*. New York, NY: Palgrave Macmillan.

Buss, S. (2005). Valuing autonomy and respecting persons: Manipulation, seduction, and the basis of moral constraints. *Ethics*, *115*(2), 195–235. https://doi.org/10.1086/426304

Centers for Medicare and Medicaid Services. (2015). *2015 Medicare Drug Spending Dashboard*.

Charmaz, K. (2014). *Constructing grounded theory*. (J. Seaman, Ed.) (3rd ed.). SAGE Publications Ltd.

Cohen, D. (1997). A critique of the use of neuroleptic drugs in psychiatry. In S. Fisher & R. P. Greenberg (Eds.), *From placebo to panacea: putting psychiatric drugs to the test* (pp. 173–288). John Wiley & Sons, Ltd.

Cohen, D. (2009). Needed: Critical thinking about psychiatric medications. *Social Work in Mental Health*, *7*(1–3), 42–61. https://doi.org/10.1080/15332980802072371

Cohen, D., McCubbin, M., Collin, J., & Pérodeau, G. (2001). Medications as social phenomena. *Health*, *5*(4), 441–469. https://doi.org/10.1177/136345930100500403

Conrad, P., & Schneider, J. W. (2010). *Deviance and medicalization: from badness to sickness*. Temple University Press.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, *39*(3). https://doi.org/10.1207/s15430421tip3903_2

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Thousand Oaks, California: Sage.

Dallaire, B., McCubbin, M., Morin, P., & Cohen, D. (2000). Civil commitment due to mental illness and dangerousness: the union of law and psychiatry within a treatment-control system. *Sociology of Health & Illness*, *22*(5), 679–699.

Dardot, P., & Laval, C. (2014). *A new way of the world: On neoliberal society*. Penguin Random House Publisher Services.

Deci, P. A., Santos, A. B., Hiott, D. W., Schoenwald, S., & Dias, J. K. (1995). Dissemination of assertive community treatment programs. *Psychiatric Services*, *46*(7), 676–678. https://doi.org/10.1176/ps.46.7.676

DeParle, J. (2004). *American dream: Three women, ten kids, and a nation's drive to end welfare*. New York, NY: Viking Penguin.

Diamond, R. J. (1996). Coercion and tenacious treatment in the community: Applications to the real world. In D. L. Dennis & J. Monahan (Eds.), *Coercion and aggressive community treatment: A new frontier in mental health law* (pp. 51–72). New York, NY: Springer Science & Business Media.

Dougherty, R. J. (2019). The psychological management of the poor: Prescribing psychoactive drugs in the age of neoliberalism. *Journal of Social Issues*, *75*(1), 217–237. https://doi.org/10.1111/josi.12313

Drake, R. E., & Deegan, P. E. (2009). Shared decision making is an ethical imperative. *Psychiatric Services*, *60*(8), 1007. https://doi.org/http://dx.doi.org/10.1176/ps.2009.60.8.1007

Estroff, S. E. (1985). *Making it crazy: An ethnography of psychiatric clients in an American community*. University of California Press.

Faden, R., Beauchamp, T. L., & King, N. M. P. (1986). *A history and theory of informed consent*. New York: Oxford University Press.

Fisher, P. (2012). Ethics in qualitative research: 'Vulnerability', citizenship and human rights. *Ethics and Social Welfare*, *6*(1), 2–17. https://doi.org/10.1080/17496535.2011.591811

Fisher, W. H., & Drake, R. E. (2007). Forensic mental illness and other policy misadventures. Commentary on "Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions." *Community Mental Health Journal*, *43*(5), 545–548.

Floersch, J. (2002). *Meds, money, and manners: The case management of severe mental illness*.

Columbia University Press.

Foucault, M. (1971). Madness and civilization: A history of insanity in the age of reason.

Foucault, M. (1975). *Discipline and Punishment*.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, *8*(4), 777–795. https://doi.org/10.1086/448181

Foucault, M. (2009). *Security, territory, population: Lectures at the Collège de France 1977-1978* (1st ed.). Picador.

Frank, R. G. (2000). The creation of Medicare and Medicaid: the emergence of insurance and markets for mental health services. *Psychiatric Services*, *51*(4), 465–468.

Gelman, S. (1999). *Medicating schizophrenia: a history*. Piscataway, NJ: Rutgers University Press.

GIlbert, N. (2002). *Transformation of the Welfare State: The Silent Surrender of Public Responsibility*. Oxford University Press.

Gomory, T. (1998). *Coercion justified?: evaluating the training in community living model - a conceptual and empirical critique*. Florida State University.

Gomory, T. (2004). Tautology and coercion in Assertive Community Treatment (ACT): the “treatment effect” of Assertive Community Treatment deconstructed.

Gomory, T., Cohen, D., & Kirk, S. A. (2013). Coercion: The only constant In psychiatric practice? In M. Dellwing & M. Harbusch (Eds.), *Krankheitskonstruktionen und Krankheitstreiberei: Die Renaissance der soziologischen Psychiatriekritik* (pp. 289–312). Universität Kassel, Deutschland: Springer.

Gomory, T., Wong, S. E., Cohen, D., & Lacasse, J. R. (2011). Clinical social work and the biomedical industrial complex. *Journal of Sociology and Social Welfare*, *38*(4), 135–165.

Guinart, D., & Kane, J. M. (2020). Incentivizing is not coercing: a commentary. *Psychiatr Services*.

Guttmacher, M. S. (1964). Phenothiazine treatment in acute schizophrenia. *Archives of General Psychiatry*, *10*(3), 246. https://doi.org/10.1001/archpsyc.1964.01720210028005

Hansen, H., Bourgois, P., & Drucker, E. (2014). Pathologizing poverty: New forms of diagnosis, disability, and structural stigma under welfare reform. *Social Science & Medicine*, *103*, 76–83. https://doi.org/10.1016/j.socscimed.2013.06.033

Hem, M. H., Gjerberg, E., Husum, T. L., & Pedersen, R. (2018). Ethical challenges when using coercion in mental healthcare: A systematic literature review. *Nursing Ethics*, *25*(1), 92–110. https://doi.org/10.1177/0969733016629770

Hughes, S., Narendorf, S., & Lacasse, J. R. (2017). A national survey of graduate education in psychopharmacology: Advancing the social work perspective on psychiatric medication. *Journal of Social Work Education*, *53*(3), 424–434. https://doi.org/10.1080/10437797.2016.1272513

Kirk, S. A., Gomory, T., & Cohen, D. (2013). *Mad science: Psychiatric coercion, diagnosis, and drugs*. Transaction Publishers.

Kuhn, T. S. (2012). *The structure of scientific revolutions.*

Lawrence, D. J. (2007). The four principles of biomedical ethics: A foundation for current bioethical debate. *Journal of Chiropractic Humanities*, *14*, 34–40.

LeCompte, M. D., & Schensul, J. J. (2010). *Designing and conducting ethnographic research: an introduction* (2nd ed.). AltaMira Press.

Lieberman, J. A., Scott Stroup, T., McEvoy, J. P., Swartz, M. S., Rosenheck, R. A., Perkins, D. O., … Hsiao, J. K. (2005). Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *New England Journal of Medicine*, *353*(12), 1209–1223. https://doi.org/10.1056/NEJMoa051688

Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *Evolutionary Anthropology*, (30), 73–84. https://doi.org/10.1002/ev.1427

Longhofer, J., Floersch, J., & Jenkins, J. (2003a). Medication effect interpretation and the social grid of management. *Social Work in Mental Health*, *1*(4), 1–31. https://doi.org/10.1300/J200v01n04_05

Longhofer, J., Floersch, J., & Jenkins, J. H. (2003b). The social grid of community medication management. *American Journal of Orthopsychiatry*, *73*(1), 24–34. https://doi.org/10.1037/0002-9432.73.1.24

Lovell, A. M. (1996). Coercion and social control: A framework for research on aggressive strategies in community mental health. In D. L. Dennis & J. Monahan (Eds.), *Coercion and aggressive community treatment: a new frontier in mental health law* (pp. 147–166). New York, NY: Springer Science & Business Media.

McNiel, D. E., Gormley, B., & Binder, R. L. (2013). Leverage, the treatment relationship, and treatment participation. *Psychiatric Services (Washington, D.C.)*, *64*(5), 431–436. https://doi.org/10.1176/appi.ps.201200368

Mechanic, D., McAlpine, D. D., & Rochefort, D. A. (2014). *Mental Health and Social Policy: Beyond Managed Care* (Sixth). Pearson.

Meldrum, M. L., Kelly, E. L., Calderon, R., Brekke, J. S., & Braslow, J. T. (2016). Implementation status of Assisted Outpatient Treatment programs: A national survey. *Psychiatric Services*, *67*(6), 630–635. https://doi.org/10.1176/appi.ps.201500073

Metzl, J. M. (2009). *The protest psychosis: How schizophrenia became a black disease*. Boston, Masschusetts: Beacon Press.

Miles, M. B., Huberman, A. M., & Saldaña, J. (2013). *Qualitative data analysis: A methods sourcebook* (Third). SAGE Publications, Inc.

Miller, P., & Rose, N. (2008). *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge, UK: Polity Press.

Moncrieff, J. (2008). Neoliberalism and biopsychiatry: a marriage of convenience. In C. I. Cohen & S. Timimi (Eds.), *Liberatory Psychiatry: Philosophy, Politics and Mental Health* (pp. 235–255). Cambridge University Press.

Moncrieff, J., & Cohen, D. (2005). Rethinking models of psychotropic drug action. *Psychotherapy and Psychosomatics*. https://doi.org/10.1159/000083999

Moncrieff, J., Cohen, D., & Mason, J. P. (2009). The subjective experience of taking antipsychotic medication: A content analysis of internet data. *Acta Psychiatrica Scandinavica*, *120*(2), 102–111. https://doi.org/10.1111/j.1600-0447.2009.01356.x

Murphy, E., & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science and Medicine*, *65*(11), 2223–2234. https://doi.org/10.1016/j.socscimed.2007.08.008

National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers.* (NASW Press, Ed.). Washington, DC.

*National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research*. (1979). *The Belmont report: Ethical principles and guidelines for the protection of human subjects of research*.

Norvoll, R., & Pedersen, R. (2018). Patients' moral views on coercion in mental healthcare.

*Nursing Ethics*, *25*(6), 796–807. https://doi.org/10.1177/0969733016674768

Nozick, R. (1969). Coercion. In S. Morgenbesser, P. Suppes, & M. White (Eds.), *Philosophy, Science, and Method: Essays in Honor of Ernest Nagel* (pp. 440–472). St. Martin's Press, New York.

Nyttingnes, O., Ruud, T., & Rugkåsa, J. (2016). 'It's unbelievably humiliating'—Patients' expressions of negative effects of coercion in mental health care. *International Journal of Law and Psychiatry*, *49*, 147–153. https://doi.org/10.1016/j.ijlp.2016.08.009

O'Brien, A. J., & Golding, C. G. (2003). Coercion in mental healthcare: The principle of least coercive care. *Journal of Psychiatric and Mental Health Nursing*, *10*(2), 167–173. https://doi.org/10.1046/j.1365-2850.2003.00571.x

Padgett, D. K., Hawkins, R. L., Abrams, C., & Davis, A. (2006). In their own words: Trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry*, *76*(4), 461–467. https://doi.org/10.1037/1040-3590.76.4.461

Pahwa, R., Dougherty, R. J., Kelly, E., Davis, L., Smith, M. E., & Brekke, J. S. (2020). Is it safe? Community integration for individuals with serious mental illnesses. *Research on Social Work Practice*, (1–13). https://doi.org/10.1177/1049731520951628

Perlis, R. H., Ostacher, M. J., Patel, J. K., Marangell, L. B., Zhang, H., Wisniewski, S. R., … Thase, M. E. (2006). Predictors of recurrence in bipolar disorder: Primary outcomes from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *American Journal of Psychiatry*, *163*(2), 217–224. https://doi.org/10.1176/appi.ajp.163.2.217

Peyrot, M. (1985). Coerced voluntarism: The micropolitics of drug treatment. *Urban Life*, *13*(4), 343–365.

Plankey-Videla, N. (2012). Informed consent as process: Problematizing informed consent in organizational ethnographies. *Qualitative Sociology*, *35*(1), 1–21. https://doi.org/10.1007/s11133-011-9212-2

Pridham, K. M. F., Berntson, A., Simpson, A. I. F., Law, S. F., Stergiopoulos, V., & Nakhost, A. (2016). Perception of coercion among patients with a psychiatric community treatment order: A literature review. *Psychiatric Services*, *67*(1), 16–28. https://doi.org/10.1176/appi.ps.201400538

Read, J. (2009). *Psychiatric Drugs: Key issues and service user perspectives*. Palgrove Macmillan.

Ridgely, M. S., Borum, R., & Petrila, J. (2001). *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*. Santa Monica, CA.

Rose, D. (2009). Survivor-Produced Knowledge. In A. Sweeney, P. Beresford, A. Faulkner, M. Nettle, & D. Rose (Eds.), *This is Survivor Research* (pp. 38–43). PCCS Books.

Rose, N. (2007). *The politics of life itself: biomedicine, power, and subjectivity in the twenty-first century*. Princeton, New Jersey: Princeton University Press.

Sacchetti, E., Vita, A., Siracusano, A., & Fleischhacker, W. (2014). *Adherence to antipsychotics in schizophrenia*. Springer. https://doi.org/10.1007/978-88-470-2679-7

Scull, A. (1984). *Decarceration: Community treatment and the deviant*. New Brunswick, New Jersey: Rutgers University Press.

Scull, A. (2015). *Madness in civilization: A cultural history of insanity from the Bible to Freud, from the madhouse to modern medicine*. Princeton, New Jersey: Princeton University Press.

Sharfstein, S. S., Lieberman, J. A., & Talbott, J. A. (2016). AOT and long-term use of antipsychotics. *Psychiatric Services*, *67*(7), 811.

Soss, J., Fording, R. C., & Schram, S. F. (2011). *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race*. Chicago, IL: The University of Chicago Press, Ltd.

Steckler, A., & McLeroy, K. R. (2008). The importance of external validity. *American Journal of Public Health*, *98*(1), 9–10. https://doi.org/10.2105/AJPH.2007.126847

*Supplement to Community Health Assessment - Service Planning Area 6: South*. (2014). Retrieved from http://publichealth.lacounty.gov/plan/docs/SPA6Supplement.pdf

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63–75.

Swanson, J., Swartz, M. S., Elbogen, E. B., Wagner, H. R., & Burns, B. J. (2003, July). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*. https://doi.org/10.1002/bsl.548

Swanson, J., Swartz, M., Van Dorn, R. A., Monahan, J., McGuire, T. G., Steadman, H. J., & Robbins, P. C. (2009). Racial disparities in involuntary outpatient commitment: Are they real? *Health Affairs*, *28*(3), 816–826. https://doi.org/10.1377/hlthaff.28.3.816

Swanson, J. W., Swartz, M. S., George, L. K., Burns, B. J., Hiday, V. A., Borum, R., & Wagner, H. R. (1997). Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. *Journal of the American Academy of Psychiatry and the Law Online*, *25*(1), 5–16.

Swartz, M. S., Wagner, H. R., Swanson, J. W., Hiday, V. A., & Burns, B. J. (2002). The perceived coerciveness of involuntary outpatient commitment: findings from an experimental study. *The Journal of the American Academy of Psychiatry and the Law*, *30*(2), 207–217.

Swartz, M., Swanson, J., Steadman, J., Robbins, P., & Monahan, J. (2009). New York State Assisted Outpatient Treatment Program Evaluation. *Journal of Chemical Information and Modeling*. https://doi.org/10.1017/CBO9781107415324.004

Szasz, T. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. Harper & Row.

Szasz, T. (2007). *Coercion as cure: A critical history of psychiatry*. Transaction Publishers.

Szmukler, G. (2015, October 1). Compulsion and "coercion" in mental health care. *World Psychiatry*. Blackwell Publishing Ltd. https://doi.org/10.1002/wps.20264

Szmukler, G., & Appelbaum, P. S. (2008, June). Treatment pressures, leverage, coercion, and compulsion in mental health care. *Journal of Mental Health*. Taylor & Francis. https://doi.org/10.1080/09638230802052203

Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, *68*(2), 216–232. https://doi.org/10.1037/h0080331

Torrey, E. F., & Zdanowicz, M. (2001). Outpatient commitment: What, why, and for whom. *Psychiatric Services*, *52*(3), 337–341. https://doi.org/10.1176/appi.ps.52.3.337

Torrey, F. E., Kennard, A. D., Eslinger, D., Lamb, R., & Pavle, J. (2010). *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*. Arlington, Virginia. Retrieved from http://coos.or.networkofcare.org/library/final_jails_v_hospitals_study1.pdf

Torrey, W. C., Griesemer, I., & Carpenter-Song, E. A. (2017). Beyond "Med Management." *Psychiatric Services*, *68*(6), 618–620. https://doi.org/10.1176/appi.ps.201600133

Trivedi, M. H., Rush, A. J., Wisniewski, S. R., Nierenberg, A. A., Warden, D., Ritz, L., … Fava,

M. (2006). Evaluation of outcomes with citalopram for depression using measurement-based care in STAR*D: Implications for clinical practice. *American Journal of Psychiatry*, *163*(1), 28–40. https://doi.org/10.1176/appi.ajp.163.1.28

Turner, L. (2009). Anthropological and sociological critiques of bioethics. *Journal of Bioethical Inquiry*, *6*(1), 83–98. https://doi.org/10.1007/s11673-008-9130-5

van Rossum, J. M. (1967). The significance of dopamine-receptor blockade for the action of neuroleptic drugs. In H. Brill, J. O. Cole, P. Deniker, H. Hippius, & P. B. Bradley (Eds.), *Neuro-psycho-pharmacology* (pp. 321–329). Washington, DC: Excerpta Medica Foundation.

Whitaker, R. (2005). Anatomy of an epidemic: Psychiatric drugs and the astonishing rise of mental illness in America. *Ethical Human Psychology and Psychiatry*, *7*(1), 23–35.

Wolfensberger, W. (1970). The principle of normalization and its implications to psychiatric service. *The American Journal of Psychiatry*, *127*(3), 291–297. https://doi.org/10.1176/ajp.127.3.291

Wynn, R. (2006). Coercion in psychiatric care: Clinical, legal, and ethical controversies. In *International Journal of Psychiatry in Clinical Practice* (Vol. 10, pp. 247–251). Taylor & Francis. https://doi.org/10.1080/13651500600650026