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Mind and Matter:

Madness and Inequality in Los Angeles

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requirements for the degree of Doctor of Philosophy in Sociology

by

Neil Gong

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ABSRACT OF THE DISSERTATION

Mind and Matter:
Madness and Inequality in Los Angeles

by

Neil Gong

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2019

Professor Stefan Timmermans, Chair

This dissertation investigates inequality in community-based mental health services by comparing public safety net and elite private treatment in Los Angeles. Drawing on more than four years of ethnographic fieldwork, interviews, and historical research, the dissertation analyzes the way social class shapes the care, control, and empowerment of people diagnosed with serious psychiatric disabilities. A substantial literature has investigated the consequences of deinstitutionalization, such as the crisis of criminalization and homelessness for poor psychiatric services users, yet far less is known about the experience of those with more social and economic resources. Comparing clinics for the poor and rich, I show how the very meaning of treatment shifts by class context. In a public safety net setting oriented to urban poverty governance, staff members work to secure their clientele access to survival resources. With few therapeutic interventions beyond psychiatric medication, care is oriented to housing and basic stability. Providers engage in what I call a "tolerant containment" approach that accepts a surprising amount of seemingly problematic behavior, like drug use and "non-compliance," with intervention focused on harm reduction and creative solutions for keeping people off the streets. In the elite private settings, on the other hand, providers have access to a broad array of therapeutic interventions and a goal of transformative care. Far from letting people choose to be "deviant," I find providers heavily invest therapeutic resources to both cultivate and control privileged patients. Building on sociological theories of privileged childrearing, I term this form of family-driven governance "concerted constraint." Holding these cases as mirrors to one another, I argue that the clinics are not simply treating mental illness, but also attempting to create different kinds of people for their respective classed milieus.

The dissertation of Neil Gong is approved

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2019

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Introduction

This dissertation is a comparison of community psychiatric care in a single urban center—Los Angeles—but two largely separate worlds. Using ethnographic methods, I investigated treatment inequality by observing public safety net care in the social service ghetto of Downtown Skid Row and elite private services in West Los Angeles. Fifty years after the closings of the state mental hospitals and civil libertarian turn in commitment law, people diagnosed with serious psychiatric disabilities spend most of their time outside of the hospital walls. Yet what this "community care" means, and the kinds of lives people can expect to live, is severely stratified by social class. In clinical psychiatric or psychological contexts, the title *Mind and Matter* might mean the difference and relation between the ineffable psyche and the physical brain. Here, in sociological context, "matter" refers also to economic inequality.

The topic of unequal psychiatric care has a distinguished quantitative tradition in the social study of health. In a pioneering work of medical sociology, Hollingshead and Redlich (1958) drew on extensive statistics of psychiatric services in New Haven, Connecticut to investigate how prevalence and treatment varied by social class. The epidemiological interest in social class stemmed from classic works of Chicago School sociology like Faris and Dunham's (1939), which found that poorer areas of the city featured the highest concentration of mental health difficulties. An extensive literature has since debated the relative degrees of social causation, that is, how environment influences the development of illness, versus social drift, with the ill falling through the class structure (for a review see Hudson 1988).

But beyond the question of what *caused* the higher rates of serious illness among the poor, Hollingshead and Redlich found major differences in treatment. While the upper classes received psychotherapeutic interventions, and the middle classes received organic therapies, many poor patients arguably did not receive any treatment at all. In fact, for those without means, the locked hospital setting was often a custodial rather than clinical institution. The authors believed these combined topics touched on two major taboos of their society, writing,

> Americans prefer to avoid the two facts of life studied in this book: social class and mental illness. The very idea of "social class" is inconsistent with the American ideal of a society composed of free and equal individuals, individuals living in a society where they have identical opportunities to realize their inborn potentialities ... Although Americans, by choice, deny the existence of social classes, they are forced to admit the reality of mental illness (Hollingshead, Redlich, 1958, p.3

They irony of this statement is that Americans might continue to deny the reality of class or differential opportunity structures, but many people would soon question the meaning of mental illness. Sociologists like Goffman (1961) and Scheff (1964) working in an extreme interactionist and social constructionist vein, and contrarian historical thinkers like Foucault (1961) would soon challenge the obviousness of what it meant to “admit the reality of mental illness.” Although working in different vocabularies and theoretical traditions, those authors questioned psychiatric science by suggesting “mental illness" served as a catchall term for deviance, with psychiatric care functioning largely as a form of social control.

Today, the long-term hospital is a bit player in the drama of managing madness. Following deinstitutionalization—the emptying and de-funding of state hospitals, civil libertarian turn in mental health law, and turn toward voluntary outpatient care—the vast majority of psychiatric service users are treated in "the community." Others may be confined in the criminal justice system, a patchwork of brief hospital stays and minimal community contacts, or left with no treatment at all. Recent government statistics paint a dismal picture: of the country's 552,830 point-in-time count of people experiencing homelessness approximately 111,000 were classified as severely mentally ill (Housing and Urban Development 2018), and 33% of prisoners and 44% of jail inmates had "history of a mental health problem" (Bureau of Justice Statistics 2017).

One way to read the following dissertation in is the legacy of Hollingshead and Redlich's (1958) work, utilizing in-depth qualitative methods rather than statistics, to paint a portrait of an unequal world after the asylum era. A number of excellent ethnographies have investigated community care, yet focused on the poor served in the non-profit and public sector (see for instance Brodwin 2012, Dobransky 2014). The question for a comparative ethnography, taking mental illness as directly comparable across settings, is how treatment, from the biomedical to psychotherapeutic to ecological interventions, varies between the poor and the wealthy.

Yet the writing presented here also draws on the tradition initiated after Hollingshead and Redlich (1958), namely the social constructionist and Foucaultian critiques of psychiatric knowledge/power. In this vein, the "reality of mental illness" is itself an object of study, and there is further attention paid to the way mental health care functions as a form of social control. The questions motivated by this tradition regard the nature of control in liberal democratic societies that claim to prize individual freedom. Here the question shifts away from the differential treatment of a stable illness. Through a lens of class inequality, I ask: what forms of behavior come to be problematized as a sign of mental illness, and in need of professional intervention? In turn, how does psychiatric care function as a form of governance, directing people's actions and maintaining social order in different settings? Here again, the issues of governance have primarily been illuminated in studies of the poor. A comparison with elite care allows us to consider the meaning of psychiatric power as it regulates different forms of social life. The task for this dissertation, then, is to consider the everyday practices of and struggles over treatment in these contrasting settings to ask an overarching question: what does it mean to manage serious mental illness in "the community" when those communities are starkly unequal?

Such formulations may belie the concrete difficulties and consequences at hand. To get at the logic of comparison, let me introduce two men who present a similar dilemma: seemingly delusional beliefs, and behavior that teeters on the point of "danger" that could authorize force. They are both convinced that they are in imminent risk of dying, while those around them believe it a delusion generating problematic behavior. Both are middle-aged white men who refuse antipsychotic medication and are within their rights to do so. Matt Wilson believes that a mysterious neighborhood man is trying to kill him, while neither he nor anyone around him has seen the man's face. Jeffrey Roth believes he is dying of AIDS, despite medical evidence to the contrary. Matt is poor and served by a county Department of Mental Health (DMH) treatment team, while Jeffrey is rich, and served by an elite provider I call the “Actualization Clinic.” The variations in their ecologies, and the way their care teams approach them, offer a window into the larger issues at stake in this dissertation.

A Tale of Two “Delusions” and Choice Architectures

Avoiding Matt’s Killer With the Department of Mental Health

On a cool winter day I drove with Beth Guthrie, a Department of Mental Health social worker, and Matt Wilson to a Super 8 motel. Before getting out, we sat in the white LA county Prius and game-planned the next interaction. Matt, rail thin with salt and pepper in his beard, listened intently. He was going to do what it took to get into this motel. Ronda gripped the steering wheel, revealing her tattoos of socialist slogans. We had to be careful: the treatment team had brought too many “disorganized” people to this motel, and the Super 8 staff was getting tired of troublesome DMH clients. Beth had called the front office beforehand and told them that Matt was not symptomatic, but merely getting his apartment fumigated. Matt was not to tell his actual reasons for leaving his subsidized apartment, and when we went inside to sign the paperwork, he and I played along with this pretense.

The real reasons might well have triggered some alarms, for as Matt acknowledged, it “sounded crazy.” Although he’d been diagnosed with schizophrenia in prison, Matt contested the label and insisted his story was hard to believe but very real.

He claimed that his neighbors had been spying on him with an infrared camera, snapping photos of him masturbating, and distributing these images throughout the neighborhood. Now, he believed a neighborhood father was coming to kill him for being a pervert who exposed himself to children. Fearing for his life, Matt decided to abandon his apartment until he could move to a new location. Matt and the DMH team had a problem, however. He did not have a portable "tenant-based" housing voucher, but a "project-based" one tied to a building development. After prison and living on the street, Matt had been part of the "target population" for a local non-profit that converted buildings into units for the "chronically homeless" with mental illness. He was gratified to have his own place, yet the bureaucratic workings of his voucher meant he was stuck. Thus, he would have to wait until the DMH housing specialists reprocessed his subsidy before he could move. He told me he would stay at the motel, a rehab, or a crisis center until he could move to a new apartment.

In the meantime, however, he presented another conundrum for the treatment team: was he a danger to himself or others? Alluding to preparation for violent self-defense against his assailant, Matt also walked back from statements that might get him forcibly hospitalized. When he complained, "I don't have a gun to defend myself," Beth replied with a tone between humor and alarm, "I'm *glad* you don't have a gun." They talked about his plan for staying safe, which for now would include staying out of sight. One day I saw Matt wild eyed, agitated and pacing. He said that Beth was putting him in the hospital, but he wasn't going to fight it. Lauren, the DMH team leader, believed he needed to go in for both his own and others' safety. Beth was worried that Matt might get in an altercation with an innocent person while on the lookout for his “killer,” since he did not know the man’s face.

Matt, like many people, was ambivalent about treatment and saw the hospital as serving different functions. To speak simply of “compliance” or “resistance” could gloss over the complexity of such negotiations. He had the right to refuse care, which he sometimes invoked. Yet as I’d learn from clinicians, it was far easier to find a hospital bed for an “involuntary” emergency hold than a “voluntary” one. Matt, for his part, insisted he had not have schizophrenia but would still go in. He told me that living with his neighbors spying on him and spreading rumors the he hurt children could very well drive him insane.

> The stress level, I'm being watched all the time… I wanted to shower, and I can't shower...Knowing that someone's watching you while you're doing that is really uncomfortable. It just stresses you out. This guy across the street just making it worse, knowing that he's told everybody near me that I exposed myself to his kids. That is the worst, because that to me, is ... People that know me know that's not true.

Thus, Matt agreed to go into the hospital to stay safe and have respite from his neighbors, while insisting he was not mentally ill.

The hospital was not a long-term solution. They held him for a few days and then released him. Matt declined to take the prescribed Zyprexa, an antipsychotic medication, and the team began to work with the tools at their disposal—they continued to move him around. After the motel Matt stayed at a sober living home, and when the team did the bureaucratic work to alter his voucher, he moved into a new apartment. Feeling safe, he holed up in his new place and began drinking again. Eventually, however, he became convinced that the neighborhood killer had found him. Hearing people talk about him through his walls, he again worked to move homes, eventually winding up back in a Downtown single room occupancy (SRO) hotel.

Matt's professed beliefs were ripe for a Freudian psychosexual interpretation of dreams and hang-ups. He was haunted by the fear of being seen naked, possibly shamed regarding masturbation, and horrified that others perceived him as a pedophile. The treatment team did not try to theorize this, however. Beth speculated about whether someone was indeed after Matt—violence and revenge could come with street and prison life—and we joked about setting up a betting pool for whether the guy would really turn up to kill him.

The story of Matt and DMH is also, in part, a story of the workers. Beth's commitments to the vulnerable extended beyond serious mental illness, and she identified as a socialist who wanted wide-scale social change. Her approach was focused on addressing homelessness throughout LA County, and I'd later volunteer with her when she began a homeless outreach non-profit in addition to her county job. The team leader Lauren also saw Skid Row as a calling, but some others claimed they were reassigned there as punishment, and viewed the work as marked by impossibility. I came to understand Matt's treatment, such that it was, as fitting—housing for the homeless, working with a person's right to refuse medication or keep drinking, and helping the person achieve basic "stability" in unstable contexts. Given the housing crisis in

Downtown LA, the lack of resources for care, and the overall difficulty of clients' situations, such a definition of "community mental health care" seemed obvious. Yet when I began fieldwork at the Actualization Clinic, I came to see a different vision of care, located in a separate ecology.

Curing Jeffrey's AIDS at the Actualization Clinic

Observing Actualization's weekly case conferences, group therapy, and assisting with a social group, I began to follow another apparent delusion of death. Jeffrey Roth was a white man in his 40s who believed he was dying of AIDS, despite numerous HIV negative tests. Although the specifics of the belief were different from Matt's, there were remarkably similar aspects regarding the legal, ethical, and practical complexity of addressing a "fixed delusion." Jeffrey had been brought to the Actualization Clinic by his family, who were concerned about his attempts to access anti-retroviral medication for HIV. He had been to the hospital after discussing plans to move to Switzerland for assisted suicide, and walking onto a roof with possibly suicidal intentions. He did not want to take antipsychotic medication, as he did not believe himself mentally ill. According to the Actualization team, he'd become paranoid about the fact that the family was paying for him to see a psychiatrist and case managers. He believed they were paying doctors off to keep his AIDS diagnosis secret and protect the family name.

Like Matt, he was ambivalent, and the hospital would not offer a consistent solution. Unless he became dangerous to self or others, or gravely disabled, he could not be held or forcibly medicated. Unlike Matt, however, Jeffrey had an extensive support network, family money, and access to elite treatment. His psychiatrist, who was also a psychoanalyst, had come up with an intriguing interpretation: Jeffrey's delusions had developed following his father's death, and dovetailed with his repressed homosexuality and a possible experience of sexual assault, leading to a belief of dying from AIDS. Furthermore, it may have covered other anxieties about the stalled progress of his life. Ian, Jeffrey's case manager, expanded on this in case presentation:

> After his father died, Jeffrey started going to massage parlors in West Hollywood [a prominent neighborhood for gay men of Los Angeles]. He reported rape, being penetrated briefly by massage therapist. He put a stop to it, but thinks he got AIDS. It's homophobia and homosexuality. His doctor thinks it's a shame thing—thinking about death avoids all the other things around being unsuccessful.

The ultimate diagnosis was Delusional Disorder, Somatic Type. This is a form of psychosis that does not feature hallucination or thought disorder, in this case focused on a physical health issue. For the Actualization Clinic, the key to understanding and approaching Jeffrey lay in using this interpretation not for psychoanalytic treatment per se, but crafting a therapeutically informed approach to addressing the man's whole life.

The team noted that Jeffrey's family was loving and well intentioned, but was also creating difficulty because of their involvement. Deirdre the team leader noted, "The family is really sick. The brother is in five day a week psychoanalysis, and supported by mom." This was another key feature of Actualization's approach to case management, thinking in terms of what is called "family systems." Someone like Jeffrey was seen as mentally ill, but this illness of the "identified patient" was also part of a complex system—in this case, of a whole sick family. Yet the family was also a key to treatment, as they financed care, and it was due to their pressure and requests that Jeffrey began considering the antipsychotic medication. The team asked the family to push him, perhaps by "leveraging family funds or family contact." In fact he had his own funds and could not be threatened with being "cut off." Yet with extensive relational work—here the development of therapeutic rapport with Ian and the family encouragement—he agreed to try a small dose.

As I followed the case I was struck by the encompassing approach to community care taken by Actualization. Working with the psychoanalytic theory, they intervened socially. The team decided to introduce Jeffrey to Richard, the semi-retired owner of the Actualization Clinic, as he needed a "father figure" after his dad's death. Richard pondered on the meaning of the AIDS delusion. "I think people who talk about death think about it more than the average person." Ian said he'd been working to understand Jeffrey's fear of death. With his interest in Buddhist psychology, Ian explained to Richard, "I get really existential with him." In part this related to Ian's identity as a clinician and a healer more broadly. With years of meditation practice and extensive use of psychedelics, Ian believed in diving deep into consciousness and unconsciousness. He'd even inscribed such commitment on his body with Sanskrit tattoos.

Richard suggested Jeffrey get various tests to rule out physiological reasons for what he was experiencing in his body. Ian further worked with Jeffrey on meditation, and understanding that the mind-body connection was so powerful that the mind could influence bodily sensation. Yet beyond addressing the delusion itself, the team began looking for ways to simply bring Jeffrey out of his shell. He'd gone from working at the family business and performing piano at a high level to being nearly homebound. Jeffrey had given up on his passion for performance, apparently too preoccupied with death.

> Ian: I told him, "Put all that in your music."
>
> Richard: What do you [Jeffrey] have time to offer the world in the time you have? What do you have to give, rather than receive? Would he play piano for old folks? He needs purpose.

This focus on "purpose" and activity was a key issue at Actualization, and a key site of intervention: treatment was not simply oriented to survival and crisis management, but giving people a meaningful life.

Over the next months Ian continued to talk to Jeffrey about the meaning of death, the mind/body connection, and his purpose in life. Whether due to the antipsychotic medication, therapeutic contact, or new relationships, Jeffrey began to reconsider whether he in fact had AIDS. He got an HIV test apart from his regular doctors and insurance, away from his family that he believed was tampering, and found that he was HIV negative. This time he believed it. Ian announced proudly in case conference, "Jeffrey now knows he doesn't have AIDS." One case manager marveled at the power of antipsychotic medication. Deirdre said the last time she saw Jeffrey, "He was so free looking." She mimicked his relaxed posture, and then demonstrated his previously strained bodily comportment.

Jeffrey continued to see his psychiatrist, and spent the next months meeting with Ian. They hadn't gotten to that next step of processing the meaning of the delusion in regards to the psychoanalytic interpretation. In particular, Ian wanted to help him address what might be his self-hatred over his sexuality.

> We, and the family, suspect he is homosexual and homophobic, but we could be wrong. I don't want to dive directly at it. It might scare him off or trigger something. And I tried to normalize it all, told him he's human. He was just looking for connection [in his trips to West Hollywood].

Ultimately Jeffrey decided to leave treatment before Ian could dig deeper therapeutically.

The crisis was averted, and although Ian wished they'd had more time to explore the existential and psychodynamic elements, he was happy with the work. Moreover, the family was apparently satisfied. As Ian joked to his colleagues, "we cured AIDS!"

*

Matt and Jeffrey's stories both converge and diverge, and open up the key issues that I'll address throughout this dissertation. First let's consider some obvious differences in their backgrounds, social networks, and the ecologies in which they live. In Downtown, Matt was like many mental health clients who were often isolated, with histories of homelessness and incarceration. It was precisely these difficulties—"chronic homelessness" and resource usage—that qualified Matt for subsidies and specialized care. Jeffrey, in West LA, was wrapped up in a dense family network, and it was his relatives who brought him in and paid for treatment. Unable to work and behaving oddly, he might very well have been vulnerable to the life of a public mental patient. Yet with both social and monetary resources, he was insulated from a trajectory like Matt's.

Second, consider a point of convergence: although each is deemed to suffer from a delusion, they are liberal subjects of rights and responsibilities. In neither case can they be held long term nor forcibly drugged simply for having seemingly crazy beliefs. Although each man's behavior regarding his upcoming "death" leads him to the hospital, this is short term and a far cry from the extended institutionalization we might have seen fifty years ago. This relates to the issue of rights and coercion, but also reflects economic realities—hospitals simply hold indigent people for far less time, and even "good" private insurance will not cover long-term confinement. Furthermore, each clinical regime valorizes the notion of "client choice," and aims to "empower" people. Rather than rely on force or domination, each must work to govern people "through their freedom" (Rose 1999). Put in a different vocabulary, the men are exposed to different "choice architectures," nudged in particular directions, with different choices available to them based on money, forms of care, and the demands of their social networks.

Third, there are deep inequalities in care resources, but these go beyond the obvious fact that the rich get more than the poor. The men get markedly *different* forms of treatment that amount to different visions of personhood. DMH's strategies for keeping Matt safe from and for others around him, and getting him a place to live, show an enormous creativity and require a lot of work. It would be unfair to call it "zero treatment" like Hollingshead and Redlich's (1958) findings. Yet it is strikingly "non-clinical" in relation to the kinds of psychodynamic interpretation, existential thinking, and search for "purpose" that one sees at a place like Actualization. As I would find among other workers in elite settings, there was insistence that even seriously mentally ill people could be engaged therapeutically—it just took the right environment, patience, and skill. Here, treatment means both medication and an attempt to form a relationship, understand the person, and change them both clinically and socially, such as helping a person regain a sense of purpose. This is also seen in variation in definitions of "success," which each clinic only partly achieved: Matt was eventually rehoused, but hardly rehabilitated. Jeffrey no longer believed he had AIDS, but would not dive deeper into the therapeutic work.

Fourth, notice that this story is not just about clients like Matt and Jeff, with their different trajectories and resources. It is, alongside this, about different kinds of workers, treatment teams, and ecologies. Oriented to client "types" like the homeless mad person or the privileged person whose behavior can no longer be dismissed as "eccentricity," clinics require different types of frontline staff with alternative expertise. DMH's social workers, community case workers versed in street outreach, and housing specialists who know how to fast track a voucher are skilled in a different way than the Actualization therapist who mixes community outings with psychological analysis, or collaborates with a variety of other providers with psychiatric or specialized therapeutic expertise. Thus, Beth's identity as a politically radical social worker addressing homelessness, and Ian's identity as a Buddhist psychedelic therapist who addresses the meaning of suffering, are salient to systems aiming for different patient recoveries.

Governing Madness, Urban Poverty, and Family Systems

While the treatment teams have shared historical roots and some overlapping dilemmas, I will argue that they are engaged in different *projects*. These correspond to the two respective social institutions responsible for madness after deinstitutionalization: municipal governments and the family. In these contexts, with different classed expectations, resource bases, and expertise, the providers have developed different tools and ideals for community care. Experiences like Matt and Jeff's speak to the governance of mental illness, certainly, but also the management of homelessness and urban public space, on the one hand, and family relations in private space, on the other.

Consider the local debate over the intervention of low-barrier, permanent supportive housing, such as that Matt lived in. Here, a person could be independently housed with neither sobriety nor medication compliance requirements. This exists alongside other more structured housing for people with mental illness, like Board and Care homes, or the shelter system. Yet for those who could not or would not enter structured settings, low-barrier independent housing offered a route from homelessness. Proponents claimed this not only to be humane, since it provided a foundation of safety from which people could address mental health and substance abuse issues (e.g. Tsemeberis et al. 2004) but also cost-effective, since it keeps people out of emergency services (Culhane et al. 2002). The sociologist Forrest Stuart (2016), who studied policing in Skid Row, found that the "Housing First" and harm reduction model was seen as a threat by the entrenched mega-shelters that dominated the area. Advocates for the area's Missions argued that permanently subsidizing people without sobriety or treatment requirements would merely enable bad behavior and keep people trapped in the cycle of poverty. In its place, they recommended their own brand of faith and addiction services.

Such actors further condemned pioneers of low-barrier housing like LAMP, a non-profit that served people with mental illness and drug addiction, and the Skid Row Housing Trust, for failing to collaborate with police. Andy Bales of the Union Rescue Mission wrote, "Crime has moved into the permanent supportive housing projects…some leaders of these housing groups actually dissuade their employees from reporting the crimes…" Police officers similarly suggested that the permanent supportive housing providers were creating zones of lawlessness. As an officer wrote in a pamphlet,

> [Residents] advised me that some [housing] managers have a very anti-police attitude; they would rather give those that break the law the freedom to engage in overdosing, narcotics sales, and prostitution. It is all done under the mantra of "harm reduction" rather than providing a real improvement to the quality of life within locations designed to provide a safe haven for those trying to conquer their addictions and have a sustained sobriety.

In contrast to those providers, the Missions and police collaborated on what Stuart called "therapeutic policing," with officers using law enforcement tools to push people towards the Missions' work and addiction programs.

The city and county's plans to revamp homeless services with low-barrier permanent supportive housing did not "end homelessness" or replace the shelter system. There were simply insufficient resources and a growing homeless population. Yet the embrace of harm reduction, housing first, and related treatment protocols among providers like the Department of Mental Health and some housing agencies requires a description and theorization of such an approach on the ground. Even Bales and other critics conceded that the approach made sense for people with serious disabilities, for whom their Mission rehabilitation might not be feasible.

One task for this dissertation is to analyze how mental health treatment functions in the context of *urban poverty governance*, when providers must not only address mental illness, but also homelessness, arrests for minor crimes of poverty, and contests over public space. If our typical theories of the state management of deviance emphasize the disciplining in welfare and workfare (Scram et al. 2014), spatial banishment (Beckett and Herbert 2009), or simple incarceration of the poor (Wacquant 2009), how should we theorize seemingly laissez faire support of those who might at other times simply be criminalized or abandoned? I'll argue that DMH and their collaborating agencies are involved in a "*tolerant containment*" of clientele, deprioritizing substantive change and giving either space to contain deviant activities, or space to be idle. That is, rather than disciplinary power and the internalization of the normalizing gaze (e.g. Foucault 1977), or punitive and exclusionary spatial control (Feely and Simon 1992), we find attempt to *neutralize* problems of urban disorder by enclosing it in safe housing.

In the other world of treatment, we find attempts to govern the behavior of privileged psychiatric patients that are explicitly *normalizing*. The social control of the wealthy is surprisingly understudied, perhaps because their behavior does not constitute a public social problem like that of the sidewalk psychotic, and perhaps because of access issues in research. When it is studied in other forms of deviance, we find that the privileged are treated with "kid gloves" when, for instance, committing crimes (Maddan et al. 2012). How are we to make sense, then, of intensive attempts to control their behavior? When we look at the experiences of someone like Jeff at the Actualization

Clinic, we must reconsider mental health care in a different project: *family systems governance*. Rather than simply giving people the space to be deviant, wealthy families pay providers top dollar to transform loved ones through treatment. Here I draw the mental health literature into dialogue with the literature on the family and social class. Sociologists have long investigated the family as a site of social control, whether at the level of gender role socialization (Lorber 1994) or as an ideological state apparatus (Althusser 1971). In the politics of mental health, the family member social movement has long attempted to rework civil commitment law to enable more rapid hospitalization. How might we expect community mental health care to function when oriented to the needs of wealthy families? Here the childrearing literature can offer insight into how class-based familial logics function.

Beyond clinical discourse, I argue that the governance logic at places like the Actualization Clinic is rooted in a specifically upper middle class strategy of child rearing. Sociologist Annette Lareau (2004) contrasts the poor or working class family's "accomplishment of natural growth," which provides food and safety and expects children to thrive, with privileged family's "concerted cultivation" that uses intensive scheduling of activities to develop the talents of children. If the "natural growth" model corresponds to the type of "tolerant containment," I observe in Skid Row, the model for the privileged is a "*concerted constraint*" of deviant behavior, and use of extensive clinical and relational tools to try and create a healthy, self-efficacious adult-child. Here the disciplinary constraint of both mental illness and everyday life, coupled with material opportunity, provides cultivation and normalization.

Throughout, I will argue that "tolerant containment" and "concerted constraint" offer radically different visions of both mental illness and patient recovery, impacting questions of both care and control. Of course, marginalized urban patients may have family involvement, and rich patients may occasionally create problems in public space for the city. My analytic separation of *urban poverty governance* and *family systems governance* points to the way the overarching clinical logics are linked to these broader organizational and institutional dynamics.

Methods and Logic of Comparison

The method I used for this research is ethnographic, based primarily on field observation and qualitative interviews. To investigate how resource and institutional variation impacts community psychiatric treatment, I engaged in more than four years of comparative field research with public safety net and elite private providers. I centered on two case management teams as focal access points for the larger ecologies of care, as the teams collaborate with medical providers, service agencies, family support groups, and other relevant actors. Each treatment team has historical antecedents in the Assertive Community Treatment (ACT) model, or the so-called "hospital without walls," widely accepted as the "gold standard" in intensive outpatient care for people diagnosed with serious mental illness (Dixon 2000). Rather than a statistical logic requiring the clinics and their ecologies offer a representative sample of public versus private care, I use "critical cases" that crystallize issues under examination (Yin 2003) and "represent with special clarity phenomena that exist widely but in more diluted form elsewhere." (Katz 2012).

Los Angeles presents a useful location for studying legally empowered service-users and resource variation for two reasons. First, California's Lanterman Petris Short (LPS) laws, which served as model civil libertarian legislation in other states, put limits on coercion into treatment. Compared with cities like New York, which have robust outpatient commitment programs, Los Angeles only recently began experimenting with such procedures and it remains a marginal practice. Second, Los Angeles is home to two iconic service locations severely stratified by wealth: the "recovery zone" (Stuart 2016) of Downtown Skid Row, for the down and out, and the "treatment destination" of West LA and Malibu, where local and global elites seek private psychiatric and addiction care. The advantage of comparing "critical" cases, as noted above, is that theoretically relevant differences are rendered in stark relief.

Such an interpretive approach to comparison aims to "clarify particularities through contrasts" (Skocpol 1984 370) and let cases "form a kind of commentary on one another's character" (Geertz 1971 p.4). Here variation is leveraged for comparative understanding, rather than fully "controlled for." For instance, despite similarities in historical background and organizational form of the *clinical settings*, and shared diagnostic *categories,* the respective *client* populations have differences. Relative to the county treatment team, the elite agency's clientele skew younger, whiter, and more connected to family. These elements are in fact associated with the focal class comparison and shed light on the regimes of treatment, care, and control.

Beginning with an initial case study of public psychiatric services in Downtown Los Angeles from 2013-2015, I noticed the way resource constraints, patient social networks, and the local politics of homelessness impacted treatment and everyday matters of "client choice." Upon learning of a private psychiatric case management treatment team on the other side of town, I decided to investigate the care infrastructure across the proverbial tracks. I conducted the second case study between 2015-2017, occasionally returning to Downtown for follow up. While I initially envisioned the comparison as one of social class, I came to see it was also about madness as a problem of the city versus of the family. As a volunteer at the Department of Mental Health (DMH) clinic, I weekly observed team meetings, client-provider interaction at the clinic, home visits, and group activities. During this time I spent one more intensive year volunteering multiple times a week with DMH's homeless outreach project, which brought me in contact with new clients, potential clients who were screened out, and other agencies doing street work. Through a recurring "homeless task force" I observed meetings between business owners and local government officials, as they debated the proper tactics for the removal of a homeless encampment.

As an intern with the Actualization clinic, I observed weekly case conferences, co-ran a social group, attended group therapy, and participated in events for private agencies in a referral network. Due to privacy concerns, I was rarely able to accompany on home or community visits. To triangulate case conference discussion, I observed the field services of a private practice case manager who had once been an Actualization client, and was now affiliated with the clinic. Furthermore, I visited the dual diagnosis (mental illness and chemical addiction) rehabs, sober living homes, and residential treatment centers that Actualization worked with, to observe daily life and speak with both clients and staff. In each case, my previous work as a case manager on an Assertive Community Treatment team facilitate entry, as gatekeepers believed I would understand the work and not disrupt the milieu.

During field observations I took “jottings” and later elaborated these into narrative notes (Emerson, Fretz and Shaw 2011), took real-time notes during meetings and some group therapies, and also conducted semi-structured interviews with clinicians, clients, and collateral contacts. I represent audiotaped or real-time notated statements as direct quotations, and paraphrase dialogue from field note observations, where brief quoted phrases should be understood as best approximations from jottings. I approached data collection with “the broadest theoretical base possible,” (Timmermans and Tavory 2012. P.180), systematically generating codes by reading my empirical materials in dialogue with the sociology of mental illness, social control, urban sociology, and the family. Emerging conceptualizations were “brought back” to the field, allowing me to iteratively refine them as theoretical categories. The research project received IRB approval from UCLA and the LA County Department of Mental Health, all quoted participants were guaranteed confidentiality, and all names are pseudonyms. Informed by evolving discussions of the ethics of studying psychiatric settings (e.g. Skultans 2005, Dubois et al. 2012), I took cues from both service users and clinicians to minimize disruption and prevent potential research related harms.

The Clinics and the Ecologies: Skid Row and West Los Angeles

Skid Row and the Gentrifying Downtown

Los Angeles is home to both an infamous and a famous treatment destination: in Downtown, the social service ghetto of Skid Row is known as "America's homeless capitol." Covered in documentaries and movies like Jamie Foxx's *The Soloist*, the area is also known as a dumping ground for the surrounding areas. After a series of scandals in which hospitals from even across state lines were found to have sent mental patients, the city established laws banning releasing patients in the area without actual referral and connection. In the midst of soaring rents and gentrification, there is an ongoing battle to either preserve existing housing and services, or transform Skid Row and scatter its services.

Residents of the area often circle through the so-called "institutional circuit" (Hopper et al. 1997) of shelters, jails and hospitalizations. Skid Row features three mega-shelters for the general homeless population and then a smattering of smaller shelters for those with serious mental illness, addiction, or divisions by gender. To understand the DMH clinic downtown requires situating it in this ecology, with its various inputs—street homeless outreach teams, referrals from hospitals, Institutes for Mental Disease (IMD's), jails—and collaborators, such as SRO hotels, Board and Care homes for those with SSI, specialized mental health housing projects, and private landlords who are willing to take on difficult residents.

The physical DMH clinic itself lay on the edge of Skid Row, a corner office with a big glass window looking into a waiting area. Here clients for the specialty team (called a Full Service Partnership or FSP, but I will also refer to simply as the DMH team) would not have to wait in the lines at the larger walk-in clinic in central Skid Row. With a private security guard and metal detector wand, the receptionist behind a plastic window, and an armed sheriff's deputy down the hall, no one would mistake the clinic for a private doctor's office. Sharing a hallway with a development called the Little Tokyo Lofts, the clinic sat at one of the many unofficial borders between Skid Row and the rest of gentrifying Downtown Los Angeles. DMH had previously planned to expand through the entire ground floor of the building, but the homeowners association put a stop to this.

Residents, paying as much as $500,000 for lofts, successfully petitioned to stop the growth of the mental health center. *La Weekly* quoted one resident, "We know where we live. We need treatment in the area. But there's a safe way of doing it. And there's plenty of space in the area." After I finished fieldwork the DMH was forced to transition the space to a purely administrative office, with the clinical team moved further into the heart of Skid Row. Harold, a DMH supervisor who oversaw both the walk-in clinic and the specialty team, recalled his initial meetings with the residents when the team first moved into the building.

> I went in and met with the Homeowners Association… one of the residents said, "Why don't you just take those people out to the damn Mojave Desert? Build housing out there for em."

Like many aspects of mental health treatment for the poor, even the clinic's physical existence was affected by the local politics of gentrification.

West LA and the Beach Cities

The positively famous destination, on the other hand, is the private treatment centers on the West side, with Malibu, and the surrounding beach areas, where the rich and famous go for addiction and psychiatric care. The Actualization Clinic emerged in the 1970's as a hospital discharge assistance program, and helped found a providers network that brings together private mental health and addiction providers for ease of referral. The elite private addiction industry began to take off in the late 1990's and early 2000's, with the founding of such luxury programs as the Canyon and Passages. In a somewhat ironic turn, the Malibu treatment scene has experienced some of the same NIMBYISM as public mental health and addiction services, with wealthy Malibu residents attempting to limit the amount of treatment centers.

The clients of the Actualization Clinic sometimes go through an altogether different system, what we might call an *elite institutional circuit*. While they also receive referrals after people come out of the psychiatric hospital, sometimes overlapping with Medicaid providers, they collaborate with groups that are unheard of in the public sector. For instance, they connect with elite diagnostic workup hospitals like Menningers, high priced Dual Diagnosis centers for addiction and mental illness, pastoral farm settings with roots in Quaker moral treatment, and other private community treatment agencies across the country. In a very different way than the "homeless patient dumping" that happens in Skid Row's circuit, treatment providers send people in and around this ecology and linked centers throughout the US, and even globally.

The physical clinic setting is housed in a non-descript building in West LA. With large photos of nature in the lobby and conference room, California lifestyle magazines on the tables, and an expansive upstairs dedicated to the Intensive Outpatient Program therapy groups, the space is a world apart from the DMH clinic. Fruit bowls and flowers further project an image of health. Yet unlike some of the glitzy Malibu rehabs with TV advertisements and Instagram accounts, the Actualization location is pleasant but not luxurious—an intentional aesthetic in contrast to the excesses of some "spa-like" treatment programs.

Organizational Features

The organizational forms appear quite similar, with an interdisciplinary team of case managers who provide "recovery oriented" service provision in the community. Each team has a licensed clinical social worker and a PhD level psychologist in supervisory roles. Each team performs tasks that are arguably non-clinical, such as taking people to appointments, assisting with daily living, and engaging with collateral contacts. With such community-based care, providers aim to move beyond simple "medical model" to whole person care. Clients, from a distance, may also appear clinically similar in terms of diagnosis, such as schizophrenia, bipolar disorder, or major depression. In each setting, people may have a history of hospitalization, and the difficulties associated with freedom and "treatment resistance."

Yet there are also significant differences. The DMH team model is set up to be largely self-contained, a sort of "one stop shop" as conceived in the earlier versions of mental health treatment teams. With a doctor, nurses, social workers, as well as numerous staff without advanced education, the DMH team covers the gamut of health provision. With about 12 workers for up to 180 clients, the client to staff ratio is approximately 15-1, far lower than in the regular outpatient clinics. They have workers certified to write psychiatric holds for when they decide coercion is called for. The Actualization Clinic, on the other hand, acts in conjunction with providers such as outside medical care, psychotherapists, and treatment centers. The majority of their clients come in with a private psychiatrist with whom they maintain connection. Serving up to around 90 people at a time, and with a client to staff ratio of approximately 8-1, they offer a level of potential individualized care typically unavailable to the public mental patient. Additionally, line-staff members all have Masters degrees, primarily in psychology, or marriage and family therapy, and a handful in social work. Rather than initiate psychiatric holds themselves, this is done by the private psychiatrist or with a call to the Psychiatric Emergency Team.

Clients also differ in terms of their backgrounds and life histories. At DMH, clients typically have histories of homelessness, incarceration, or a series of hospitalizations. Indeed, these correspond to the basic criteria for prioritizing admission:

> Authorization for FSP enrollment occurs centrally, following community outreach to identify and recruit unserved clients with extensive prior-year homelessness (six months or more), incarceration (two or more episodes of at least 30 days total), inpatient psychiatric treatment (28 or more days of acute care or six months or more in an institution for mental disease [IMD] or a state hospital), or

> emergency psychiatric treatment (ten or more episodes), or dependent on family and at risk of these outcomes. Transfers from usual care are limited to 20% of FSP slots, with written justification of being underserved or inappropriately served by usual services (Starks et.al 2017)

In terms of age, the DMH team treats clients from 26-59. More than half of the clients usually have a disorder of a psychotic illness, with others typically diagnosed with bipolar disorder or major depression. Clients are majority minority.

Actualization, on the other hand, has no explicit criteria that potential clients must meet. They serve age 18 and older, and are open to people of a variety of diagnoses. Thus, while approximately 30% of their clients are diagnosed with a psychotic disorder, and approximately 20% with a bipolar disorder diagnosis, they serve a greater number of people diagnosed with depression, anxiety, or eating disorders. The key dimension is whether a family can pay for services. Furthermore, their clients skew younger, encompassing people in the earlier stages of developing psychiatric disabilities and so-called "Failure to Launch" clients, alongside the older more "chronic" patient. Most are Caucasian, although there are privileged families of color who contract the services as well. Although many clients have histories of hospitalization, there is far less criminal justice involvement, and almost no homelessness. Thus, the Actualization Clinic serves a clientele with differences in terms of race, social class, and institutional trajectory.

The Opportunities and Difficulties of the Comparison

Such variation presents both an analytic opportunity and a difficulty for comparison. If one was to assume that “schizophrenia,” for instance, is a singular illness, one can directly compare how it is treated across settings and then see how social influence shapes outcomes. This was the logic that guided the World Health Organization’s famous International Pilot Schizophrenia Studies, which found that people in poorer nations seemingly had better long-term recovery outcomes than in the USA or UK. This stunned researchers, who have since grappled with what it meant: was poverty protective because people still had to function in a subsistence economy? Were family structures in “developing countries” kinder than in “developed ones?” Were antipsychotic drugs, less available in places like India, actually doing damage long-term in the United States? Or, as some critics suggested, were there simply different diagnostic procedures across countries, such that they were in fact comparing apples and oranges? (see Hopper et al. 2001 for a summary of the ongoing controversy).

As even biomedical researchers note today, at least part of the social constructionist critique of DSM diagnostic criteria is correct—the manual may allow people to somewhat reliably agree that a particular set of behaviors indicate schizophrenia or depression, but not necessarily be capturing the same thing. There are multiple routes to psychosis, and a spectrum of expressions. In the dream of a genetically derived taxonomy, there are numerous schizophrenias that will eventually be disaggregated. Thus, for any medical or social study hoping to hold mental illness constant, there is a danger of comparing unlike things. As Andrew Lakoff (2006) showed, even researchers attempting to get to the genetics of bipolar disorder nonetheless drew their research samples from DSM derived groups. They had to simultaneously acknowledge that they might have a sample of unlike things while trying to pinpoint what was held in common.

In practice, psychiatrists and other mental health clinicians across settings continue to struggle with pinpointing diagnosis. What I'm interested in is less critiquing the scientific status of such categories, than seeing what they lead to. My chapter 4, for instance, will focus on the way diagnostic specificity and psychiatric labels come to matter in very different ways in the two ecologies. Thus, my study does not look at outcomes in the same way as the WHO studies, and my method does not drive toward aggregate claims such as who does better clinically. Instead, it asks how behaviors that get diagnosed as schizophrenia, or defined as psychosis, as mania, or as willful or not, are treated in different settings. My comparison is thus of the ecologies and treatment regimes, and I do not try to make authoritative claims as to whether people have the same underlying illness.

Another potential difficulty here is one of selection. The FSP teams are public safety net clinics, and the county has a mandate to serve the people who are in most dire need. This returns to the social drift and social influence question of classic social psychiatric epidemiology: are people at DMH worse off because of their lack of resources in earlier life and the harshness of the street or jail, or were they simply sicker to begin with? The Actualization Clinic takes what it considers some of the "hardest" cases around, with multiple hospitalizations or stints in dual diagnosis rehab, and occasional criminal justice contact. Yet they also screen out clients with significant histories of violence, and others that might disrupt their therapeutic milieu. Part of what families are paying for is to not be around the kinds of people in public mental health services. Thus, some of the clients at FSP may have no clear analog at Actualization. In such cases, when I visited the residential facilities that Actualization works with, I learned of wealthy clients who had attacked people, or menaced their families while high on methamphetamine, etc., and their trajectories. In some cases, the clinics may play a different role in their respective circuits. Rather than see this as an analytic deficit, I attempt to trace what it means for the possibilities of care.

For my purposes, the vastly different forms of care present an opportunity to see what is organized around the concept of mental illness. As the above example of Matt and Jeffrey suggest, the shared experiences of madness and tensions around civil liberties can manifest in very different ways. At times the forms of care will seem to be addressing the same problems under vastly different resource constraints. At other times it may seem to be apples and oranges, despite each offering "community care" for what are formally the same serious mental illnesses. The DMH team does not host networking events at beachside hotels, and Actualization is never tasked with joining police on homeless sweeps—these are divergent worlds organized, in part, by the same categories. My task in this study is to show how these different worlds both connect and diverge, bringing concepts of mental illness, treatment, and choice in and out of focus. Holding the cases up as mirrors to one another, I let them provide, as Geertz put it, a "commentary on one another's character."

Chapter Organization

The dissertation begins with a history of community mental health care before exploring the different treatment ecologies. It then homes in on questions of treatment and the life of diagnostic categories and the alternative approaches to governance.

Chapter 1, "Community Care for Different Communities" offers historical background to contextualize the present study. It briefly considers the asylum era and the process of deinstitutionalization, and then examines the building of the different care infrastructures of today. Moving from national level processes to the specifics of Los Angeles, it sets the stage for the key issues of different treatment circuits, the meaning of "treatment" itself, and the forms of choice offered in everyday care.

Chapter 2, "Sorting Out the Down and Out: Mental Healthcare and the Governance of Urban Poverty" examines the ecology of public mental health services in Downtown Los Angeles. Following the FSP team members as they embark on a collaborative homeless outreach project, I show how psychiatric labels function as resource lines, and how the broader politics of homelessness impacts treatment provision. Here we learn of the variety of connections the team has to police, business owners, and a variety of service providers in the impossible goal of addressing homelessness and urban disorder. In effect, I show how mental health care functions in a larger project of *urban poverty governance* when hyper-policing comes under legal scrutiny.

Chapter three, "Getting Better Together: Mental Health Care and the Governance of Family Systems" moves to the elite private sector, showing how families with resources come to places like the Actualization Clinic. Using a series of illustrative cases, I examine the different set of tasks and possibilities in high-end care, as well as the overlapping questions of what treatment is appropriate and the meaning of patient rights.

Here I argue that mental health care unfolds in a project of *family systems governance,* with a different set of goals than the DMH setting.

Chapter four, “Epistemic Cultures of Care” considers what treatment means for the rich and the poor. Beginning with a focused comparison of two women diagnosed with major depression with psychotic features, it shows the available services that come to make sense in the two clinical regimes, considers the role of psychiatrists, diagnosis and medication, and everyday case management. If “treatment” is what treatment providers do, then I show how different expertise and practical possibilities manifest in divergent worlds of knowledge. Here I attempt to offer an alternative to existing accounts of diagnosis than varieties of sociological labeling theory and inquiries into the historical construction of particular illnesses, by tracking the networks of actors that develop around a diagnosis.

Chapter five, “Between Tolerant Containment and Concerted Constraint” addresses the question of how care, control, and choice work together—in essence, mental health care as a form of governance. Here the political flashpoint of governance *over* choices, that is forced hospitalization or demands for medication compliance and sobriety, must be matched with an analysis of governance *through* choices. I consider and how authorities manipulate incentives so they are nudged in one direction or another. Clients in each setting may experience contrasting arrays of freedom, choice, and resource dependence with different possibilities and definitions of empowerment. Here I argue that the treatment teams have substantially different logics—what I call tolerant containment and concerted constraint—tied to ideas of what is possible in care, and what is demanded by the large ecology.

The conclusion synthesizes the arguments of the individual chapters and discusses the implication of the findings.

Chapter 1

Community Care for Different Communities

This chapter outlines the history of mental health services in the United States, then homes in on a focused account of California and ultimately Los Angeles. Beginning with a brief exploration of the asylum era, it moves next to the dismantling of the state hospital system and the development of community based services. California, like so much of the United States, drastically reduced its state hospital populations without adequate community supports for the discharged. Patient numbers declined some 80% between 1959 and 1973, with many people sent to stretched or even non-existent municipal or familial resources (Kemp 1991). The policy and personal consequences have been well told, and I move between existing scholarly accounts and some interview data. In outlining this history at the national, state, and local levels, it sets the stage for the examination of separate ecologies, treatment forms, and choice architectures for the rich and the poor that follows in subsequent chapters.

“Deinstitutionalization,” as its come to be known, was the product of powerful socio-economics forces, hopeful purposeful reforms, and unintended consequences that was eventually seen as a major policy failure. More than a single moment, it was the twenty-five year undoing of an archipelago of state hospitals and legal statutes facilitating civil confinement, into a community system that was funded piecemeal and relied largely on voluntary participation, with few hospital beds even for those who wanted treatment. Some of my informants were old enough to have lived through the beginnings of community care, and drew on their own experiences to make sense of the causes and consequences as amateur historians. Such practical reflections, alongside the documented historical record, direct us straight to the core issues of resources and the meaning of care and choice.

Vic, a white nurse in his 50s who had worked in jail and emergency team units, wanted everyone in the DMH office to read "The Insanity Offense," by the psychiatrist E. Fuller Torrey (2012). The book described the closing of the asylums and subsequent rise in patient homelessness and trans-institutionalization into the prison system. While Fuller Torrey is controversial for his prescription of highly coercive care as a policy response, the "Insanity Offense's" basic description of the failure of American mental healthcare is a common enough narrative. Surely it spoke to places like Downtown Los Angeles Skid Row, the paradigmatic "service dependent ghetto" (Dear and Wolch 1987) that boomed with homeless ex-mental patients, ex-cons, and various people hovering just above street destitution.

For Vic, whose career had begun in inpatient settings before coming to penal care and street work, the book made sense of the overwhelming futility of the task at hand. If he were a sociologist, he might say the problems were so structural and systemic that individual agency was largely restrained. Vic passed the book around the office, and at that time I was waiting to get it from Beth, the recently graduated social worker we met in the introduction. Beth was frustrated with Vic's resigned cynicism, painting him as a burnt out county worker who minimized work, waiting to qualify for his pension. She would struggle to remain hopeful before too burning out and moving on, like all but one caseworker at the team I studied.

How should we think about history in an account of everyday life and treatment? In his research on the "everyday ethics" of frontline mental health staff, the anthropologist Paul Brodwin (2013 p. 29) notes, "Staff members do not know, because they do not need to know, that all these structures [of their job] have a history." No doubt most everyday practice does not, indeed *cannot*, require extensive historical reflection. There are simply too many basic tasks in the now that need to get done, and workers are not historians or social scientists engaged in the counterfactual accounting or regression analyses to understand which factor or policy led to what. Yet looking at the state of Los Angeles, and specifically the homelessness of Downtown, some vague sense of the asylums haunts workers. When Vic riffed on an old Pete Seeger tune, singing, "Where have all the state hospitals gone? They've gone to the graveyard, every one," others nodded. Betty, an African American nurse said, "Yeah, I know that song."

Once I stood outside the clinic with Vic as we watched Merle, an African American client, leaving to head back to his place. Merle had previously been homeless and caught up in the criminal justice system, now living on his own in a subsidized unit. Turning to me Vic shook his head and said, "Do you really think Merle is better off being placed in an apartment—where someone has to shop for him, get him an id, help him with this and that? But yeah, he's 'independent.' " At least in the state hospital, Vic believed, he would have had his healthcare coordinated. Vic had a romantic vision of the asylum, and had once listed off things like pap smears, daily activities, and bowling, among other life needs.

Yet I saw the difficulty of comparing Merle's existence in the apartment to a lifetime of confinement. He could walk around, smoke marijuana, and meet people downtown. The team helped him keep his housing and probation appointments. Mostly he requested his medication injection, although he for a time refused when the team's doctor left. He was also entangled with the Skid Row loan sharks who prey on addicts and the disabled, and was re-arrested later, losing his home in the process. Merle was hospitalized long term, only after being processed through the criminal justice system. For some workers, the imagined asylum offered a backdrop against which to understand the everyday problems of under-resourced community care. In such a fantasy, Merle's drug use, medication inconsistency, victimization at the hands of local toughs, and criminalization at the hands of the police, might all have been prevented with a simple solution—the state hospital.

Telling the story of the DMH team in Skid Row, as well as the private services of the Actualization Clinic and their collaborators, requires we place "the community," or really various *communities*, against the actual history, and the fantasy, of the asylum era. In the following sections I consider the development of the asylum system in America, the criticisms and attempts at reform, and the eventual deinstitutionalization movement. I then turn to explain the development of community-based services, criticisms of both inadequate services and potentially problematic civil liberties, and the different fractured and sometimes separate infrastructures of care for people of different backgrounds. For this study in particular, I describe the creation of two ecologies: a public safety net system for the down and out, and an elite private circuit for the privileged.

Conceptually, my periodization of this history corresponds in part to taken-for-granted "eras" but also to what Haydu (1998) called "reiterated problem solving." For Haydu, the clearest way to compare an issue across historical time is successive attempts to solve a complex problem, which then creates new problems and a kind of path dependency for the next available solutions. In the chapter at hand, I consider each era in terms of how it manages “madness,” or later, “serious mental illness.” There are a series of different solutions to problems that remain problematic to this day: 1) what should treatment consist of, given the poor knowledge of disease mechanism and lack of cure? 2) What types of choice should be given to people who are on the border of legal capacity? And 3) how do authorities define success?

The Short Life of the American Asylum[1]

Care for serious mental illness in the United States has gone through a series of reforms that are arguably cyclical, rather than direct progress or evolution (Morrissey and Goldman 1984). Strikingly, the past three hundred years have seen movements to take mad people from the community to asylum confinement, then to the community, and for some, now back to the asylum. This may be a product of the inherent difficulty of managing madness, with the proverbial grass always appearing greener on the other side. The physical confinement of madness has a pre-history dating to the monastic foundation of Bedlam, but the advent of houses of confinement has a much more recent history. In the mid-19th century American reformers like Dorothea Dix advocated the establishment of therapeutic asylums that could offer hope to the mentally ill (see Parry 2006). For Dix, “the community” was hardly the place in which people would heal, for they were often

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[1] The history of the American asylum, moral treatment, and deinstitutionalization is massive and controversial. The overview throughout draws on major works like Dear and Wolch 1987, Grob 1991, Scull 1989, Scull 2015.

neglected or eventually routed to a non-therapeutic confinement like the workhouse or gaol. Indeed, in some cases it was precisely the home that had seemingly led to disturbance in the first place.

Early advocates suggested that the asylum would simultaneously relieve the community of the disorder of madness and provide the best possible environment for healing. Drawing on the language of "moral treatment," they believed that they could provide humanistic and individualized care. The language of "patient rights" to refuse confinement, so prominent a hundred years later, was almost unthinkable (Brodwin 2013). Ideologically, this was rooted in classical liberal theorists' belief that madness was a limit case in the expansion of rights. Even among advocates of expanding freedoms to women, racial minorities, or the lower classes, those with mental disturbances lacked the "Reason" to be free. Instead, a kind of paternalism and coercive care in the best interest of the mad individual was common sense. Political economic developments such as urbanization and a turn away from subsistence living brought profoundly disabled people into dense cities, where deviant behaviors were increasingly visible.

In contrast to its prominence in the cultural imagination, the large-scale public asylum was a surprisingly recent and short-lived invention. The celebrated origin story in the United States was Dorothea Dix finding lunatics confined alongside criminals in Cambridge jail in Boston. She began to write sensationalistic tracts about the abuses, and beginning in 1843 she fought for legislation state-by-state, and advocated for the creation of separate, special confinement for the mad. She argued, the asylum "has become so general among all civilized and Christianized nations, that the neglect of this duty seems to involve aggravated culpability." She advocated a "moral treatment" that would remove chains and instead guide institutionalized people with kindness and discipline.

Moral treatment had earlier roots in Quaker methods of non-medical treatment, such as that of Samuel Tuke in Britain. Perhaps most famously, such ideas were made medical in the French hospital Bicetre, a massive institution that housed around 4000 imprisoned men. Although a hospital in name, it was largely home to criminals, pensioners, people with syphilis, and others deemed either undesirable or unable to provide for themselves. Of these 4000, there was a ward of 200 deemed mad. Hoping for therapeutic reforms, administrators appointed Philippe Pinel, who had worked in private sanatoria for insanity, as the "physician of the infirmaries."

Rather than bring his medical expertise to bear upon care, he apprenticed himself to a former patient, Pussin, who was now the lay "governor" of the ward. Using non-medical and non-violent means, Pussin and Pinel worked toward a humanistic approach that minimized restraints. Pinel advocated the extended contact with patients, learning from conversations to understand the natural course of their disease, and to consider psychological alongside physical processes behind their madness. In a legend commemorated in paintings and prints, Pinel removed the iron shackles and freed the patients on the ward, marking the first steps of a humanistic psychiatry.

Contrarian historians and social theorists have challenged the precise meaning of these reforms. Most famously, Michel Foucault (1961) argued that when Pinel removed the chains he subjected inmates to a "gigantic moral imprisonment." They replaced crude force with surveillance, judgment, regimentation of movement and activity, and an account of madness as a moral failure. As patients internalized the physicians' authority, Foucault suggested, they became docile and even less free than those who are chained. For Foucault, rendering madness as mental illness and confining it was a key component of the emergence of Enlightenment reason. In his theoretical apparatus, it was also one of the birthplaces of modern disciplinary power alongside prisons, where small techniques of correction came to replace outright physical repression. Such techniques would then flow out to the rest of society.

Although certainly controversial, Foucault's hyperbolic interpretation was grounded in the pioneers' words themselves. As Pinel claimed, psychological engagement must be backed with "an imposing apparatus of repression." Another pioneer WAF Browne, wanted to continue "the discipline and inspection exercised during active pursuits in the night, and during silence and sleep. Control may thus penetrate into the very dreams of the insane" (both quoted in Scull 2015). Whatever one's stance on kindness and the removal of restraints, we can say sociologically that moral treatment certainly constituted a *different* form of control than physical restraints.

Whatever the goals of moral treatment as an aggressive kind of rehabilitation, it soon become more an ideal than a reality in the asylum. Where small-scale operations for the privileged might retain moral treatment, as the hospital censuses rose, individualized treatment became impossible. By the end of the 19th century, public asylums had become large warehouses, with some reaching the scale of 3-4000 patients. In such colonies, the sheer "numbers renders the inmates mere automatons, acted on in this or that fashion according to the rules governing the great machine." (Quoted in Scull 2015, 305). Some state hospital patients were confined for most of their lives, with little hope for improvement or release. Defenders of the asylum system could no longer claim that they offered competent moral treatment, and soon shifted their justifications from comparing reality to the goals of ideal care, to simply comparing present reality to the worst conditions people experienced *prior* to the asylum system.

In summary, the asylum era in the United States offered a one-stop shop for the management of madness. Regarding care and treatment, people's life needs were provided for, and superintendents promoted ideals of moral treatment. In practice, there was a wide variety of experimental somatic procedures, some moral treatment, and custodial care. Regarding choice, alienists/proto-psychiatrists had broad powers to confine a person based on "need for treatment" standards. Success, especially under stretched capacity, was defined in terms of avoiding the worst of the previous era.

Critiquing the Total Institution

In the 20th century, journalistic exposes such as Deutch's 1948 *The Shame of the States* documented the gap between reality and rhetoric. In the pioneering 1958 study *Social Class and Mental illness,* sociologists Holingshead and Redlich found that wealthier patients received various somatic and talk therapeutics, while many poor people received essentially no treatment beyond custodial care. Locked up and untreated, they had neither liberty nor hope for change.

The journalistic exposes and academic studies largely decried the inadequate funding that seemed to lead to neglect. They did not suggest that all hospitals should be closed, or that there was something inherent in the hospital form that required shuttering. Yet the next wave of reform came to insist that the problem was not underfunded hospitals, or cruel workers, but the very nature of the “total institution” itself. Goffman’s *Asylums* (1963) would render the mental hospital in a class of such isolated, controlling environments as prisons, army barracks, and even interment camps. In an ironic reversal, reformers came to believe that “the community” would be the healing place for the incarcerated mental patient. Where Dorothea Dix had proclaimed institutions the place to shield patients from the harm of community life, many new reformers did not advocate for better asylums so much as abolition. In the mid-1950’s, the Federal government would lay the groundwork for the transfer of care.

There were technological, ideological, and material drivers of what would later be called deinstitutionalization. The key technological development was the introduction of the phenothiazine drugs. American hospitals began using Thorazine in 1954 and Haldol in 1958, with the effect of calming belligerent patients and justifying discharge to community settings (see Gronfien 1985). As is still the case today, patient response ranged from seemingly miraculous recoveries to unbearable side effects and blunt affect, and everything in between. Whatever the ability to improve function, heavy doses of antipsychotics could certainly control behavior. With the sudden ability to manage back ward patients, the antipsychotic medication revolution produced an early optimism that people could be transferred to the community.

Foucault’s (1961) critiques of moral treatment did not address the contemporary mental hospitals per se, but his take on psychiatry’s history dovetailed with present day research. The polemical ethnographic findings of Goffman (1961) and others suggested that hospital institutionalization itself was dehumanizing. Treatment in hospital settings did not prepare people for community life, but further life on the ward. Szasz (1963) famously argued that mental illness itself was a myth, a designation for social deviance that lacked the scientific basis of neurological or other physical medicine. The sociologist Scheff (1964) constructed a powerful theoretical edifice to argue that "mental illness" was in fact produced through labeling processes and stigmatization that pushed people into sick roles. The dissident psychiatrist Laing (1964) questioned what sanity meant in an "insane world," and suggested that mainstream society should learn from the mad. In sum, the burgeoning "anti-psychiatry" movement made three interconnected arguments: First, that psychiatry could not actually distinguish madness from sanity, showing it to be a far from scientific enterprise. Second, that its methods were actively non-rehabilitative, with asylum care leading to chronicity and a lifetime of disability. And third, that if there was no clear thing such as mental illness, than psychiatric care could only be understood as a tool to contain deviance.

The rights revolution and logic of democratization, mobilized in that era by racial, gender, and anti-colonial social movements, facilitated debate over whether psychiatric patients should be entitled to civil liberties to choose and refuse care. More broadly, the 1960's saw idealism about the ability of government programs to solve social problems. Kennedy's 1963 Community Mental Health Centers Act promised the creation of federally funded clinics to receive and treat patients coming out of hospitals. The development of other Federal programs like Medicaid, and later, SSI and disability incomes for the mentally ill, allowed for the possibility of community living.

Most crucial was the issue of funding. Andrew Scull (1977) has powerfully argued that deinstitutionalization was a structural outcome of a fiscal crisis in the Western welfare state. Criticism of psychiatric practice and labeling created popular interest in hospital reform, but as noted above, this ideological territory and muckraking was hardly new. What was different in the 1960's was growing recognition that state hospital budgets were unsustainable. As a commissioner of mental health in Massachusets put it, "In a sense our backs are to the wall. It's phase out before we go bankrupt." (Scull 2016 p 370). Right-leaning politicians saw an opportunity for massive savings in a move from state-based custodial to county-based community management, funded in part through the development of Federal entitlement programs.

A strange bedfellows coalition of civil libertarians and fiscal conservatives worked together to dismantle an institutional system that was characterized as both wasteful and oppressive, a seeming win-win across the political spectrum.
As one hopeful commentator noted, "in the long run the abandonment of the state hospitals might be one of the greatest humanitarian reforms and the greatest financial economy ever achieved" (cited in Scull 2006). For other leftist thinkers, however, the seemingly radical position of critiquing psychiatric oppression merely gave ideological cover to an attack on a state welfare function that, not without its obvious problems and abuses, provided shelter and sustenance to millions of people across Western societies (see Sedgwick 1982*)*.

In summary, the earliest stages of deinstitutionalization offered an alternative vision of managing madness. Institutional treatment was seen as oppressive and ineffectual, and new medications promised the possibility of self-directed community care. Civil liberties discourse provided a language for the right to refuse care, which indeed became the primary rights issue in mental health (opposed to rights *to* treatment, protections against discrimination, etc. see Brodwin 2013). Success in those early years was literally measured in the reduction of hospitalized patients, often with little regard for where in the community they ended up.

Community Care and its Discontents

The turn toward community mental health care had severe unintended consequences, with psychiatric service users experiencing high rates of housing instability and homelessness, trans-institutionalization from the hospital to prison system, and poor access to social and rehabilitative services. Homelessness boomed throughout the 1980's with the general increase in poverty and large-scale destruction of low-income-housing, and psychiatrically disabled individuals constituted an especially visible portion of urban homelessness. With the rise of broken-windows and quality of life policing, large numbers of psychiatrically disabled individuals were and are routinely jailed for minor disturbances that might have previously landed them in hospitals. As Metzl (2010) has further shown, some forensic hospitals were quite literally repurposed as prisons, and patients rebranded as prisoners.

Some of this failure can be attributed to simple underfunding—consider that only a third of the planned 2000 locations from Kennedy's 1963 Community Mental Health Centers Act were ever built, and the program was essentially defunded through the Reagan era. In 1980 President Carter had signed the Mental Health Systems Act, which proclaimed to make good on the promise of Kennedy's never-adequately-funded earlier plans for community centers. Reagan repealed Carter's bill with the 1981 Omnibus Budget Reconciliation Act, which turned to a block grant model to return responsibility for care to the states. Overall Federal spending decreased, and hospital beds across the country continued to dwindle. Beyond the impacts on mental health budgets, Reagan's cuts to other public services like housing subsidies meant a dark time for Americans with disabilities.

The 1970's and 80's, however, also spawned significant developments in community-based treatment. With various models like Training in Community Living, Mobile Community Treatment and others, public and emerging non-profit agencies experimented with attempts to create encompassing care on an outpatient basis. The Wisconsin Program for Assertive Community Treatment (PACT) model became the premier approach, institutionalized and distributed across the country and world. Later known simple as "ACT," this and ACT-like programs used a multidisciplinary team of psychiatrist, psychologists, and social workers to create a so-called "hospital without walls." An immense literature investigates the effectiveness and cost effectiveness of ACT, with general agreement that it is the "gold standard" for community based care (see Brodwin 2013 for a history and summary).

Estroff's (1981) ethnographic study of the pioneering Wisconsin PACT team is instructive for making sense of what such life actually meant for patients. What PACT offered, ostensibly, was a treatment approach far beyond simple medication management. It included, in proclaimed order, 1) vocational and work-related skills, 2) Activities of Daily Living, 3) Social and Recreational Activities, 4) Family, and 5) Medications, psychotherapy, and nursing care. In the early days of PACT, working with recently deinstitutionalized patients in the mid-20's age range, there was some cause for optimism. Yet while Estroff entered fieldwork believing everyone in treatment would get better, she soon lost this naïve perspective. People remained suicidal or psychotic, and experienced disabling side effects from medication.

Documenting client's failures to leave the sheltered employment program for competitive work, she warned of a trap in which people would become dependent on the new Federal SSI program and essentially incentivized into a new kind of illness "career." With the pretense of rehabilitation through the work program, Estroff found clients were simultaneously stigmatized for the very dependence that society was offering. She concluded,

> Being a full time crazy person is becoming an occupation among a certain population in our midst. If we as a society continue to subsidize this career, I do not think it humane or justifiable to persist in negatively perceiving those who take us up on the offer and become employed in this way. (257).

In short, despite the emphasis on work and finding a valued role in the community, many clients did not achieve this. They felt trapped between demands that they improve yet further found that too much success (in terms of work) would impede the care that they had in place.

Other states did not scale ACT and ACT-like programs during this time. In Los Angeles, the everyday lives of ex-patients and those who might have previously been hospitalized long-term were arguably bleaker from a treatment perspective. Large scale "Board and Care" homes, which took people's SSI as payment for a shared room, meals, and medication management, didn't even pretend to offer rehabilitative services. In an ethnographic examination of the business side of the system, Emerson et al (1981. p. 783) offered this matter-of-fact observation:

> … the SSI-derived economic base of the current board and care system fails to encourage rehabilitation, and in fact offers a number of disincentives to this end. This funding procedure generates strong pressures toward minimizing costs; treatment programs and services are expensive, and are only rarely provided in board and care. (Emerson et al. 1981. p. 783)

In the simple terms of money in and money out, it made little sense for Board and Care operators to invest in transforming its residents.

As Grob (1991) argued, the early waves of deinstitutionalization led to a separation of “treatment,” in the sense of addressing illness, from “care,” meaning quotidian life supports. Predicated on the ideas of prevention and early intervention, the younger people released from the hospital were supposed to get therapeutic “treatment” services in the new Community Mental Health Centers and become self-sustaining. The senile aged patients were largely trans-institutionalized into nursing home settings that provided “care” without treatment. As the funding for CMHC’s dried up, however, many people reliant on public services would go without either.

What neither Estroff nor Emerson’s studies conducted in the 1970’s quite predicted was the emergence of wide-scale patient homelessness and revolving door of incarceration of the next decade. Downtown Skid Rows and marginal urban areas would become what Dear and Wolch (1987) called “service dependent ghettoes,” where large numbers of ex-patients were either warehoused in halfway homes or left to languish on the streets. In less technical terms, those authors would label places like Los Angeles' Skid Row "Landscapes of Despair." Rotating in an "institutional circuit" (Hopper 1997) of brief emergency hospitalizations, shelters, and jail cells, many received brief bursts of bio-psychiatric treatment alongside punishment and abandonment.

Families, now de-facto tasked with managing relatives, began to organize. With few resources from the state, and stripped of the formal power that they'd once wielded, they first sought mutual solace and then policy change. Perhaps the first major California family support group, Parents of Adult Schizophrenics (PAS) began in 1974. Uniting with other similar grassroots chapters, they formed the California Association of Families of the Mentally Disabled (CAMFD). CAMFD then joined with 58 other such groups across the country to form the National Alliance for the Mentally Ill (NAMI). They had two express goals: first was the reduction of stigma through the propagation of a biological model of mental illness. By reframing mental illness as akin to diabetes, they hoped to render psychiatric disorder understandable, and to combat such ideas as the "schizophregenic mother"—the notion that family dynamics had generated schizophrenia. Second was advocacy for improved community based services. By the 1980's they exerted enough political power to influence mental health policy. In California, for instance, AB 3777, which established new forms of integrated, comprehensive community care (see Padwa et al. 2016).

In the next section I turn from the federal and state history to its local manifestation for the study at hand, and the development of something to replace the hospital system. The LA County Department of Mental Health (DMH) is today the largest municipal mental health system in the United States. It directly operates more than 80 programs and contracts with 700 more, with a range of services offered across age groups and provided by NGO's, non-profits, and individual providers. It is a massive bureaucratic enterprise, with funding from State, Federal, and local revenue streams flowing to both the public clinics and the non-profit contractors. To make sense of DMH requires that we step back again, and see deinstitutionalization through the lens of local government. In LA County, early hopes of a comprehensive bio-psycho-social psychiatry, with preventative programs and impact on the health of communities as a whole, gave way to an overwhelmed system simply trying to keep the indigent sick from homelessness.

Los Angeles County Department of Mental Health

The birth of county DMH is inseparable from the hopes and failures of the deinstitutionalization movement, and its evolution as a system can only be understood properly in the context of the subsequent crises of patient homelessness and incarceration. Here I tell the story of LA County's system, branching out to the state politics of California, and ultimately the machinations of Federal budgetary alignment. Such history can help connect the micro-observations of street outreach and clinical care in one county program to the macro contexts that shape it.

As a sprawling behemoth with an annual budget over $2 billion, it is easy to forget that DMH was only created in 1960. It began during a period of great hope for community based care, as well as an apparently genuine belief that the transition away from State mental hospitals would save money across levels of government. The following derives from Padwa's (2009) oral history interview for UCLA's archives on public mental health with Harry Brickman, founding director of DMH. Recalling what was previously available for those outside of state hospitals, Brickman explained there were few outpatient services to support people in the community. This also meant room for innovation. With an interest in preventative care that would keep people from developing more serious conditions, he saw the opportunity to craft a community-based system that drew on the traditions of sociology and anthropology, in addition to clinical psychiatry.

Brickman had completed his psychiatric residency at the famous Menninger's Clinic in Topeka, Kansas, one of the pioneering psychoanalytic centers, that remains a premier private setting to this day. There he studied under the psychological anthropologist George Devereux, who taught residents about the impact of culture on psychopathology. Working later at UCLA's Neuropsychiatric Institute (NPI) he collaborated with the pioneering sociologist Harold Garfinkel, founder of what become known as "ethnomethodology." Garfinkel taught Brickman sociological ideas about the way an attribution of illness, such as an official diagnosis label, changed a person's place in the rest of the social order through the "sick role." Brickman's opportunity to create this new preventative, community based care system came about in part because of shifts in the philosophy of care, and in part because of budgetary reasons. Clinicians and critics of psychiatry were already toying with the idea that people would be better served in community care than institutions.

With the passage of the Short-Doyle Act of 1957, the State of California would fund half of a county's expenditures for "preventative services" should they establish outpatient services in clinics, inpatient services in general hospitals for 90 days or less, and rehabilitative services. Beyond clinical services, the state would reimburse for education to the public and consultation with other welfare departments "to help them to deal more effectively with children's or client's mental health problems before they become severe enough to require psychiatric treatment." (Auerback 1959). This ideal of prevention and local care was enticing, and did not yet signal a wholesale abandonment of the State hospital.

Brickman recalled, "…the idea [was] that eventually, the State would transition out of the mental health business, but would retain the State Hospitals indefinitely for those with major mental illness." Thus, there would be both a county system to handle local outpatient work in the community, and a longer-term State Hospital system to send those with more serious disability. In 1960 the county Board of Supervisors voted to create the new Department of Mental Health, which would effectively take over some of the State's responsibilities and get the 50% matching funds from the State of California.

The budget realignment between state and county Brickman encountered at the birth of the LACDMH was further impacted by upcoming Federal changes. President Kennedy's 1963 Mental Health Services Act would establish community mental health centers across the country, moving the financial burden of care from the states to the Feds. In 1965 the Medicaid and Medicare act would provide greater coverage and benefits to patients living in the community, with a notable exclusion to reimbursing psychiatric hospital care. States were incentivized to remove people from such hospitals, as the feds would only pick up the bill if the person were served in an outpatient setting. Brickman's plans to create a County system of preventative social psychiatry alongside chronic care never fully took off, however, because the State Hospitals would soon be shuttered, leading to a rapid influx of more serious mental illness in the community.

California was in some sense the model for deinstitutionalization. When Ronald Reagan was elected governor in 1967, he cut 2,600 jobs at the Department of Mental Hygiene and took 10% off of the budget. That year he also signed the Lanterman Petris Short (LPS)Act, effectively ending long-term involuntarily confinement outside of criminal justice avenues. It established the new standards for when a person could be held against his or her will, moving from a so-called "need for treatment" to a "danger to self or others" criteria. Some patients rights advocates deemed LPS a "magna carta" for mental patients' rights. The efforts to deinstitutionalize rapidly were in fact bipartisan, with leftists fighting for patient freedom and conservatives concerned with the hospital expenses. This intertwining of civil libertarian activism for individual rights *from* government intervention and budget cuts for bean counters points to the contradictions of what would later be called "neoliberal" logic: many psychiatric patients were indeed newly free to leave mental hospitals, but what this freedom amounted to was another question altogether, since there were not adequate supports in "the community."

The first impact was infrastructural, overburdening the new county system. For Brickman, at the helm of LA County's new DMH system, the rapid closing of the state hospitals without adequate development of community care was not only a public tragedy—it was also a personal betrayal. He claimed then-governor Reagan made a direct promise to him that they would have time to prepare before they were hit with the wave of state hospital patients.

> I had a conference with Ronald Reagan, and I have somewhere… a picture of Ronnie and I shaking hands and the handshake was that they would not close down the State Hospitals, until we in the community had an opportunity to develop halfway houses and transitional facilities for those with major mental illness. We shook hands, and, I think within a month, he began to close down the State Hospitals…The result of it is that they began to dump them on the streets. They closed down the State Hospitals. We had a big problem with the homeless and there were some studies that indicated that something like 40% of the homeless were chronically mentally ill people. So what happened was that we were obliged to close down many of our preventive services and increase our outpatient psychiatric services. (Brickman with Padwa 2009).

With chronic, precariously housed patients thrust upon them, Brickman's preventative and sociologically informed community health had to take a back seat.

Playing catch up from the get-go, the dream of keeping people from entering "mental illness careers" or "the sick role," rather than simply managing a mass of severely disabled people, would be perpetually hampered by budget crises. Brickman, in a separate interview for USC's archives, noted that the new outpatient programs became predominantly psychopharmacological as a matter of practicality.

> It turned into clinical services that were largely dispensers of medication with little or no concomitant psychotherapy. In my view then, and still, this was unfortunate. But in certain ways, we were so overwhelmed with clinical caseloads, that in many ways, we had no alternatives. (Brickman 10)

The second, related impact of LPS was a new set of standards for coercive treatment that initiated a series of ethical and practical dilemmas. Beyond the huge new caseloads overwhelming the underfunded centers, LPS granted patients far greater rights to refuse treatment even if seemingly disturbed.

For Brickman, the new emphasis on voluntary commitment and restrictions on involuntary care were "a fundamental mistake as far as I'm concerned." Although he had designed the new Psychiatric Emergency Team (PET) model, which could go into the community to initiate holds, the problem was how to manage the patient who was mad but neither "danger to self," "danger to others," nor "gravely disabled." He expanded,

> Although I'm appreciative of and sympathetic to the civil rights orientation, I think it went too far. As a consequence, the mentally ill appeared more and more among the homeless on the streets…these are people who are disruptive, these are people who call for, largely, compassionate responses on the part of the public who are concerned what's going to happen to these people. (Brickman 11)

Here we see how deinstitutionalization's infrastructural and civil liberties elements—the offloading of State hospital patients without adequate building of municipal services, and the granting of patient liberties without what Brickman called a "compromise" for commitment—dovetail to produce what became a new figure of the 1970's—the homeless ex-patient who was, as Treffert put it in 1973, "Dying With Their Rights On."

For those who had been hospitalized, long-term care was extremely difficult to secure. Those who voluntarily accepted treatment were returned to the community. And financing long-term hospitalization was nearly impossible in the public sector, due to the lack of beds and what is known as the Medicaid IMD exception. As a stipulation to prevent a return to hospital warehousing, the federal government declared that Medicaid funds could not be used to hold a person in an Institute of Mental Disease (IMD), or any setting of 16 people or more that focuses more than 50% of its beds on the mentally ill. Here again, the emphasis on rights of patients to avoid the total institution actually worked. The insufficient hospital beds, combined with the difficulty in financing the stays, meant that many who might otherwise be held, are released.

The lack of adequate community resources meant that many in health crisis received neither robust community care nor hospital care, and instead found themselves incarcerated in penal settings. By the 2000s, Los Angeles County Jail vied with a handful of other urban houses of confinement for the dubious title of "largest mental health facility" in the country.

The Recovery Model and the California Mental Health Services Act

At the turn of the 21st century both federal and state systems have moved toward a "recovery" approach, positing the ability of psychiatric patients to become independent from intensive mental health care, “empowered,” and fully recovered from disability. Yet where some observers see the final fulfillment of deinstitutionalization’s promise, promoting “psychiatric consumer” choice and protecting people from the iatrogenic effects of treatment dependency and a reductionist medical model, others have more critically noted the fulfillment of deinstitutionalization’s other promise: the slashing of state services for the severely disabled under the guise of deeply held American values of independence and autonomy (see Braslow 2013). In a seeming repetition of the strange bedfellows coalitions of the 1970’s and 80’s, once radical critiques of psychiatric paternalism are dovetailing with cost-reduction logics.

The roots of the Recovery orientation are to be found in the radical psychiatric survivors movement. Ex-patients suggested that services themselves were profoundly disabling, leading patients to become essentially stuck in their patient sick roles. Reorienting to individualism and independence, the recovery approach would help people thrive and become full members of the larger community. With its focus on empowerment and self-sufficiency, the recovery approach resonated strongly with American neoliberalism. As Braslow (2013) argued, the language is strikingly similar to that of Clintonian welfare reform that pushed many vulnerable people into workfare programs. Yet the policies stemming from the recovery movement cannot easily be reduced to cost-reduction. The California Mental Health Services Act (MHSA) of 2004 aimed to reorient the entire public mental health system to recovery, and drew on a millionaires tax to raise budgets by roughly a third.

The centerpiece of the MHSA was the expansion of Full Service Partnerships (FSP’s), a variation on the Assertive Community Treatment team model. The care was mandated to be holistic, intensive, and ready to do “whatever it takes.” With flexible funding beyond the Medicaid billing often required for services, they could address client needs for housing, food, and other basic elements of survival. Both DMH policy rhetoric and research reports on Full Service Partnership teams describe their practices as an adoption of the “Housing First” model. Here, rather than requiring people be “housing ready” in terms of sobriety and psychiatric compliance, the idea is that housing is itself a precondition for addressing mental health and addiction needs. The most widely disseminated Housing First model, Pathways to Housing (PTH) in New York City, attempted to place all homeless clients with psychiatric disabilities from streets to apartments. They would then secure people specialized housing vouchers and take payee direction of client SSI funds, ensuring rent was paid (Tsemberis et al. 2004) while allowing clients to spend the rest of their money as they wished.

Ironically, even as PTH was becoming a model program, they were in dire financial straits, and later caught up in scandal for failure to pay landlords. Indeed, they would go on to lose their contracts for Assertive Community Treatment services in New York State. Yet the key features of the model, namely the turn towards low-barriers to entry and a harm reduction ethos, became a new orthodoxy.

Ashwood et al.’s 2018 RAND report for LA County DMH states the FSP services “take the “Housing First” approach and aim to do “whatever it takes” to improve residential stability and mental health outcomes for people with serious mental illness,” in turn referencing older reports like Gilmer, Stefancic, et al. (2010.) Those earlier reports noted the adoption of permanent supportive housing and harm reduction ideologies, but there was, in fact, a mix of rapid housing in subsidized apartments, Single Room

Occupancy hotels, and older parts of the mental health housing ecology, such as Board and Care homes, and shelters or continued street dwelling. The ability to rapidly put people in individual apartments was not only about a theoretical switch toward harm reduction, but also a resource dependent one—there were not always vouchers available. Most importantly, it signals the adoption of harm reduction, increased tolerance of medication refusal, and an arguably laissez faire view of client choice.

Basic material restrictions also impeded the rollout. In Los Angeles, DMH estimated that over 100,000 people could use enhanced services, but could only secure 4,333 FSP slots in the first three years. How did the county balance this new opportunity to provide intensive services with its overall inadequacy? They conceptualized the importance of "flow" that would take people from intensive services down to "Wellness" centers and out of intensive services. Here critics like Braslow (2013) have seen the neoliberal edge even within the massive expansion of services: justified through the idea that long-term services were inherently disempowering, the high investment in care would only be temporary. Both clients and clinicians resisted these attempts to achieve flow out of FSP's, however, and in fact often keep clients for years. Clinicians often did not believe people ready, and clients often feared that the economic advances that they'd made (e.g. housing, benefit access) would be compromised if they left programs and attempted to survive through paid employment. As policymakers concluded, "concern for continued success at lower levels of care and resistance to ending/transitioning a positive therapeutic relationship" impacted the possibilities of flow.

As Padwa et al. (2016) show with case studies of two women who had transitioned from homelessness to independent housing with the help of FSP's, the same concerns of economic vulnerability that haunted Estroff's subjects in the 1980's applied in the 2000's: only the life of a professional patient guaranteed security. Giving up treatment involvement might mean a loss of survival income, insurance, and an eventual return to the streets. Given the lack of a "recovery oriented society" (Henwood and Whitley 2013), the goals of independence and self-sufficiency could appear as a cruel trick.

Yet what did these ideals mean for people who were not so vulnerable to homelessness, incarceration, and destitution? Public mental health care was but one part of a larger system of services serving a very different group of people to Brickman's sidewalk patients in the 1970's, and the FSP patient of the 2000s. Similar issues surrounding the meaning of treatment, how to balance civil liberties with safety, and what kinds of lives people could expect to live, were being reworked in another clinical world.

The Elite Institutional Circuit

Los Angeles and the whole of Southern California has long been a destination for elite private mental health and addiction services. Even before the 1960s, when California became a beacon of mystical counterculture, there were traces of interest in self-actualization. When in 1904 Dr. McBride started the "Southern California Sanitarium for Nervous Diseases" his motto for care was "Not just to live, but to enjoy living."[2] Later renamed the Las Encinas hospital, it eventually became a place for celebrities and the

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[2] https://www.lasencinashospital.com/sites/default/files/attachments/Program%20Services%20Brochure.pdf

wealthy to come for psychiatric or addiction treatment. The hospital itself is today bifurcated, still housing elite patients yet also taking on others with private insurance or Medicaid for brief stays. In the time of managed care, affiliated psychiatrists note that private insurers rarely reimburse for more than a 72-hour hold, and that some of the dynamics seen of "emptying beds" (Rhodes 1991) in poorer settings are comparable.

There's a separate history to tell of the transformation of the private hospital system and the emergence of outpatient alternatives for the more privileged, paralleling the development of LA County DMH but diverging in content. With the United States' insurance system largely predicated on employer-based coverage, the majority of people diagnosed with serious mental illness eventually end up covered by some form of government insurance, as many struggle to secure and maintain full-time work. For those with means and excellent insurance either through family plan or simply paid privately, however, there are alternative forms of care that similarly arose around deinstitutionalization.

Rather than the "institutional circuit" of brief emergency hospitalizations, jail, and shelter, an alternative elite institutional circuit exists for the more privileged. These include potentially longer hospitalizations in private hospitals, residential treatment centers, specialized Intensive Outpatient Programs (IOP) and partial hospitalizations (PHP), and a variety of therapeutically oriented transitional homes that offer far more programming than Board and Cares. Some of these are trans-local, as the circuit for those with means extends outside the bounds of the CA. Famous private centers like Menningers Hospital, where Brickman from DMH trained, continued to serve as a site for other centers to send difficult cases. Therapeutic farms, often with a lineage that dates back to the Quaker practitioners of moral treatment, similarly serve a rarified clientele of national and even international origin. With small patient numbers in pastoral locations, such places at least offer the possibility of moral treatment and rehabilitation as once envisioned.

The Actualization Clinic, one of the central private centers in the present study, begins also with deinstitutionalization. Richard, the owner of Actualization, had been a psychiatric technician in a private mental hospital, and his wife, Erin, a psychiatric nurse. In the mid 1970’s a doctor asked Richard to help with a woman who was leaving long-term care at Menningers in a bid for community integration back home in Los Angeles. Soon he developed a business model, working to assist in hospital discharge for wealthier patients whose families could afford extra assistance. Joseph, a PhD psychologist who had previously run a locked psychiatric facility, brought clinical expertise to complement Richard’s lay social activities. Alongside talk therapy, which clients typically already received from private therapists, the team’s goal was to help people “get a life.” Richard’s treatment team would seek to keep clinical therapeutic work as one component, alongside medication, that could work with the team’s specialization in psychosocial activities and rehabilitation.

Given the way some county mental health workers framed deinstitutionalization as a disaster, and Ronald Reagan as an enemy, I was struck when Richard explained his vision.

> Richard: I was strongly influenced by Reagan. He closed all the state hospitals, so he was the first president that got my attention. And it wasn’t cause I thought

> what he was doing was wrong, it was cause I was the community psychiatric guy and he was closing the state hospitals, and it seemed like a dang good thing to me, right? Let's move people back into the community and treat them there. Well I had just developed the last few years a treatment team. That sounded good to me.
>
> Neil: I know that at least for people in the public sector, they agreed with closing the hospitals but they felt like the funding that was promised never came through, and so they blame Reagan sometimes for that, that he never delivered on the funding that was supposed to happen.
>
> Richard: Yeah that part I don't know about. I just agree with the fact that you don't treat people in these big warehouses.

Thus, in my early conversations with Richard, I saw that the narrative so common at DMH, that people had been abandoned by closing the hospitals, was simply not part of the discourse at Actualization. Given his work with wealthy families, who could afford private hospitals in times of crisis and private outpatient care when people were in the community, it appeared that his clientele was insulated from the worst of the destruction wrought on the poor. It wasn't that he was callous, so much as working in a different world than someone like Brickman at the Department of Mental Health.

In his world, there was also less fear of the rapid and inappropriate discharge. As some scholars have argued, hospitalization itself had become something of a luxury good.

> Increasingly, the length of hospitalization is influenced by monetary considerations. Brief hospitalization is the rule for the indigent. As insurance companies increasingly restrict the number of hospital days they will pay for, only the wealthy can afford long-term hospitalization. (Halleck 1991 p. 115)

Intensive treatment actually did not take place in hospitals, I learned, but in residential programs outside of inpatient settings. In many cases, the meaning of inpatient care had changed in the private sector as well. Since insurance companies would rarely pay for long stays, the hospital had become a place for stabilization rather than healing.

Dr. Monaco, a psychiatrist who had collaborated with the Actualization Clinic described phasing out of his hospital practice a decade before. A psychiatrist since the 1980's, he described a frustration with the private hospital he'd worked at, akin to Brickman's feeling that DMH psychiatry had become pill-oriented by necessity. He explained,

> With the depressing changes in the healthcare system, I have to say psychiatric hospitalizations are so depressing compared to what they used to be like. Now if you've got like an average five to seven days length of stay with not a lot of treatment, it's really more of a biomedical approach to treating symptoms with some "Seeking Safety groups," but not much.

He felt that this basic stabilization and minimal psychosocial care was giving psychiatry a bad name. Helping to found a residential program for people with thought disorders, he claimed he could actually practice as he’d been trained.

> I was trained to really treat people in a holistic way. I would say bio, psycho, social, spiritual continuum. And it requires really a problem solving, complex issues. And it's really, at the end of the day, the fundamental thing is it's the relationship. If you can't develop a good relationship with the patient and have a good understanding of what that relationship has really in many ways highlighted by your understanding of psychodynamics, even though that may not be the primary mode of treatment, it's hard to get people into recovery.

Dr. Monaco acknowledged that working in such a way meant excluding the vast majority of people. His program cost forty thousand dollars a month, and patients or families could only hope to get partial insurance reimbursement.

The anthropologist Tanya Luhrmann (2000) documented the remaking of psychiatry in the 1990’s, as psychodynamic care was largely phased out in favor of biological interventions. This was due in large part to managed care, which remade American healthcare and demanded a stronger evidence base for interventions. Psychodynamic therapy, especially that provided by psychiatrists, proved far too expensive and difficult to prove efficacious. Depth-therapies largely fell by the wayside, in favor of short-term interventions such as cognitive behavioral therapy, which were increasingly delivered by lower-ranked clinicians like psychologists and social workers.

Dr. Monaco echoed this, explaining that the younger generation of psychiatrists at his hospital primarily met with patients for ten-minute blocks, and did not develop relationships.

Another psychiatrist in the Actualization network explained her work with Gateways, an elite residential program.

> The goal of psychiatric inpatient hospitalization is to basically keep a patient safe and to get them on some medication that can stabilize them for the short term. There is a need for short-term psychiatric hospitalization… In a hospital setting you wouldn't necessarily have intensive treatment, intensive therapy. In somewhere like Gateways you have a patient not only have constant surveillance in terms of medication, but we also provide therapy as a tool to allow them to not only use medication as the only tool possible for their recovery.
>
> A lot of times we have patients go into inpatient, who then decide, family and staff decide it's not time for them, they can't go home, it's not, they're still there's a long way to go still, but maybe the inpatient hospital is just not allowing them to move forward in a way they really want to. And so a place like Gateways is used as a continuation of the hospital which allows them to integrate more treatments into their recovery.

Thus, rather than long hospitalization, where a stable person would wait among acute patients in the process of stabilization, private residential treatment centers offered rehabilitative services to those who could afford it. Gateways offered numerous forms of psychotherapy, from psychoanalytic to behavioral methods. Also like Dr. Monaco's program, Gateways was out of most people's financial reach.

Intriguingly, this far greater capacity for intensive treatment options in private services actually coincided with some deficiencies. Sheldon, a sociologist and clinical social worker, co-ran a private community based reintegration program in another state with a psychiatrist. His treatment team collaborated with Actualization, and the programs shared clients in part of their broader network of programs. Reflecting on the differences between the public and private mental health systems, he noted that there were things in the public sector that people like he and Richard had brought to private care.

Sheldon and others realized that many of the innovations in community based services, like Assertive Community Treatment, were not covered by private insurance and ironically less available in the private sector. While more privileged people had greater access to therapy, high-level psychiatry, and hospital or residential centers, and far fewer social needs related to homelessness or poverty, they might miss out on care coordination and community assistance. This offered a market opportunity. He explained,

> You [patient] go to a psychiatrist, you get a little symptomatic and they send you to a wilderness program or they send you to a hospital and there's no in between, that somebody who's connected to community mental health agency and has a case manager might be able to get at the point of some level of symptomology, right? That was the sort of market thing I think a lot of people saw was needed.

He also noted, however, that what a poorer person received in that community mental health agency was not the official vision of Assertive Community Treatment. As in the history of the hospitals, the vision of care rarely stood up to the simple overwhelming numbers of people. In his experience running a public ACT team, he felt that he was mostly just monitoring people to take their medication, rather than helping them transform toward "recovery."

Sheldon further bemoaned the situation of middle class people, who were too well off to qualify for the public community care but could not afford high-end treatment like his or Actualization's, since it was not covered by insurance. But by working for direct payment, he'd been able to skirt the kinds of regulations that come with either public sector oversight or insurance. He simultaneously criticized the lack of oversight he saw in other private agencies, but believed it enabled his innovative work. When I asked about the hoops one must jump through to establish a community based private care agency, he was himself surprised at how easy it was to get into.

> There's nothing. We've had our lawyers make sure, but the Department of Public Health only tracks people that take insurance. That's about it. And then Department of Mental Health has no interest us because we're not working with clients of the Department of Mental Health.

Thus, he found opportunities in the private market both to make a lot of money compared to being a public mental health team leader, and to do innovative work.

The Affordable Care Act and the Private Ecology

The Affordable Care Act of 2010, commonly known as "ObamaCare," played a major role in remaking the ecology of mental health and addiction services. For poorer people who had previously been too well off to access Medicaid, it shifted the cut-offs. It also made private insurers address behavioral health in ways they had not. With parity laws requiring insurers to have expansive coverage, a whole industry of addiction providers cropped up to provide services and collect bills. As numerous journalistic exposes have shown, this resulted in unscrupulous practices like excessive billing for multiple urine tests and kickbacks between providers. John Oliver's *Last Week Tonight* brought this to wide public attention in 2018, documenting the lack of regulation, and the so-called "Florida Shuffle"—providers in addiction hotbeds (like Florida or Southern California) milking insurance benefits from addicts as they relapse over and over again, with little incentive to actually get people clean since it would end business. Insurers and lawmakers have since attempted to better regulate rehab and alter the incentive structure to limit such business models.

The story with psychiatric disability is a bit different, with private insurers attempting to figure out how precisely to address the high service utilizer with serious mental illness. As the mental health policy scholar Howard Goldman (2010) noted, the new legislation would have numerous advantages for people diagnosed with serous mental illnesses like schizophrenia. It would allow them better access to public plans without having to apply for SSI, and facilitate access to private plans that would not have been available before. He wrote, "Perhaps most important of all, they will not be disqualified from health insurance because of a pre-existing condition, as schizophrenia would have been considered prior to the new legislation." Expanding on the parity laws from 2008, all plans from 2014 on would be required to have behavioral health coverage with the same level of benefit as general medical services. Yet the insurance industry lacked some of the tools most common in the public sector. Goldman noted, echoing Sheldon's above comments, "Many of the evidence-based practices, such as Assertive Community Treatment teams and supported employment, are not typically covered by health insurance. It is not clear how these services will be covered." Goldman speculated that state mental health providers might expand coverage, but was not sure what direction this would take.

During my time at the Actualization Clinic I would learn that private insurers were in fact struggling to figure out the ins and outs of serving people in the community. Previously, private insurance companies had simply been able to deny the severely mentally ill coverage and avoid the types of people with repeat hospitalizations. There were either lifetime limits on hospital and outpatient coverage, or people would age out of parental plans and then not be coverable. In my early months at Actualization they began negotiations with Breyer Insurance (pseudonym), a behavioral health "carve out" company that managed the mental health and addiction components of a larger general health insurance provider.

A Breyer employee had previously collaborated with Actualization through a "single case agreement," where the insurer had agreed to pay Actualization's fees for one particular patient, and now thought it might make sense to work with them on a regular basis. Faced with new, previously uncovered clientele racking up bills, they wanted to pilot a broader collaboration with Actualization's case management and IOP program. In the following field note, Breyer agents come to an Actualization team meeting to discuss the pilot program.

> The Breyer clinical staff members, a counseling psychologist and Marriage and Family Therapist, explain why they want to collaborate with Actualization: they have new clients who are in and out of the hospital and utilizing services in a way Breyer is not used to. Many of these people purchased the private insurance on the Covered California marketplace. Now after long stretches without treatment, they explain, these patients are getting *a lot* of intensive services. The Breyer MFT gives the example of one woman who is in the hospital 26 days out of the month, and then goes right back in. Breyer is trying to figure out what to do with these people, because the missing piece "is the discharge and feet on the ground."
>
> The Actualization team goes around to introduce what they do, such as the specialties in CBT, DBT, or Buddhist therapies. One therapist discusses working with the county and non-profit FSP teams previously, which were also used for high service utilizers. He says those teams are similar to Actualization in the community care approach, but with a much higher client to staff ratio and less staff expertise. Joseph the psychologist emphasizes that they treat and work with the whole family, although Deirdre, a social worker and clinical director, clarifies that it's not family therapy per se, so much as teaching the family skills. "We remove the parental element and place it on us, because we are, quote, 'healthy parents.'" She suggests the families are often sicker than the client, and that if you

just try to treat the “identified patient” it doesn’t work.

After discussing the kinds of bureaucratic requirements they’d have, such as weekly update notes, the Breyer representative says that they may have plans for as many as 30 people and would like to start with 10. They then ask about the data for client outcomes. Deirdre says, “You mean hospitalizations, because it is about money.” The Breyer rep bristles. He says that it’s actually about “quality of life,” and “everyone knows that an inpatient stay can be one of the most traumatizing things.” They want to know if Actualization can help people stay out of the hospital.

They turn to me and ask about how researchers approach this. I say that I’d assisted on state funded evaluations before that looked at the whole state with FSP’s, but there we had long-term quantitative data. Actualization, like many elite private-pay providers, did not track outcomes in this way. Richard turns to the guy and says “you can find a statistic for anything out there. “What they need to do is start with the 10, and we’ll show them what we can do.” The representative says they’ll need to look at LAT’s clients before, to convince the people upstairs. The team notes a number of success stories of frequent fliers who hadn’t been to the hospital in a long time. The Breyer rep says that’s what he needs to be able to tell the finance guys and network guys, that “you could spend $5000 on a shot at the ER or $40 on meds over at the pharmacy.”

> Rep: “So say someone comes to you without a pharmacy. Do 100% of your people have a pharmacy now?”
>
> Deirdre: “Of course!”
>
> Rep: that’s the kind of thing they want to know.
>
> Finally they ask if Actualization will be able to go see someone who is homeless, if they can track the person down. Deirdre says, “We have someone right now, who is homeless moving his car around. We go see him.”

Soon thereafter, Breyer began sending test cases to the Actualization Clinic.

Notice some of the key issues at stake here. For Breyer, the goal of working with Actualization is to keep people out of the hospital. Deirdre, who I knew resented insurance companies, suggested that they were primarily interested in evidence of cost-reduction. Yet the Breyer rep argues that keeping people out of the hospital will improve quality of life. Like the logics of deinstitutionalization in general, the argument was that these things could align. With high service utilization clients burning through resources, they saw even expensive private community case management as an option for cost reduction and improved outcomes. As I’ll explore later, however, the ability of the Actualization Clinic to implement their therapeutic work would be compromised not only by Breyer’s reimbursement practices, but also by some of their clientele’s inability to access the larger ecology.

Chapter Summary

In this chapter I turned to the history of deinstitutionalization to outline some key issues at stake in contemporary mental health care. We can think of this in terms of what Haydu (1998) called "reiterated problem solving." Here the problem is how to care for people who are seriously psychiatrically disabled when there are no cures per se, and controlling people while respecting their rights. In the 19th century early advocates sought to create asylums to address the abandonment and incarceration of mad people. Yet by the mid-20th century those same hospitals that promised healing were largely custodial institutions. With a shift toward recognizing patients as bearers of rights, including the right to refuse care, the hospitals were problematized as oppressive.

Deinstitutionalization presented some new problems that were addressed differently in different sectors. For the LA County DMH, the flood of ex-patients meant that their plans for expansive care were replaced with a medication model that offered little in the way of therapy or rehabilitation. The new patient-rights laws and inadequate hospital infrastructure often meant that people who might have once been hospitalized would now end up on the streets or in jail. The ensuing crises around ex-patient homelessness and incarceration helped birth both the family member social movement and the patient led recovery movement, sometimes at odds, but both pushing for new community based services. California's Mental Health Services Act offered community treatment oriented in large part to addressing homeless and underserved clientele. This meant a focus on housing and addressing the myriad social and health needs tied to street homelessness, poverty, and criminal justice involvement.

In the private sector, the hospital system presented similar problems in the turn to managed care. For many middle class people, private insurance might fail to cover important services provided by Medicaid, and some would indeed turn to the public sector in order to access community care. Yet for those with excellent insurance and money for private pay, deinstitutionalization did not necessarily mean the same types of crises. People could stay for longer hospitalizations or attend residential programs for intensive therapies. Boutique community treatment teams could help people engage in activity, find new roles, and connect to the wide variety of specialty treatment programs.

Despite these broad differences, both public safety net and elite private providers would still need to provide answers to these shared questions: First, what is mental health care oriented towards—that is, are ideals of recovery and rehabilitation about individual symptom reduction, ending homelessness, cutting insurance costs, pleasing family members, self-actualization, or something else? Second, what is treatment—given that there are myriad interventions for mental health needs, what is appropriate given client characteristics and the resources at hand? And third, what does clinical choice mean—if people do not necessarily want treatment, but cannot be forced legally, how is care organized? Finally, linking the goals of care to its implementation, what does success mean?

Chapter 2

Sorting Out the Down and Out

In this chapter I map out the ecology of public safety net services in Downtown Los Angeles. Bound up in local state and business projects of urban poverty governance, the DMH team collaborates with other agencies to classify people, sort them into different resource categories, and ultimately work to dismantle a homeless encampment. In a moment of political uncertainty, when activists successfully sued police for homeless property destruction, the mental health workers find themselves on the front-line of a protracted battle over public space. For the DMH treatment team, the street clearance projects offer an opportunity to access special housing resources and help those they believe deserving of specialized care. Yet the difficulty of accurate street diagnosis, and a wider economy in which psychiatric care is viewed as an avenue to survival resources, means there is difficulty figuring out who is actually appropriate.

This chapter helps illustrate the particular dynamics surrounding classification, treatment, and choice in the context of urban poverty. It shows how actors like local politicians and business owners may attempt to use mental health services toward their own ends, yet also shows the limits of such power plays. Rather than a story of the local state's ability to control the lives of the poor, it shows pockets of "freedom" for the abandoned, and illustrates the struggles of myriad agencies to pursue their mandates while addressing the larger issue of homelessness in Los Angeles.

…

On a cool January afternoon in 2013, I sat with representatives from an assortment of Los Angeles city and county agencies in a dimly lit church basement. We had gathered for the latest meeting of the semi-official "Spring Street Task Force," dedicated to removing a homeless encampment across from the historic Olvera Street district in Downtown. Under pressure from a coalition of Chinatown business and political leaders, whose patrons and constituents encountered homeless people near the bus stop, the county Board of Supervisors deployed both law enforcement and service providers to clear out the tent city. Yet the standard practices of policing encampments were under attack, for a group of activists and Skid Row residents had secured a court order—known as the "Lavan Injunction[3]"—that would prevent LAPD and the city from confiscating and destroying property.

Jean, a bespectacled representative from the City Attorney's office, explained the consequences of the city's failed legal appeal. "The latest ruling from the 9th circuit, which will apply to all of the West Coast, is that unattended property is covered by the 4th and 14th amendments." This meant they would need to respect people's possessions even if the objects looked to be trash. "That's crazy," exclaimed Harold, an elder African American supervisor from the Department of Mental Health (DMH). Others nodded in agreement. Jean assured them the city would continue to appeal, but in the meantime they had to pull the police back. In fact, the city wanted the Task Force to invert the order of contact.

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[3] See Lavan v. City of Los Angeles, in which plaintiff Tony Lavan accused the police of improper property confiscation. The court issued what became known as the "Lavan Injunction," requiring new procedures for respecting belongings. Other major civil liberties rulings included Jones v. City of Los Angeles, which stopped police from enforcing sit/lie laws and criminalizing sleeping on the sidewalk, unless there were adequate shelter beds available.

> We're trying to put social, public health and mental health services and sanitation, as the leadership. We're asking LAPD you are not the lead, you are the helper in case someone gets out of hand…this is a hard pill to swallow, but this is the right lens through which this needs to happen.

The US Supreme Court would subsequently refuse the City Attorney's petition for review. With the injunction standing, the city of Los Angeles and other municipal governments would have to solve a practical problem: *how could they manage street populations when their favored tool—policing and property confiscation—was under legal scrutiny?*

For activists and homeless citizens in Downtown Los Angeles, the court order was a significant victory. As the sociologist Forrest Stuart (2016) has shown, Skid Row residents had been subjected to a radical experiment in hyper-policing that pushed them into treatment programs and confiscated their belongings, with few of the advertised positive benefits. The flood of new officers and tough-love "therapeutic policing" had not significantly lowered crime rates, and few people stayed in mega-shelter addiction programs when directed by law enforcement. Critics contend such policing-approaches to homelessness can in fact compound poverty and prevent people from exit.

Where Stuart's fieldwork ended with the triumph over these policies, mine began with the new practical problem for the city. Although the injunction might temporarily protect people from police contact, it could not magically conjure resources to end homelessness. Los Angeles still had a drastic deficit in affordable housing stock, stretched social services, and ever increasing populations in the tent cities. No one was yet sure what could replace heavy-handed policing in the management of homelessness downtown.

The City and County's eventual response, "Operation Healthy Streets" in Skid Row and the collaboration on Spring Street would justify encampment clearance not in the name of law enforcement, but mental and public health. Rather than send police in to clear tents, the city would identify an area for street cleaning, deploy mental health and public health workers to engage people, then bag, tag, and store non-hazardous belongings on the day of the power-washing.

Jean from the City Attorney's acknowledged this would be deeply inefficient and the property might come right back, but it was the only option after the ruling. "You all know that the more connection, the more interference, repetition, the better chance we have." Where the business owners wanted "police sweeps," with its metaphor of a broom to trash, she offered a less satisfying one: "In the city we call it a funnel."

But what would motivate people to accept services, acknowledged by many in the room as inadequate, without police enforcement? The majority on the street clamored for rapid housing vouchers, but these were reserved for people with serious psychiatric disabilities. Most of those "truly ill" who appeared to qualify based on severe mental health needs, on the other hand, had rejected the housing. Eva, the chair of the meeting representing a County Supervisor, stated that they could not ignore the "criminal element" imported to Spring Street from Skid Row. Others were stuck in a policing mindset as well.

Georgia, a representative from the Los Angeles Homeless Services Authority (LAHSA), recommended a "Connect Day" where the Task Force displayed every available resource to justify a sweep.

> Take it or leave it, this is the last day before law enforcement comes in. We get people out there with services, even haircuts, so that we can say that we've offered everything that the city has to offer. And if you're still refusing…

Yet the Task Force decided that this could not work any longer. They were unsure how to initiate property clearance without a clear safety or public health hazard.

The city did not want to risk the fines or legal action from arresting the wrong people or wantonly destroying property. Harold from DMH said that outreach workers and law enforcement had yet to figure out who was a criminal, or if the drug purchasing and credit system had in fact been imported from Skid Row.

Jean agreed. "The 'homeless' is not a monolithic population. There are mentally ill people, felons, rockers, all kinds of people."

Until the Task Force knew who was who, then, they could not simply threaten encampment dwellers with the police. The plan was to continue to survey the area, sort people out into categories, and link them to appropriate resources. Yet as Harold whispered to me, this would neither resolve the legal dilemma nor the resource limitations. DMH could not force the "non-dangerous" or "non-gravely disabled" into care, and most people would not qualify for the housing linked to intensive services.

DMH and LAHSA outreach workers were unsure what it would mean to be this new front line of contact.

Far from a story of the local state's power to dominate the poor and marginalized, this chapter illustrates the way progressive law—hard won rights for both homeless people and psychiatric patients—generates gridlock and temporary spaces of precarious freedom. With scrutiny on policing, restrictions on coercive psychiatric care, and grossly inadequate social services, the project was seemingly bound to fail. For our purposes, it provides an entry point to understanding the larger, impossible task assigned to public mental health care in Downtown Los Angeles: not only managing psychiatric illness and crisis, but poverty and homelessness as well.

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Three months before the City Attorney's announcement the outreach workers had been slightly more hopeful. As a volunteer assisting with the initial survey of the area, I sat in a DMH meeting with Harold and his two top workers at the Downtown intensive treatment team to discuss the allocation of new vouchers for both Skid Row and Spring Street. It was "use it or lose it," but if the project processed people fast enough they might be able to make a case for accessing more housing. Political attention meant potential liability, and the workers needed to document and account for the obvious cases of severe mental illness. Yet such scrutiny on the area also meant more resources at the workers disposal. As the leader of the DMH Homeless Outreach Mobile Engagement (HOME) team told me, the sometimes-ugly politics of street clearance and gentrification might give them the opportunity to really help people.

Harold hosted a meeting to connect DMH with providers from LAHSA and a local non-profit, as they were all separately assigned on projects to “clean up the streets” of Downtown. Each team explained their capabilities and criteria. DMH’s intensive team could take the severely mentally ill, with housing resources and 24/7 mobile supports. The non-profit’s Integrated Mobile Health Team would address both psychiatric and medical issues, although this meant it would require multiple diagnostic criteria. The LAHSA team could take those “just homeless” people without such diagnoses. The outreach workers had a week to warn people before the cleanings and possible police sweeps, perhaps resulting in some people’s entering services on their own.

In the heat still simmering from summer, the combined DMH and LAHSA team walked the streets of San Julian to hand out hygiene kits and look for those who might pass the high thresholds of disability. The outreach workers could perform miracles, but only when the funding, client characteristics, and bureaucratic machinations aligned. A LAHSA worker named Danielle had worked on the city’s “Project 50,” which housed the fifty “most vulnerable” homeless people in Skid Row without sobriety or psychiatric compliance requirements. It was meant to demonstrate the cost-effectiveness of rapid housing that could keep people out of jail and the ER, and she held out some hope that this type of “Housing First” approach would be replicated.

A substantial body of research in cities across the nation has indeed shown “Housing First” to be a cost-reducing solution to chronic homelessness (see Tsemberis et al. 2004). Yet such supportive housing is typically only available for a small number of people—those “high utilizers” who eat up a large percentage of funds (Willse 2010). In both Project 50 and the current outreach efforts there were simply resource limitations, and the criteria for qualification—extreme medical vulnerability or severe mental illness in addition to sufficient periods of homelessness—meant that the average down-on-their-luck person would hardly qualify for the housing.

How did workers sort out who was appropriate for rapid housing and mental health services, versus detox or the missions? As they saw it, there was mental illness and *mental illness*—one learned to ignore everyday suffering and hunt for clear psychopathology. Workers agreed street diagnosis was murky, but there were clear cases, like the man who wrapped himself in black trash bags, or the woman who blessed us by saying, “May your cars never be without fuel!” Sometimes a person stood out amidst the chaos, and this is what workers waited for.

Betty, an African American DMH nurse, offered hygiene kits to most people with disinterest. Yet she got excited when we encountered an older black man who lay on the sidewalk, unmoved by the people passing before his gaze. Gaunt and with flies perched on his dreadlocks, he hardly seemed to register that Betty had approached him. For the clinician seeking “true madness,” this might indicate catatonic depression or schizophrenia, rather than just another junkie on a nod. It was several encounters before he told us his name—Darryl—and claimed that he had been homeless since 1987.

“This is where I am,” she said, handing him a card with the FSP’s office location. “Darryl, I’m Betty…come down here to see me so we can help you out. When you gonna come?”

Darryl didn’t make eye contact.

“You want me to come pick you up? Sometime today? Later today? Well we’ll try, what’s your last name?”

That day I drove the county car to help Betty take Darryl to the FSP program. The team placed him in a bed at the LAMP, a homeless community center known for a progressive, high tolerance approach, and began preparing his housing voucher paperwork. They were astonished when the information management system (IMS) turned up zero hits on his name. He was not a “high service utilizer,” but the opposite kind of outreach gem: a clearly disabled person who had slipped through the cracks, with apparent decades of homelessness, yet was more than willing to go into an apartment when offered. He would eventually be housed in an independent unit in Northeast LA.

The first days of the Spring Street outreach seemed promising, as there were fewer people than San Julian and twenty vouchers specifically assigned to the block. I drove with Carlos, a sixty-year-old DMH housing specialist with a long history in street outreach, to meet up with a pair of homeless men who might qualify for the housing. Carlos had heard that they could enroll people temporarily to help get them setup in housing, and then move them down to a lower level of services. This offered a way to engage someone who might not normally qualify, but wanted the assistance. Waiting on the sidewalk was a small older white man named Abe, with a hunched back and hair down to his shoulders. As he paced, stooped over with his gray beard touching his chest, he resembled a wizard who had stumbled onto the wrong movie set.

Earlier that day Abe’s friend Dave had collapsed while clutching his head, and the DMH team arranged for him to be taken to the hospital. Carlos said this might indicate a sufficient disability for the vouchers. Dave was released that afternoon, with the attack diagnosed as a cluster headache. Sitting in his wheelchair against a fence, Dave mumbled words that only Abe could understand. The pair had moved from Colorado Springs, preferring Los Angeles weather to winters out in the cold.

Carlos explained that the two of them would have to come to the mental health clinic to be screened by a social worker. Gesturing with his hands, Carlos indicated he knew this might be a big deal for them. As an ethnographer in training, I marveled at his ability to connect with men like Abe and Dave, who looked askance at others on the street. It was already a big deal, Carlos said, that they trusted us with Dave's wheelchair and bag during the hospitalization. As he squatted down to someone's eye level, or talked about his traveling days when he'd seemingly visited every single person's hometown, I envied Jose's ability to quickly establish rapport. He schooled me in the art of outreach, scolding me, for instance, when I finished a to-go meal in front of people on the sidewalk.

Yet soon other hurdles unrelated to interpersonal style became clear. Take for instance, Abe and Dave. Abe received SSI for some sort of disability, but he did not appear to have serious psychiatric needs. Dave's series of hospitalizations were possibly neurological, rather than psychiatric in origin. Carlos was happy to find out that the guys had been on Spring Street for two years, and had been homeless in Colorado before that. This was a sufficient "homeless history" for them to qualify as "chronically homeless." Yet when a DMH nurse said the guys could pay for a hotel with their disability incomes, Carlos rushed to say that they shouldn't. Paying for one's own lodging could potentially disrupt a person's qualification, starting his or her "homeless clock" all over.

Even when the team found people who qualified in terms of both the psychiatric history and homeless history, they ran into other problems. Ronnie, a Latino man in his 50's, was living on Spring Street and said he had a record in the psychiatric information system for his ten-plus years of prison mental health care. Having been medicated when he heard voices in his cell, Ronnie qualified for FSP and the housing. Yet Carlos, who was handling the case, explained to me that Ronnie's sex offender status would make it incredibly difficult to house him.

"What can you do housing wise?" I asked. We were standing beside Carlos's cubicle in the Skid Row office. Carlos sighed and sat.

"No, there's nothing. Don't even ask. If you have to register [as a sex offender] we can't even start, not even an outside chance."

"Aren't these 'shelter plus cares'?" DMH often use this specialized kind of voucher that obviated criminal background checks, so the hiccup surprised me.

"No," he replied. "These are "regular" homeless Section 8. If there's any kind of background check, you're done."

"But you guys are gonna enroll him?"

"We already enrolled him," Carlos spat. "There are pressures on us. He might not even be that mentally ill, might be a former drug addict. But we can't house him, nowhere permanent."

When I asked what DMH could do for Ronnie, Carlos shut me up with a blunt assessment: "[He's] lucky as a child rapist to not have been killed out there."

If stories like Darryl's demonstrate the potential of compassionate outreach and subsidized housing to move people from streets to home and intensive support services, those like Abe’s and Dave’s point to the far more common difficulty of securing resources for even those with documented disabilities. People may meet some criteria but not all, putting workers in the awkward position of making promises they cannot deliver. Or, as with a person like Ronnie, they may be disqualified on the back end because of unanticipated discoveries like sex offense histories. This all assumes, furthermore, that people want the services or housing as offered. Indeed, some of those deemed most appropriate in terms of severe pathology were precisely the people most distrustful of workers.

By tracing the role of mental health workers in the street outreach and clearance project, this chapter illustrates how two key dynamics interact in the context of severe urban poverty and gentrification. In the configuration at hand, *flexible diagnostic categories* become linkage points to resources. Precisely because there are no objective criteria for mental illness, outreach workers and relatively healthy homeless people can bargain over housing reserved for the “truly mad.” *Client choice* means that even severely disabled people have the right to refuse services designed for them, in turn opening up opportunities for less-disabled people to enter into those slots. Yet this generates pushback from long-term care providers who see their role as treatment, not poverty management. This all brought various actors back to the question of *success* and *for whom*: was the goal helping the mentally ill, housing the homeless, or simply clearing a street?

Navigating the Injunction

For the business owners, the definition of success was quite obvious: their goal was to get people out. Unlike Operation Healthy Streets in Skid Row, which no one expected to truly succeed in terms of street clearance, the business owners asked municipal officials to fully address the Spring Street encampment—that is to say, actually remove people. Since Spring Street was a smaller area with a far shorter history as a "social problem" than Skid Row, I was able to track the project from start to finish. Here I learned about the inter-organizational logic of street clearance, with participation from business representatives, local politicians, police, and social service agency heads. By triangulating between multi-agency meetings, street outreach interactions, clinical care, and simply hanging out with homeless folks on the street, I began to piece together a nuanced picture of the relations between the moving parts.

As noted, the local business elites had complained about homeless people reportedly harassing Chinese senior citizens at a bus stop. For Mr. Tang, a representative of other Chinatown entrepreneurs, outreach and psychiatric services were hardly the preferred method of street clearance. He first requested that police and sheriffs investigate the encampment for criminal activity and confiscate unattended property. At the earliest meetings in the church, business representatives expressed frustration that their requests for sweeps of the area were not answered. Yet with the ongoing lawsuits, officials were wary to agree to direct police sweeps without an adequate provision of services. Before the City Attorney confirmed their stance on the injunction, the group believed that there would still be sweeps.

Georgia from Homeless Services continually pitched the "Connect Day" where all the various agencies would set up booths and inform the Spring Street homeless of available services. With her long tenure in the area, Georgia articulated the logic of threats to mobilize services that Stuart has termed “therapeutic policing.” For law enforcement, this involves offering people the option of avoiding arrest by enrolling in a shelter rehabilitative program or accompanying another service provider. For service providers, it offered a way to leverage “non-compliant” or “service resistant” people into shelters, mental health care, or other provisions “for their own good” with threat of punitive sanctions. Yet as noted at the start of the chapter, these tactics had come under scrutiny with the various legal actions taken against the City.

About a month into the process Mr. Tang asked that they move directly to policing. He said in frustration, “Haven’t we done enough outreach? The one’s who are idiots have got to go.”

“No, we haven’t done enough outreach,” responded an older African American county official. He talked about people’s rights and the court ruling. Furthermore, how could they distinguish the “idiots” from those who are just homeless? Many were not criminals, but poor. “The problem,” he insisted, “is way bigger than Spring Street.”

The Board of Supervisor’s rep stated that they would proceed with the Connect day, and then move to clear the street. “For those who need—

Mr. Wong interjected, “And those who are *eligible…”*

This, of course, was a key distinction. Many people *needed* resources, but that did not necessarily mean they would qualify for them. Eva said DMH could focus on the ones who are really sick, but then after that the others would have to go.

Another Chinatown businessman, Mr. Hsiung, asked her to affirm her boss's position. "Does the County Supervisor want a cleared out Spring Street or a permanent encampment with services?"

Eva responded emphatically, "No, she wants it gone. It's a quality of life issue."

Hsiung described his experience with previous encampment projects in the language of battle. He spoke wistfully of the smooth process by which the city had removed homeless people during the construction of the LA Live entertainment complex. As he lamented, "We had different rules of engagement then."

To my left I heard Harold whispering to another African American official. He noted that for some of these people being moved would be "the end of the world."

Yet the businessmen also expressed sympathy for those who were not perceived troublemakers. Mr. Hsiung asked what they planed to do with undocumented immigrants, who could not qualify for housing and other resources. An older LAHSA worker said they could go into rehabs or Spanish AA. Harold explained that DMH, as a mental health provider, had some leeway to accommodate people without papers.

The Task Force continued to plan the "Connect Day," although some participants raised criticism that they might not have legal grounds to declare a "get-out-by" date. DMH would continue to outreach the mentally ill even if the plan was to simply remove others. This logic of exceptional treatment seemed to appeal to the Task Force more broadly. Even Mr. Hsiung and Mr. Wong, who had called for an end to outreach, began identifying people they thought to be mentally ill. Mr. Wong had taken particular interest in an African American man named Jack who lived outside of a Vietnamese sandwich shop, and asked the DMH team to help him.

Here the business owner's definition of success—clearing a street—could presumably dovetail with the goal of housing homeless people and aiding those with psychiatric disabilities. Yet as we will see, meeting the diagnostic requirements was only part of the equation: a person still had to voluntarily enter services. Thus there was another classificatory decision beyond mental illness itself—if a person refused care, would he or she meet forcible treatment standards, defined by dangerousness or grave disability?

The Limits of Coercive Psychiatric Power

I accompanied the DMH Homeless Outreach Mobile Engagement (HOME) and met with Jack on the sidewalk. Wrapped in a large coat and with a thick black beard, he said he had recently come out of the hospital. He said he liked to stay in Chinatown because he was part Chinese. When the workers asked if he wanted food he said he liked donuts and hot chocolate, but hadn't had a meal in awhile.

Mona, a Filipina nurse and outreach worker approached Jack and first described the possibility of a structured living situation. "There will be a place where you have breakfast lunch and things in between. And if you want to stay indoors you can just lay there. It's your call, you know."

When Jack said he wasn't interested, Mona asked if he'd prefer an apartment. "I ain't got no money," Jack replied dismissively.

"Let's say you could just magically move into an apartment," Mona said, smiling. "What would it look like?"

Jack was incredulous. “I don’t believe in that. I don’t believe you could just magically move into anywhere.” Everyone laughed and he added, “Not these days and times, and not for a Black man. Indoors. Just be free. Unless a rich man is trying to take care of you or something like that.”

A middle aged Asian woman rushed out of the sandwich shop, greeted Jack good morning, and handed him a Vietnamese sandwich before rushing back. Mona said, “You want food and there it is! Like, maybe if you really wish for a place it will happen that way. You were just talking about food, and there is food.”

“Maybe,” Jack replied. “I’m blind so I can’t really appreciate no apartment right now.”

Mona tried one more attempt at persuasion. “When you talk about “not for a black man”… But you know our president is half black. So it’s changing times. Something to think about, okay.”

We walked back to the main Spring Street encampment, agreeing that his claims to be Chinese and blind, although certainly possible, did not seem accurate. Mona believed him mentally ill, and her technique here—discussing the “magic” of food appearing and apartments manifesting out of thin air—was a playful one she could use to engage non-rational people. Yet the workers also agreed that there were no grounds for a psychiatric hold. He was surviving and accessing food on his own, supported by the Vietnamese sandwich purveyors who apparently fed him. Therefore, he was not a danger to self, others, or “gravely disabled.” The HOME team had made their offers of medical treatment and housing, and established that Jack did not meet criteria for a 5150—the welfare and institutions code for involuntary psychiatric hold—and thus left it up to him.

In the subsequent meeting I was surprised when Harold reported to the Task Force that they found Jack had no mental health or substance needs.

Mr. Wong appeared shocked, saying, “I don’t mean to be ignorant, but what exactly does mental illness mean then? He’s sleeping out on the street for a very long time, and doesn’t use drugs.”

“Poor judgment,” replied Lauren, the leader of the DMH team.

The HOME outreach leader said her staff had seen Jack over the years, and he continually refused their offers. Much like outreach workers in other studies (Rowe 1999), the LA staff had a rule of thumb: it was precisely those people most appropriate for the housing who would probably refuse it.

“It’s a sad sight to see,” said Mr. Wong.

“It’s true,” Harold said. “But he can refuse medical treatment.”

Eva asked if DMH could seek a conservatorship and become his legal guardian, but Harold explained it would be extremely difficult to secure from a community setting. In California, such a conservatorship would only be possible after a long-term hospitalization and grave disability—with Jack, they couldn’t even get him in the front door.

Harold had previously told the Task Force that DMH would not be able to forcibly clear the streets, even if people were truly ill. Unfortunately, from his perspective, Los Angeles had failed to implement an outpatient commitment program for coercive care at lower thresholds. Such a plan for “Assisted Outpatient Treatment” was in fact in the works, but would not be off the ground for a few years. Thus, only those who had proven longstanding dangers to self or others would be forced into ongoing care.

Even those who were "5150'd" would usually be released within 72 hours, with public conservatorship only possible in the most extreme cases.

> The city and we as a society refuse to force people into treatment. It's a balance between peoples' rights and recognizing that they need help. We can't force them to take medication…they need help but cannot reason.

Lauren followed up, "There's a gap between what people *need* and what they're willing to do." DMH could not force a person into the hospital or housing simply because of madness or homelessness. Arline Matthieu (1993) observed such an attempt to remove homeless populations through psychiatric commitment in 1980's New York City. Police and emergency crews had pushed homeless people into hospitals and shelters, and in response a homeless woman and civil liberties organization filed suit. In an embarrassing turn of events for the city, a judge concluded that the activities were illegal. It was a far cry from the asylum era, where local authorities could simply hospitalize people with little oversight. In California, known for its especially strong psychiatric patient civil liberties, the DMH workers would not be cajoled into such practices.

Thus, the Task Force members found themselves in a conundrum. With the new "rules of engagement," they could not confiscate property and drive people out of the area. Police officers expressed hesitance to engage in the kinds of practices prior to the lawsuit, such as threatening people with arrest to "motivate" them into shelters. Although the public health street cleanings might force people to temporarily move, and offered occasional state-sanctioned property clearance, it could only act as what the City

Attorney representative called a "funnel" to services, in contrast to a metaphorical broom. Even when Mr. Wong got on board with the idea that there should be help for the seriously mentally ill, he found that the strongly institutionalized patients rights laws in California prevented coercive care. Furthermore, Jack and others who *could* qualify for a higher level of services and rapid housing seemed always to refuse it.

The LAHSA workers announced at the meetings that people were declining their offers of Winter Shelter. The Department of Public and Social Service coordinator explained that he had helped many people apply for SSI benefits, but these could take months to process. People on the street wanted subsidized apartments, but the twenty vouchers allotted to Spring Street were only for those designated seriously mentally ill. All the Task Force could do, then, was continue outreaching. The tactics of public health cleanings and mental health outreach could work as "disruption," but not as clearance, unless a person both *qualified* for and *accepted* a subsidized housing placement. A representative from the Chief Executives office told me that the old approach was to send Sheriffs in first, then follow with outreach. This was much easier and more satisfying from his perspective. He called the meetings at the Spring Street Task Force, in contrast, a "dog and pony show."

Creating a Crisis

Mona's approach to Jack's case, honoring his refusal of housing and assistance, was indicative of the way DMH outreach workers interpreted patient civil liberties. It was something I saw repeatedly throughout the outreach projects in both Skid Row and on

Spring Street. In subsequent chapters I will show that county mental health services can take a laissez faire attitude towards deviance, allowing people to use drugs and refuse medication once safely housed. Yet in getting people *into* that housing, they are not opposed to leverage generated by the larger ecology. What might happen if the police were involved? The case of Anita, an elderly woman who lived beside the church to be close to God, is instructive here. She'd been targeted for the Older Adult FSP mental health program. Despite qualifying for subsidized housing, she told workers that God had commanded her to stay near his house.

A few weeks after the City Attorney's office explained the new protocol, LAPD passed through Spring Street accompanied by a sanitation truck to haul property, in preparation for a later street cleaning. Whether it was due to compassion or the legal injunction, a middle-aged white officer named Drucker slowed the process and tried to ensure everyone had an opportunity to claim belongings. Matt, part of a group of homeless men who liked to drink on Spring, called out while Officer Drucker was poking through Anita's unattended property.

"Hey Officer," Matt called out. "That's the old lady's stuff. Can I go look for her?"

Officer Drucker replied that he didn't want to destroy anyone's things, so he could wait for a bit until she reclaimed her property.

Matt and I ran down to the church office. No one in the office had seen Anita, but they agreed to store her things until the evening. As Matt and I crossed the street to tell Officer Drucker, Sheryl from DMH outreach approached us. She and Jarred, a worker from the Older Adult FSP program, were looking for Anita as well. She frowned when I said that Matt was trying to help claim her property before it was taken. No, Sheryl said. It was better to let the officer confiscate her items.

Officer Drucker stated he would be happy to move Anita's things to the church if we asked him to. Yet Sheryl explained that the old woman was severely mentally ill and resistant to services. "We're more concerned about the person than the belongings."

Jarred turned to me and said, "This could be a motivation for getting her to come with us."

Officer Drucker and the sanitation worker began going through her things and loaded them into a truck. Jarred said softly, "I hate to create a crisis, but it will help. We can get all the other stuff back." Then, directly contradicting Officer Dime's offer for storage, Jarred added, "You can't stop the police from doing this."

I understood the logic. As the flipside of therapeutic policing, Jarred needed the property destruction to get her to come into the program—as she was not technically a danger to self-or-others, or gravely disabled, Anita had the right to refuse. Officer Drucker called us over and showed us rat droppings in Anita's sleeping area. Thus, they declared it a public health hazard and took her camp to the dump.

From Sheryl's perspective, DMH's obligation was to facilitate the introduction. When she announced that Anita and another older woman with mental illness had been connected to Older Adult FSP, I asked her what she meant by "connected." She said that the introduction was made. "We've done our part," she said. "Now it's [Older Adult] FSP's responsibility to engage them and make sure."

A week later Jarred was out on Spring Street again, looking for Anita. When I asked about "creating a crisis" he noted that he must have looked "really insensitive." He was excited, however, for my research and analysis of conflicting forces. “Yeah, you’ve got the cop, the social worker…yeah!” Since there was no engagement thus far, and it seemed like nothing else would change, he and Sheryl thought they would use the property confiscation. “But I still don’t know if we’ve done the right thing. I mean, here we are a week later looking for her. Who knows what will happen?”

In fact, Anita still refused to go to the mental health program. She remained on the street, but now no longer had her possessions. Matt, her Spring Street neighbor who had wanted to save her property, said he had never noticed she was mentally ill until the workers pointed it out. He invited her into his tent when she was out in the cold at night, but he then saw that she was “cuckoo” when she tried to fight with him, and kicked her out. He told us that she didn't have the capacity to make choices, and that she needed “to be in Camarillo.” When we told Matt that Camarillo State Hospital had closed down more than a decade ago, he offered his lay account of deinstitutionalization. “Ronald Reagan is the one who threw all the crazy people out of the hospitals, then started building prisons… to get more DA’s, more public defenders, more cops, more CO’s, so they’d get a lot more jobs by treating people like sheep.”

Whatever one makes of Matt’s account, the outreach workers shared his belief that Anita lacked decision-making capacity. Anita was precisely the kind of “deserving” crazy homeless person that everyone in the project believed should be protected. Rather than force her into care, which was illegal, she was entitled to her choices. Workers hoped that a “crisis” could alter her desires and make her choose “correctly” in their sense. She did not, and now lived next to God’s house without a blanket.

Yet as Jarred protested in self-defense, what else was he supposed to do? Unlike a clinician in another era who could simply force Anita into care, Jarred could manipulate Anita's environment, utilize the police when possible, and offer resources, but at the end of the day it was still her choice. Many workers were deeply ambivalent about these civil liberties. What kind of person chose to sleep next to the church over an apartment just down the road? Was it ethical, they wondered, to let such people make decisions? For some workers, it was precisely *choice* that was the problem.

Imagining the Asylum

After a morning round of outreach in Skid Row, I stood in the DMH clinic with Marlon, a middle aged white clinician from the Psychiatric Mobile Response Team (PMRT). A fit and well-dressed nurse, Marlon and his partner had been assigned for a few hours of morning outreach alongside the DMH team during Operation Healthy Streets. Frustrated with people's refusal to accept offers of housing accompanied by services, he was convinced that homelessness was largely a matter of choice rather than circumstance.

> The thing is they're [officals] gonna realize that there is more housing than there are people. But people don't want to go inside. This woman [today] told me she doesn't want to go inside because there are too many rules.

After years of placing people on 5150 holds, and seeing people with severe mental illness return to the streets, he had become disillusioned with allowing such people to make their own choices. Beyond the problem of madness itself, he believed many people preferred the lifestyle. In opposition to the activists who demanded more affordable housing, he claimed that homelessness wasn’t a problem of resources.

This last claim was simply not true, analyzed in a wider frame. At the time, as at the time of this writing, there were tens of thousands more homeless people in Los Angeles county than affordable housing units or vouchers. When I pushed Marlon he said he believed the Skid Row Housing Trust (a non-profit Housing First agency that DMH, LAHSA, and others worked with) had opened up plenty of new units, but people were not going inside. As I had recently seen people trying to get on the Trust’s waitlists, I had to question his statement. Yet this claim speaks to the experiential mindset of those who are continually called upon to help that portion of the homeless population that is psychotic and rejects psychiatric assistance.

For Marlon the ultimate proof was people who got access to resources, but then continued to live like they were homeless until back on the streets. Marlon said he once engaged a man who had won a six-figure lawsuit after being struck by a county car. Renting a beautiful loft and paying for six months up front, he soon refused to go outside, clean, or use the air conditioning. Someone called the police, and when they wouldn’t take him, called PMRT. Marlon found that the man was storing feces in bags throughout the apartment. Relaying his exasperation, Marlon echoed the public health concerns of Operation Healthy Streets and articulated a solution that he knew others might find distasteful. Looking at Betty, his partner, then me, he shrugged.

> What do you do? I mean, thinking outside of the box, literally, it could be like animal shelters. And hear me out, I know it sounds inhumane, but you could have people in concrete rooms that drain to the center and people could come in and hose people down. You can't force these people on meds, and the thing you have to think about is sanitation. You've got to keep these people clean because of disease. I don't know what the answer is.

The animal shelter analogy was particular to Marlon, but the sentiment was not uncommon. Other DMH workers claimed that California needed a return to the old state asylum model.

Critical social scientists would likely argue that Marlon's perspective "medicalizes homelessness" e.g. Snow et.al (1986), Matthieu (1993), Gowan (2010), Lyon Callo (2008)—that is to say, it transform political-economic problems of poverty or housing supply into individual ones of mental illness and addiction. Rather than see homelessness as a product of structural factors such as deindustrialization, other shifts in the labor market, the destruction of public housing, or inadequacies of government benefits, it is construed as an individual problem. Hence, Marlon's mistaken assumption that there is more housing than people on the street. Yet given DMH worker's experiences with people like Jack, Anita, and others, Marlon's perspective resonated. They frequently met people who *did* refuse offers of free housing, at least housing presented by a psychiatric worker. Workers felt largely impotent in the face of legal protections and the lack of public sector hospital beds.

From a sociological perspective, however, it would be a mistake to suggest that DMH wasn’t doing anything to deal with homelessness simply because it was not forcing people. The limits of coercive psychiatric power actually enabled a different kind of interactional and classificatory work: outreaching relatively healthy people to transform them into official clients and get them goods reserved for the “truly ill.” Here the dynamic of *client choice* connected with that of *diagnostic uncertainty*—severely mentally ill people’s refusal opened up possibilities for others to be classified. In the next section I address the way diagnosis circulates in an economy of goods and housing for poor people, and solves problems for some workers while creating problems for others.

The Diagnostic Economy

When the Task Force finally hosted the Connect Day in the winter, various agencies met in the church to set up booths and hawk their wares. Harold and I walked from the church to inform people on Spring Street of the event. As we discussed my research, he gestured at the Connect Day and said, “You get a front row view of the inadequacy of our safety net.” Echoing what he’d said in the meetings, Harold told me that the county needed lower thresholds for civil commitment of the severely disabled, as well as significantly more resources for the rest of the population. As a progressive child of the 1960’s, Harold complained about politicians who were only interested in appealing to the middle class.

Stomping a cigarette out with his black cowboy boots, he sighed and told me his frustration with existing services. Rather than universal benefits, our system decided only some people in need were worthy. “I tell young social work students, it’s the “Poor Laws” of Elizabethian England. Separating people into the deserving and undeserving poor, and not a damn thing has changed.”

I could see what he meant. Yet from my observations some things *had* changed. What did the “deserving poor” mean in this context? It was not those who wanted to work, or get clean, or give their hearts to God, as it might be in another situation. Given the available resources, the official criteria was “seriously mentally ill” and “chronically homeless.” With housing ostensibly available, yet only for this designated group, DMH workers were officially assigned to find people who passed diagnostic criteria and service utilization thresholds. Some DMH and non-mental health agencies, in turn, saw this as an opportunity to help those who might not officially qualify. This was possible, in part, both because of the flexible construction of disorder and because many of the “truly ill” in the targeted areas had already refused the housing.

Given the lack of precision in psychiatric classification, outreach workers could plausibly refer both those they see as “truly ill” and those they could bureaucratically construct as such. Within the geographic boundaries set by political decisions, outreach workers engaged in both a *semiotic* project, where they read various types of signs to classify people in meaningful ways, and a *strategic* one, where they attempted to match people to programs with specific criteria.

A politically defined outreach effort can change the semiotic project because the workers are tasked with aiding a wider array of homeless people in a shorter amount of time. In the examples I gave earlier, Daryl was an ideal case of someone who everyone agreed was disabled, and voluntarily went into services. When other profoundly disabled people like Jack and Anita refuse, however, outreach workers can alter the threshold of pathology and perceive less serious forms of disability as salient and worthy of outreach and resource linkage efforts.

For mental health outreach workers, the street clearance projects and specially allotted housing vouchers meant also that they had a higher chance of getting people into resource-rich programs. For the HOME team, the goal was typically to place people into an FSP, either Downtown, Compton, or the Older Adult, since the intensive treatment programs had a reputation for rapid housing. After observing Mona refer a person who seemed only mildly disabled to FSP, I asked about how she makes these decisions. Like other street level bureaucrats, she had a great deal of discretion (see Lipsky 1980), and also had to anticipate the discretionary practices of other agencies.

Mona and her partner Shane explained that the gatekeepers' motives are often mysterious, leading outreach workers to abandon strict criteria and refer frequently. The HOME team themselves had no housing resources, so referrals were their best tool.

"For me," Mona said, "Sometimes I'll just give it a try."

Shane elaborated, "They might kick back the referral if it's not a serious enough mental illness…the agencies are choosy sometimes and not so choosey sometimes."

"What do you mean?" I asked.

He shrugged. "[It varies by] individual workers, or they have other criteria that's not on the books. We don't know."

Given that the other agencies were "not so choosey" sometimes, the outreach workers' came to see labeling large numbers of people and referring them up the chain as a reasonable strategy. Without clear criteria, their best bet was to just refer lots of people and hope that it sometimes works.

"If you want housing, you have to get evaluated at DMH"—Danielle, LAHSA worker

During Operation Healthy Streets I shadowed LAHSA outreach workers as they informed people of the upcoming street cleanings. Danielle was an older African American woman who described herself as an "advocate" for the homeless. With her own history of mental health difficulties and poverty in early life, she was committed to helping those in need. Danielle explained to me that access to housing vouchers was controlled by the Department of Mental Health. This was true both because DMH had a line on special vouchers, and because it offered the diagnoses that were useful for accessing the other resources controlled by non-profits in the area. While the Great Recession wreaked havoc on many non-profit and basic welfare services, DMH experienced fewer shocks because of the California Mental Health Services Act. This funding came from a "millionaires' tax" and provided stable resources that could not be re-appropriated for other state purposes.

If the HOME workers and FSP workers usually sought the seriously mentally ill before turning to the moderately disabled, Danielle believed that DMH's resource monopoly justified sending almost *everyone* there. Prior to one of the Operation Healthy Streets cleanings, she approached a group of African American men and pointed out the dates for the impending power washing. She then explained,

"If you want housing you have to get evaluated at DMH."

"I'm not crazy," said one of the older men.

"You know you gotta be crazy to be out here," Danielle countered.

The men laughed, but she insisted that DMH was simply the best access point.

Sociologists have argued that psychiatric diagnosis can cause stigma and negatively impact a person's identity, but Danielle worked to convince people they could simply use it to their advantage. Far from a "degradation ceremony" (Garfinkel 1956) that separated out the crazy from the dignified homeless person, this suggestion was offered so matter-of-factly that it seemed de-stigmatizing in its broad application. As welfare scholars have pointed out, applications for disability benefits for psychiatric disorders spiked after welfare reform in 1996 (see Dobarnsky 2012). This was an off-the-books tactic, but Danielle believed that this was the best way she could help people.

Part of this was because of the inadequacy of her agency's resources. Most people she outreached refused the offers of winter shelter. LAHSA on occasion had access to hotel vouchers, but these only lasted a few days and did not necessarily come with follow-up assistance. Once LAHSA transported Tamara, an older Latina on Spring Street, to a hotel in Gardena but did not assist her afterwards. When I next saw her back on Spring Street she approached a group of outreach workers and yelled, "Are you guys LAHSA? Screw all of you. Make me walk back from Gardena with all of my stuff."

The transport and hotel voucher to another part of the county could temporarily clear a person out, but did nothing to stop them from moving back. Homeless people like Tamara resented this as an attempt to get rid of them without providing real help. When a DMH worker suggested she go over to the main outpatient clinic, she stated that she was already a client there. She did not appear to suffer from any significant psychic distress, however, and said she didn't want to start any program where she could not be with her boyfriend with whom she shared a tent.

Abe and Dave, the homeless white men from Colorado, also became fed up with the offers. The LAHSA team found a craigslist ad for a place in Kern County that they could afford together with their SSI, but there were many problems. Aside from the fact that it was in another county, the apartment had stairs that Dave could not navigate in his wheelchair. Abe told me that he felt jerked around by the different agencies.

> All of these people coming down and talking to us, and they say there are all these different ways we can maybe help you...there are other people out here who are worse off than us and we're seeing all these people out here and nothing's happening. It makes me really angry. And I'm sane, but after all this I'm getting kinda insane. I'm ready to blow.

Abe told me "what we really want is that Section 8 from DMH." This was wishful thinking, as they would ultimately not qualify, but it points to the limitations of LAHSA's resources. If being mentally ill got you permanent housing, Abe and Dave would try to be mentally ill.

Several months into Operation Healthy Streets Danielle proudly told me that she had taken more than 40 people to DMH to get processed. She recognized that few people she met wanted what her agency could offer, so she selectively drove clients to DMH and coached them on what to tell the clinicians. Unlike the group of men who she simply told to go to the clinic, Danielle chose to shepherd select people through the process. One morning I accompanied Danielle to pick up Shana, an African American woman living on San Julian Street, and coach the woman on DMH procedure. Outside the clinic, Danielle told Shana what she would need to say. As a street-level worker without clinical training, Danielle could not create consequential bureaucratic records of her own, and therefore attempted to help people by taking them to a classifying agency.

When Shana went in for her appointment, Danielle told me the woman claimed not to have any mental health problems. "Well, I told her you're homeless. Aren't you upset? And she said yeah, she's angry and down. And I told her *that's mental health*, that's signs of depression." Yet Danielle was still worried that, even if Shana said the right thing, the DMH outpatient clinic would not think her severe enough.

> But let me tell you, I bet you that here they're going to tell her that she's fine, she doesn't have any mental health problems. Unless you're schizophrenic and talking stupid, they're not gonna do anything.

When Shana came out of the clinic she asked that we drive her to the needle exchange, as she could sell the needles on the street for a dollar. After we dropped her off Danielle whispered to me that, "She wants help but doesn't want to tell anybody."

Even when people were prioritized, the main DMH clinic could only do so much. Danielle had engaged Jenny, a white woman in her thirties, and I drove her and a DMH outreach worker to the clinic. She said she'd been diagnosed with bipolar disorder, and had previously taken medication but had not in several months since she'd been on the street. Despite being fast-tracked for the Connect Day and Spring Street project, the workers stated they could only see her for a full meeting in one week. In fact, they were so backed up that they were only seeing people that day that had first come in one and a half months ago. Although she'd said she'd previously been suicidal, the fact that Jenny currently expressed no such ideation meant they could not get a doctor's appointment today. For medication access, they would send her to Exodus Urgent Care. For now, she lacked the kind of history that would justify a spot with the intensive team.

In other cases I followed Danielle and her partner Don as they helped people apply at the Skid Row Housing Trust. This organization similarly prioritized people with mental health diagnoses, so Danielle and Don transported a man to an urgent care and other treatment centers to pick up a paper copy of a previous diagnosis. Here Danielle and Don were not coaching him on how to speak to clinicians and *generate* a diagnosis, but merely secure his mental health history as a bureaucratic object. Later, when he wasn't able to get his paperwork, we picked him up and took him to DMH to get a new evaluation that might help with his housing.

While Danielle seemed to believe that many people truly had unrecognized mental health needs, she at others times used diagnoses in a purely strategic way. One morning I shadowed Danielle and Don as they took a homeless African American man named Bobby to a Burger King and then to a motel. Bobby shook so violently that at times he could not stand. Danielle, wanting to help him save face, explained to the fast food workers that he was not a drug user, but had a neurological disorder. Although his speech was interrupted by his shakes, Bobby engaged us in friendly conversation in the car and told us about his youth before moving to LA.

When they took Bobby to the hospital for his violent tremors, Danielle found that he had been hospitalized for schizophrenia many years before. She and I were both surprised by this, as Bobby's condition appeared to solely impact motor function. She smiled at me and said, "I don't see it [schizophrenia] but I'm going to use it for FSP!" That the label was *schizophrenia* was key, as Danielle had other referrals to the teams that did not gain traction because of weak records or less severe diagnoses. In the end the man lost control of his ability to walk, so he was reclassified and qualified for a skilled nursing facility rather than psychiatric care, but the case points to the strategic use of diagnosis to open up various resources avenues. Danielle wanted to help Bobby, and psychiatric services would be a route to get him housed.

Tasked with serving the general homeless population that did *not* have psychiatric problems, Don and Danielle became convinced that their best bet was to channel people through DMH. This was not simply because the two of them saw people's problems as psychiatric, but because the local ecology required it. Don and Danielle knew it was dififcult for those without psychiatric histories to get housing, so in order to help they took people to *make psychiatric histories*. For the HOME and LAHA workers, then, sending people of ambiguous psychiatric disability up the DMH chain for resources was logical and even moral. This, however, could create friction between long-term care providers and the outreach workers, whose sole job was to get people processed into such programs.

"Those 'no-diagnosis' mean she's full of shit" –Vic, psychiatric nurse

What did this mean for the clinic workers? If some had come to believe that people who refused housing were likely the "truly ill," they in turn believed that people clamoring after services were likely malingerers—addicts or crafty poor people trying to work the system. While shadowing a young psychiatrist named Dr. Usman, I learned that some DMH staff had come to see the instrumental diagnosis as a routine part of the job.

Although he worked primarily in the regular clinic, Dr. Usman was temporarily at the FSP filling in. In between patients he remarked that he much preferred the intensive-team work to the clinic, where he had to evaluate people off the street. When I asked why, he stated that half of the clients at the main clinic were not mentally ill at all, but needed things like housing and welfare. He explained that he often diagnosed them with an Axis 1 disorder Not Otherwise Specified (NOS) and prescribed an antipsychotic or mood stabilizer.

The Axis 1 designation made sense to me as a "workaround diagnosis" (Wooley 2010) but I was confused as to why he was giving people such heavy drugs. With the side effect profile of antipsychotics, it seemed strange and even dangerous. Yet Dr. Usman explained he was aiming to calm potentially violent people. He spoke with disdain of the clientele who came to the Skid Row clinic. "There is no medication for anger," he said. Still, the drugs were necessary "so they don't hurt anybody." Thus, for reasons different than the LAHSA workers, Dr. Usman was collaborating in the project to bring all sorts of people into DMH's system. He saw it as an issue of protecting the public.

Such instrumental diagnosis, and especially the outreach worker's referrals, led to frustration for long-term care providers. For the team this meant they had to frequently screen clients who appeared to suffer primarily from homelessness rather than psychiatric disability, although they had records suggesting mental illness. Consider this initial contact between Francesca, a white social worker, and a young African American woman referred by a street outreach team. The woman, thin and with tattoos on her neck and arms, stood quietly while Francesca looked her up in the system. Unlike the non-profit FSP teams that received state funds, the directly operated county clinics were required to screen people who came in or were referred. Thus, Francesca had gotten used to having to deal with people she didn't believe to be truly ill.

Looking at the woman's records from the IMS, Francesca noted a series of codes and said to the woman that FSP is for people with *severe* mental health needs, with many hits in the hospital or jail.

"Jail, that's me," the woman said softly.

Francesca explained that she was not appropriate, and Betty the nurse told her how to get to the walk-in clinic, where they see people with lower-level needs. After the woman left Francesca showed me the chart and said, "This code is for depression. This is for no diagnosis, so is this one. You know what that means? Axis 2 [personality disorder]."

Vic, a psychiatric nurse, chimed in, "Yeah, all those 'no diagnosis' means she is full of shit."

Francesca said, "Yeah, I really laid into [referring outreach worker] in the email. She said this woman has bipolar, schizophrenia, and signs of depression..."

Here Francesca's "inter-organizational knowledge" (Emerson 1991) of the use of "depression," and "no diagnosis" in the clinic, hospital and jail settings gave her hints as to the reasons for the outreach worker's referral, and she rejected it. In ongoing clinical care such workaround diagnoses are of little consequence, but in the referral process it can create considerable confusion and even anger. Here Francesca's project was not only to read the signs from the potential client, but also to try and interpret previous bureaucratic records and the scheming of other workers.

There was a personal side to this, as well. Francesca's mother suffered from psychiatric problems, and was having financial difficulty paying rent. Since her mother was not chronically homeless, however, Francesca could not secure her a specialized housing voucher for the mentally ill. The regular Section 8 wait lists were purportedly 11 years long. Francesca was upset that FSP, designed for serious mental illness, sometimes helped people who were primarily suffering from social problems or addiction. Francesca felt her true role was to treat the mentally ill, yet there was pressure from both above—instructions from higher ups to accept street outreach cases from contested areas—and below—being flooded with referrals containing vague diagnoses—that encouraged her and the FSP to enroll non-appropriate people.

Francesca carried this attitude when she was called upon to evaluate people on Spring Street. Given her concern with accurate diagnosis and screening out malingerers, she tried to create "controlled" settings by bracketing out the resource linkage dimension and its perceived incentivizing of disability. She explained to me that we should not tell anyone that the FSP program had housing vouchers. "That way," she said, "we can know if they're really appropriate for our program or just faking." This attempt to "purify" such interactions rarely worked, however, for other workers like Danielle had often already informed people that the intensive treatment team had the resource.

This was in addition to the team screening referrals from both the jails and the Institutes of Mental Disease (IMD's). Consider a concurrent outreach at the courthouse, referred by a public defender. I shadowed the community worker Carla, who, like Francesca, believed that some inappropriate people were trying to gain access to FSP's resources. The public defender noted the referral was one of her favorite clients, a sweet guy who "can do well compared to a lot of people." I will not describe the evaluation or the man, as it was not a public setting, and incarcerated people cannot fully consent to participation. Most crucially, from Carla's perspective, he seemed to have an intact memory but said he could not remember why he was in jail. To her, this meant he was either lying or it was all drug related. As we left she said, "He wants that get out of jail free card."

Back at the office, Carla told Lauren and Betty that she didn't think he met criteria. Lauren ran his integrated service number. Just going off the codes, she determined that he had no hospitalizations, and only mental health contact in jail. "Psychotic NOS [not otherwise specified], Mood Disorder NOS, paranoid schizophrenia." Betty said with a suspicious glance, "Well those other ones [make sense], but I'm surprised they gave him schizzz [schizophrenia]." She agreed, though, that his claim not to remember why he ended up incarcerated indicated a con to get out of jail. "You know what time it is!" she laughed.

Here again, they must work through considerable ambiguity. Carla lacked advanced training, but had some lay expertise through having worked in the field for several years. The trained clinicians—a psychiatric social worker and psychiatric nurse—must trust her opinion and attempt to corroborate it with the man's records. They view the jail mental health diagnoses as unreliable, but this variability also meant it was hard to interpret. Alongside the workaround diagnoses like “mood disorder NOS,” there was a highly consequential one—paranoid schizophrenia. With precious few slots, and current emphasis on the homeless outreach, such a person appeared not to be a priority.

The Federal Sequester, “Public Safety,” and the Definition of Success

We won’t solve homelessness, but the one thing we can do is improve public safety.
-Sean, councilman’s representative

By March the Chinatown representatives were livid. Connect Day had come and gone, and the encampment remained. At this point the outreach workers had repeatedly established that many of the “truly ill” did not want services, a handful had been referred to places like FSP and another housing agency, and those others who wanted housing would not qualify. Those latter people, in turn, did not want the few resources like winter shelter made available to them. Despite what one Task Force member estimated as two million dollars worth of outreach and street cleaning, they still could not justify the desired police sweep of the Spring Street encampment.

What’s more, the plan for housing the few people who might qualify for the specialized vouchers was falling through. The Federal Budget Sequester of 2013 effectively froze the processing of housing vouchers that had not yet been initiated. If the plan had been to shift from policing to mental health outreach tied to housing, now there would need to be a new plan until the national austerity measures were lifted. This was not the first time that federal or state budgets affected dealings, and it would not be the last. The problem was, as one official had previously said, far bigger than Spring Street.

Harold told the Task Force that the issue was essentially out of local government's hands. "We need a change in national policy where we say that no one can be homeless." With the Federal sequester and budget cuts, he said they would have to be more efficient and creative with the resources available. "Without a national social policy commitment," he added, "there's not much that can be done."

Eva from the Board of Supervisors' office responded, "Yeah, but this is about public safety."

"They [law enforcement] can't handle social problems," Harold pointed out. "They have a judge telling them and clarifying what they can and can't do."

A sheriff's deputy concurred. "We're bound by Jones v. City and the Lavan case. Jones says you can't do anything without a place for the person to go, and Lavan says you can't touch their property."

A psychologist who worked with the sheriff's department spoke up. "I don't want to offend anybody, but I believe agencies are pushing the homeless onto each other." She'd even met people who were also being displaced to LA from other cities and states. Furthermore, the county psychiatric hospitals were "flooded." "What," she asked the room, "does it say about us as a society?"

Such grand rhetorical questions were not answerable in a political meeting. Eventually a representative from a city councilman's office got down to brass tacks. "What is our goal? We won't solve homelessness, but the one thing we can do is improve public safety. Let's clean and have Officer Drucker come through." The new plan, then, was increasing the frequency of sidewalk cleanings on Spring Street. A representative from La Plaza, a Mexican American cultural center, said that she needed the area cleared out soon because she had a major fundraiser.

Some outreach workers became upset at the prospect of being party to a simple street clearance project. A DMH homeless outreach worker told me, “We’re just here to justify the police.”

I asked if he felt used, and he nodded.

“Yeah, but if you’re gonna use us at least give us some resources.” Without those vouchers or other material goods, they were simply outreaching people with nothing to offer. Yet what else could they, or the Task Force at large, do?

First, the legal ruling prevented the policing of the encampments. Then, they learned DMH could not coerce even the obviously mentally ill. Now, permanent supportive housing for even those who qualified was temporarily suspended due to Federal austerity. Outreach workers instead focused their efforts on the construction of a highly detailed contact log demonstrating that they had referred people to DPSS, the DMH clinic, or another agency.

For some time they continued to refer people to the main clinic, suggesting that people might receive housing there. Yet that clinic was similarly impacted by the budget sequester, so this was directing people toward a dead end. Without the resource for actually housing people, there was a significant organizational goal displacement—not securing mental health treatment for the mentally ill, nor housing the homeless, but merely documenting contacts.

The concern for public safety was echoed on the street, although it took on a more conspiratorial tone. Gottfried, an older white man living on Spring Street, claimed the police were not enforcing any basic rules. Although he had moved there because the police bothered him less than on Skid Row, he was now convinced they were deliberately allowing the area to become dangerous so as to eventually justify a large sweep. He said he had complained to an officer about a group of drinkers down the block, with the officer responding that he was unable to do anything.

Some DMH workers grew frustrated and got on board with the project of pushing people out. I observed the following interaction when Shane, the DMH outreach worker, confronted Gottfried. Shane was baffled that the Spring Street encampment still stood. Unlike those who did not believe it right to clear people out without resources on hand, Shane did not see any conflict between being a mental health worker and instructing people to scatter. He approached Gottfried and asked why he had not left.

"So tell me sir, I'm curious. You describe this place as being such a-

"It's going downhill cause the cops are letting it," Gottfried replied.

Shane shrugged. "So why stick around?"

"Where do I go?" Gottfried asked. "This was a nice sweet spot, if the cops would do their job…We want to get away from Skid Row… "

Shane replied, "Well not here."

Later that day Shane told me he did not believe in perpetual outreach, so long as workers had made a good faith effort at assistance.

> Well they've been doing this for how long? You have to sit there and try to give them real help, not just go through the motions. But a time has to come when the results are not productive, cause people leave but new people come in, we have to try new tactics. And one of them is to force people out.

Thus, while some mental health workers believed themselves to be a countervailing force to policing homelessness, others felt their mission aligned in a project of street clearance.

For DMH workers like Shane, Spring Street's "regular" homeless people were not a primary concern. Indeed, they were a distraction from the chief mission: finding the mentally ill and securing them treatment. This had become clear to me when Mona and her HOME teammates arrived to see that some people had apparently moved around the corner. When I asked if we would follow up and look for them, as we had spent months getting to know them, Mona said they might do that for the severely mentally ill. Otherwise, they were assigned to Spring Street *the place*, not the people on it.

Two months after Shane and Gottfried's conversation, I arrived to find that the police had finally cleared the Spring Street encampment. This was due neither to securing people housing and treatment through DMH, nor convincing people to leave on their own, nor some change in the law at the court of appeals. Spring Street had finally become a "public safety" concern. Whatever the truth of Gottfried's conspiracy theory, the lack of police intervention seemed to precede new levels of violence. One of the LAHSA workers claimed that she called the Sheriff's office when a large homeless man threatened her, and they never responded. There was report of a stabbing, and when I arrived one morning the street was empty. I spoke with an older white woman who traveled around with her pets. She told me that Gottfried had gotten scared off, but many of the others would still come by to sleep near the church at night.

A pair of LAPD officers sat in a parked police car on the corner. They explained that they were assigned to sit there the whole day, but nothing had happened on the street since the stabbing. The homeless people on Spring Street, both the "truly ill" who refused service-linked housing and the non-qualifying, had moved their tents around the corner to a neighboring park. Soon after the Spring Street outreach team members returned to their regular duties.

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The eventual clearance of Spring Street via a return to policing punctuates the question of "outcomes" for treatment provision in this context. What was "success," and for whom? The DMH outreach workers made a good faith effort to find the "truly mad," yet respected people's right to refuse. Other workers tried to help the marginally ill get diagnosed, but also worried that the pathology would not be severe enough for housing qualification. Long-term providers in turn accepted a handful of placements, but did their best as gatekeepers to reject the marginal cases sent by the outreach teams. More than anything, they had established a holding pattern. There was a clearer success for the Chinatown business owners: with the development of violence and a "public safety" framing, the police came back to push people off the street.

From the perspective of studies of urban marginality, we can read this as the impossibility of addressing homelessness with treatment. As Harold argued, the problem was structural and dependent on Federal resource commitment—when the austerity measures set in, even the plan of housing people through mental health services fell through. The Task Force members also recognized that clearing the street with police was not a true solution—a representative from a neighboring park complained that displaced Spring Street people moved to his property. For our purposes, however, it is hardly surprising that mental health providers cannot resolve urban homelessness. Sociologists have long argued that psychiatry and medicalization, like policing and criminalization, cannot address the broader problem of poverty.

Yet for this dissertation, and from the perspective of understanding safety-net mental health care, this outreach offers a number of key insights. This chapter has shown how LA county public mental health care is entangled in projects far beyond providing medication or psychotherapy. What does the task of managing homelessness in Downtown LA, the "homeless capitol of America," mean for care? Let's return to the three dynamics of the construction of illness, client choice, and ambiguous definitions of success. By showing how these interact in Downtown LA's context of street clearance, this chapter also lays the groundwork for elaboration in subsequent chapters focused on long-term care, and their contrast with the elite private services for the wealthy.

First, labels here largely circulate in a *diagnostic economy* in which survival resources such as income and housing are tied to official bureaucratic designations. Under some circumstances, psychiatric diagnoses have the potential to channel people into new life opportunities. This instrumentality, however, also creates a general suspicion that people may be malingerers. Second, *client choice* here is understood through the lens of the right to autonomy and rights to refuse treatment. Psychiatric labels cannot generate action on their own, as it also requires consent in the absence of dangerousness—some severely disabled people simply avoid care. Third, the fact that psychiatric services are present under the auspices of various projects to remove encampments begs the question: is success treating the mentally ill, housing the homeless, or simply getting rid of undesirable people?

For workers like Marlon, the fantasized solution of an "animal shelter" to manage the non-compliant seriously mentally ill speaks to the legacy of the asylum and helps us theorize the form of public psychiatric power. In another era, Marlon might have simply put people in state hospitals. Today they are statistically more likely to spend time on the street or in prison (Lamb and Weinberger 2005). Psychiatric power here cannot repeat the asylum era tactic of mass institutionalization, for this is neither legally acceptable nor materially feasible without the hospital infrastructure. Instead, psychiatric power works to channel people into and out of resource pathways, dependent on *voluntary* action.

Yet if this means that psychiatric power is less concentrated and potent, it is also surprisingly dispersed: all sorts of people who might not have engaged psychiatric services end up in DMH clinics in search of housing and SSI. It is in this context of *urban poverty governance* and resource constraint that public mental health must attempt to address psychiatric disability. In the next chapter I describe the ecology of intensive private services in West LA and how people enter into care, and the contrasting puzzles and practical problems that mental health must solve.

Chapter 3

Getting Better Together

In this chapter I map out elements of the private care ecology. Without a central, shared effort like an encampment removal, I begin at some key places where stakeholders meet, such as National Alliance for Mental Illness (NAMI) meetings, and then introduce a series of cases to illustrate the dynamics of elite care. I organize the chapter by explaining how people come to places like the Actualization Clinic, and the key question of access. I then ask what money can buy, such as highly specialized care, personable workers, and reputational management for families. I also explain what money can't buy, namely "compliance" with treatment and legal control over a person who is within their rights to choose their own care. I will argue that mental health work here is often bound up in a larger project of *family systems governance,* with providers working not only to process or transform the individual client, but also to satisfy the relatives—often the actual paying client. Working *with* the family system, care is explicitly relational, and about helping people and families to *get better together*.

At times treatment providers govern patients *for* the family, such as bringing someone under control or occupying their time. In other cases they govern the family system itself, when providers perceive relatives as part of the problem. Intervening in a series of longstanding familial relations rather than the local politics of urban space, the Actualization Clinic and their collaborators have a different task than DMH. Rather than constructing clients as a public menace or nuisance, they are like a spoiled adult child, a threat to familial reputation, or simply not fulfilling their potential. In place of the biopolitics of managing a population, these providers work with individuals in family systems that must grow and transform as a unit.

Hopeful Futures at the NAMI Speaker Series

The National Alliance for the Mentally Ill speaker series, held monthly in a community center, attracted families from across Los Angeles. I arrived one winter evening in 2015 to hear the testimonies of service users who were in “recovery” from serious mental illness and living full lives. I helped set up the chairs around plastic tables, and introduced myself to some families as we passed food and chatted. The Family Services Coordinator at the Actualization Clinic, Joseph, made the rounds and introduced me to people around the room. Leonard, one of the speakers who I knew from card games at Actualization’s social group, waved and brought me to meet his mother. She wanted me to know that Actualization was the key provider that helped Leonard turn his life around after years of repeated hospitalization.

Zara, the local NAMI president, addressed the crowd by speaking first of her own struggle with an ill child and the needs of community at large. “One in four families in my neighborhood has a member with a mental illness, with anxiety, depression, schizophrenia, bipolar, so many ways that the brain goes awry.” From her experience, she learned that “people need therapy, medications, and an educated supportive family.” That education is what NAMI could provide, such as courses on the biology of mental illness. Turning to the panel of speakers, she said they were “four heroes and a heroine.” They had survived immensely difficult times and were now giving back to the community.

Leonard opened the presentation with his story of recovery. A Jewish man in his late 30s, Leonard cracked a wide smile as he looked up at the crowd. He had been a successful student at an elite university, planning a career in investment banking, when he suffered a psychotic break while studying abroad. Thus began a long saga in and out of more than twenty psychiatric hospitalizations and various programs. The cycle had only stopped a few years ago, when he began the Intensive Outpatient Program (IOP) at the Actualization Clinic. He had not been hospitalized since, and was working a part-time job.

Reading from his prepared notes, he said that the program had taught him to understand his symptoms and offered a series of tools for coping in everyday life. For instance, they had taught him the notion of performing an "opposite action" to what he was feeling when ill. When he felt like staying in bed, he'd learned, that was the time to go workout. He thanked Actualization as a whole but pointed to Joseph as the person who helped him the most. Joseph, who stood in the back of the room in a black suit jacket, t-shirt and jeans, crossed his arms and beamed back. Although Leonard had to give up his dream of a big money career, he said he had become a better person through his struggle. "I lost my mind, but I gained my heart." He was now beginning a new journey, pursuing a Masters degree in psychology. He hoped to help other people diagnosed with serious mental illness, and perhaps work with the elderly.

Geraldine, a woman in her late 30s who spoke next, once had plans to become an actress. But she began to experience what was diagnosed as mixed-states bipolar disorder, where she could have a manic anxiety in the middle of an intense depression. She returned to living with her parents in her 20s and began to drink heavily to dull her pain, which she said caused her medication to stop working. She attempted suicide and her friend called 911, landing her in the psychiatric ward. There she came to see that disease was separate from her, and she learned that it was a biological disease like say, diabetes. While in the hospital she realized that there were others going through the same pain as her, but on the streets and without resources. Imagining how difficult that was, she begin a journey to help others.

She started to volunteer at Step up on Second, a non-profit mental health agency, teaching creative writing to poorer mentally ill people. She then got both a Masters in pubic policy and one in social work. She instructed the audience to volunteer, because it gave her a whole social network. Additionally, she says that it gave her an answer to what she called the "what do you do" question—a painful query when one spends the day on the family couch. Now she could say, "I volunteer at Step Up." From there, she moved on to paid employment in the mental health field.

The next two speakers addressed the various kinds of treatment that they'd been through, from intensive drug rehabilitation in Utah to meditation, self-help, and organic healthy eating in an LA sober-living home. One spoke of his recent experience in a new program near the beach that specialized in clean eating and juice cleanses, and how he'd even been able to titrate off of his medication with the intensive holistic regimen. They used 9 holistic steps to transform the mind and body, and daily affirmations to remain positive.

The final speaker was Dev, a South Asian American man who some in the room knew primarily as a clinician. Like Leonard he'd been successful in college until he began to suffer strange thoughts, went to the psychiatric hospital, and was diagnosed with schizoaffective disorder. Upon exiting a hospitalization he was stable, but could not think clearly. A neuropsychological test revealed profound deficits, and his doctor explained no medication could help in this regard. For Dev, with a professor for a father and high-achieving relatives, this was devastating. “In Indian culture,” he said, “your whole self-worth is tied to education.”

He pointed to Joseph in the back of the room, and like Leonard, said that the Actualization Clinic was special compared to what he had seen in the mental health system. Joseph in particular made the difference. “Meeting Joseph was the first time a person cared more about me than just a job, really cared about me getting better.” What Dev found especially helpful was that Joseph focused on “abilities rather than disabilities,” and looked for what one could contribute to the world. Learning that Dev had played college tennis, Joseph took him to the courts. Dev recalled thinking, “what good is tennis if I can’t have a real life?” He didn't want to do anything or leave the house, but Joseph pushed him into healthy activities and a routine, not accepting that Dev wasn’t ready. “Readiness,” Dev said, “is in hindsight.”

He began volunteering at a senior center, and someone told him he was talented at care work. Dev said, “I thought to myself, maybe there is still something I can offer the community.” Dev returned to college and finished his degree. Then, with assistance from his family and on campus disability services, he pursued a Masters degree in social work at a private university. Now he ran a business as a life coach for others with similar struggles as his own, collaborating with Actualization while drawing on both his “lived experience” and his advanced clinical training.

Zara took a moment to introduce Joseph and the Actualization Clinic to the audience. “Leonard and Dev,” she said proudly, “got their lives back.” She explained more about the Actualization clinic’s special approach, which was to meet people in the community and fill in gaps not only in treatment, but life activities. Dev added, “The research tells us that the key is one special relationship, and for me it was Joseph.” Joseph accepted the compliment but deflected the attention from him back to the speakers. He said, “They’re the ones who did the work.”

There was an air of hopefulness in the room, as people probed further into these stories of recovery from serious mental illness. A young white woman, holding her mother’s hand, shook and appeared on the verge of tears when she asked Geraldine’s advice for how she managed self-hatred. Geraldine explained that many of the outward markers of success, such as her marriage and her advanced degrees, had not helped in the way she expected. Meditation, on the other hand, allowed her a period where she was not focused on such thoughts. Another speaker also described breath-work and other holistic lifestyle practices.

One of the audience questions that night, however, addressed a dilemma beyond finding the right treatment providers, a strong relationship, and healthy living. Marsha Tanaka, a Japanese American woman in her 50s, raised her hand. I knew from speaking to her that she paid for the Actualization team and a $7,000 a month dual diagnosis sober home, but was still struggling with her 25-year-old son, George, diagnosed with a psychotic disorder. Her situation pointed to something crucial: even with access to high-end treatment, her son did not want it. “All of you have insight into your illness,” she said. “Was there a turning point?” By this she meant that each of the five speakers understood and agreed that they were mentally ill, and she asked about different ways to keep non-compliant people medicated, like antipsychotic injections instead of pills the person would stop taking.

Dev agreed that “lack of insight” was a primary difficulty. He’d trained with Dr. Xavier Amador, a psychologist who had pioneered an approach to help people whose neurological impairments meant they could not know they were ill. Since a person’s brain dysfunction prevented awareness of illness, it was no good to try to attack it head on. “You can’t go with the “medical model” approach, telling someone they have an illness and providing psycho-education,” said Dev. “They’ll just say ‘fuck you!’” Given the strong patient rights in California restricting forced care, they would have to engage their son differently. Rather than telling someone that they had a mental illness and forcing them into treatment, which might be counterproductive and legally challenging, they could use an approach called LEAP: Listen, Empathize, Align, and Partner. In essence, Dev advocated working with a person with impaired insight on what they perceived as their needs, and slowly convince them to try medication.

The “impaired insight” concept remains controversial, with critics suggesting it silences patients’ legitimate disagreements with diagnosis or treatment, and lacks a sound scientific basis. Yet as practical shorthand, it summarized what was particularly frustrating for the Tanaka’s and some other families at NAMI, and showed the apparent limits of what money could buy. What good was all this expensive treatment if George didn’t agree he had an illness and didn’t want the psychiatric care his parents offered? Whatever the scientific basis or definition of “insight,” the legal empowerment of seemingly irrational people bridged the massive social chasm between "service dependent ghettos" like Downtown Skid Row and the private clinics of West LA.

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That night at NAMI, the speakers in successful mental health "recovery" all shared three things in common: access to private care, family involvement, and an eventual willingness to try treatment. Access, I'd learn, was complicated. While the wealthy could afford to simply pay cash, other families would spend months convincing private insurance providers only to be denied or covered for alarmingly brief treatment. Providers like Actualization would occasionally provide scholarships, but more often would refer people to in-network or public services. That three of the five speakers had or were pursuing post-graduate degrees spoke to the upper-middle classed definitions of success and recovery.

Both Leonard and Dev singled out Joseph from the Actualization Clinic, saying that it was the personal relationship they built that helped them the most. One of the key things private care can offer is personal time and connection, with relationships that aren't bound by bureaucracy. Additionally, as Dev mentioned, "readiness is in hindsight." Joseph pressured him to get better, and Dev was grateful that he'd been pushed beyond his original willingness. This pressure, after a period of struggle, was later seen as care. The public display of affection wasn't mere advertising for the Actualization clinic. I'd come to know Joseph's kindness and humor as one of his doubles partners at a local tennis pickup game, where he introduced me to former clients with whom he still played.

At another NAMI meeting I heard parents describe taking their adult child off of private insurance to try and qualify for services through the public and non-profit system. Insurance companies rarely pay for community-based treatment that is in some sense non-medical, such as Assertive Community Treatment-style outpatient case management. The FSP programs funded by the California Mental Health Services, delivered through the county and non-profits, are supplemented by the state millionaires tax because many of the services cannot be billed to Medicaid. Families often must choose between going onto public services that they imagine as deeply inadequate or frightening, and private care that includes substantial out of pocket expenses because insurance will rarely offer comprehensive coverage. For those who could afford it, there were myriad options.

Yet Marsha Tanaka's question about insight and how to get her son to participate in treatment cast a shadow on the hopeful mood, and helps us see the way this chapter contrasts with and compliments the previous. The contrast is striking, in such terms as the personalized care, beach side treatment homes, and specialist doctors that come with money. For many in even the upper middle class, Actualization-level services were a financial burden, yet the Tanaka's did not want their son to enter public services. They were in fact going into debt to finance private care for their son, but saw no other option. The overlap with the other ecology regards the fact that George did not believe himself mentally ill, and did not want to be in treatment. Yet rather than abandoned to the street, or in a program that merely kept him housed, his family was financing an intensive treatment regime with "healthy activity." In a painful irony, the Tanaka family was going into debt for treatment George reportedly found oppressive, causing great family strife.

Let’s take a closer look the Tanakas, whose struggle illustrates the larger dynamics at play. Trying to both control and protect her son, Marsha and her husband Arnie had to learn the ins and outs of California mental health law. With the help of Actualization and other providers, they’d begun to interact with George in a new way, and were able to offload work to these organizations. In addition, their story illustrates the way social class, in both its material and cultural manifestations, enables and constrains what is possible in this project of governance. The Tanaka’s help me explain how care in this ecology unfolds as a project of *family systems governance*. While poorer families at NAMI no doubt try to work the public system for their relatives, and even the socially disconnected homeless clients of Downtown have occasional family involvement, the family plays an outsize role in elite private care. This is because they are often the paying customer, and thus can influence the direction of treatment.

Hearing both the “success” stories and the horror stories of NAMI, people like the Tanaka’s must project their hopes and fears into the future: would their son be like Dev, Leonard and Geraldine, speaking of their recovery and successful careers at a NAMI meeting, or a psychotic street person on Skid Row or Venice beach? Despite the many gradations in between those extremes, the Tanaka’s had reason to believe their son might become the latter. In the next section I tell their story, which serves to illustrate some of the more general dynamics at the Actualization Clinic and its ecology.

Managing the Adult Child with “Impaired Insight”

Arnie and Marsha Tanaka invited me to their home in West LA, where we ate pizza and discussed our respective roots and connections with Japanese American communities in California. Their house is modest, yet like much property in the area it is valued at over a million dollars. They explained that their son, George, had become hyper-religious while away at college on the East coast. Arnie at first thought he was just dealing with stress, but found George's statements increasingly bizarre. George decided to leave college and come home to help tend to his elderly grandmother, but contributed little to aiding her. He became increasingly preoccupied with God and began banging on the walls of his room with tools. His parents didn't know what to do, but given advice from Marsha's friend, who had a similar experience with relatives, called 911.

Although the friend told them a "5150" [emergency psychiatric hold] call would be discreet, Marsha said the reality was far from it. "They sent six cop cars, all lights, sirens coming down the block and I'm thinking, "I thought this was supposed to be quiet?" While this initially worried them that such a display might escalate to a scary situation, the psychiatric hold was actually dead in the water. Like many who did not know California's LPS laws, they were shocked when the officers determined George was neither dangerous nor gravely disabled, and therefore entitled to his right to refuse care.

> Marsha: They said, "There's nothing we could do, because he's not harmful to himself, to others, all that criteria." I said, "There's eight cop cars out here and you can't do one thing? You can't take ..." "No, ma'am, I'm sorry we can't do that." I just said, "This is ridiculous." I just walked back into the house.

> Arnie: That’s when you feel like, you’re hopeless. It’s like my God, you can’t do anything?

The police eventually got George to leave. Yet kicking him out of the family home for the first time, his parents found they could not “hold the line” and keep him out. They weren’t prepared to leave him to fend for himself. As Marsha explains, “That was like a Thursday night. Then Friday night he came back and we let him back in the house. Because we didn't know what else to do.”

It came to a head when they hosted a party at their home, and George had returned to his bedroom to bang tools on the wall. Arnie described it as surreal and like a television comedy of errors, where he had to keep his guests outside, unaware of the drama inside, while figuring out what to do with his son. When he called 911 this time a sympathetic law enforcement officer worked with them to construct George’s behavior as dangerous, as they could claim the wall might fall on someone.

> As I'm talking to the officer, he goes, "well, there's nothing ..."I'm going, "Oh no."…I just mentioned, "Well, he's pushing that wall down." [The officer] just jumped on it. The police officer wanted an excuse. He jumped on it. I just thought, "Oh, thank God." That's how they took him away.

The officer helped initiate a 5150 hold and took George to the hospital. After a brief time at Harbor UCLA, he was transferred to a private hospital for two weeks.

The Tanaka’s found their experiences with the hospital system equally frustrating, however. Marsha called and was told that the hospital could not disclose what was going on with their son due to HIPPA regulations. Despite this, they were responsible for him financially, as he was on their insurance, and they first had to meet a $10,000 deductible. Upset that they were simultaneously cut out of the loop and financially on the hook, receiving various bills, they were further shocked when George was released from hospitals with no warning and directed to an outpatient program in Skid Row. At another point they found out he'd been staying on Venice Beach. As Arnie put it, describing George's brief forays into homeless life and the specter of Downtown Skid Row, "I mean it's close, you know you think that it's so far away. But it's like here we are I have a son that actually thought about it."

The standard procedure of treating a man in his mid-20s like an adult—protecting his medical information, not disclosing his whereabouts to his mother, and letting him choose to go to an ostensibly dangerous part of town—was experienced by the family as harmful. This speaks to the more general transformation since the civil libertarian turn in mental health law, treating families as antagonists to patient rights. This is a common complaint of families as they deal with both public and private hospital services, which routinely cut them out unless patients agree. It also contrasts with the treatment the Tanaka's found at NAMI and then paying for Actualization services, where their needs were prioritized.

Constructing Privileged Non-Compliance: Anosognosia and Affluenza

Marsha told me Actualization was invaluable in helping them through a crisis when George disappeared. He had sold his car and flown to Puerto Rico, where he purportedly believed the Tanaka family were royalty and he had to educate the locals. At a loss, the Tanaka's deferred to Richard, the director of Actualization, who calmly coached them through the scenario. He advised them when to send George money and when to withhold it, mediating and eventually convincing him to return. Unlike the hospital, Richard worked collaboratively and kept them in the loop. During another crisis, Richard walked them through a plan to take George in for a brief meeting at a hospital Richard trusted, where George was committed. Richard then helped them "hold the line" when George called and pleaded for them to get him out. It was especially painful when they had to keep him out of the home, and restrict offers of help and resources.

Richard had developed this type of expertise—working with clients who didn't believe themselves ill, managing parental anxiety, and creating systems of behavioral incentive—through years of trial and error. George, Richard told me, was an *"anosognosia and affluenza"* case. The "anosognosia" referred to George's lack of insight into his illness. The "affluenza" referred to a common issue for Actualization clients who came from class privilege: without appropriate boundaries and expectations, people like George were spoiled by entitlement. Richard pointed to the fact that George simply assumed that if he sold his car to finance his Puerto Rican journey his parents would buy him a new one. Unlike some older psychoanalytic theories of the "schizophregenic mother," Richard didn't believe the family *caused* serious mental illness. Instead, the families had created situations in which patients never learned responsibility, and this was disastrous when the child grew into an adult with serious mental illness.

What kind of action does this construction—viewing a patient as suffering from anognosia and affluenza—authorize? On the one hand, if a person *can't* know they are ill, clinicians may act open minded about strange, seemingly delusional beliefs, in an effort to align. On the other hand, this construction of patients as obstinate or spoiled children, and families as enablers of poor behavior, allows Actualization to take on a paternalistic attitude and enforce order that the family has not. It is an affectionate care that is also firm, with the team "holding" the line where the family fails to do so. With a belief that clients have the potential to improve and live productive and meaningful lives, workers and families can justify sinking enormous resources into treatment.

In George's case, the Actualization team helped to develop and enforce a structured schedule in line with upper-middle class expectations. He moved into a dual diagnosis mental health and sober home and his case managers helped him enroll in community college classes. They monitored him, offered counseling, and found activities he wanted to do. Soon he was playing on a sports team, back to his old hobbies, and completing coursework. At age 25 and in school, George had the makings of a "successful" upper middle class recovery story, and the Tanaka family remained hopeful for George's eventual independence. Richard and the Actualization Clinic had been responsive to their wishes, and helped establish a promising regimen, although the Tanaka's confided in me that they were not sure how long they could sustain this—they had run through their savings and were borrowing from family. Furthermore, he had not gotten on board: they joked that he thought of the treatment home as like a "prison."

Marsha and Arnie, like other upper middle class parents at the NAMI meeting, could look to the presenters like Leonard, Dev, and Geraldine, as offering hope. These thirty and forty-somethings, like George, had entered crises during college and spent time in the hospital and private outpatient treatment. Either in careers or pursuing post-graduate work, they had learned to manage what they now agreed were problems of serious mental illness. Would the Tanaka's look back on George's twenties as a period of "failure to launch?" For now I'll pause at this moment of precarious hope to address a different question at the intersection of family aspiration, money, and client choice: if George had wished to stay in Puerto Rico or live on the streets of Venice Beach, and resented living in the $7,000 a month holistic sober home, what did it mean that his parents contracted, paid for, and directed his care through the Actualization Clinic? Put differently, I was trying to figure out who was the "real" client.

Who are the Clients?

At cash pay clinics like Actualization or their collaborators, when family members first contact the providers and foot the bill, a question lingers that shapes care in both subtle and profound ways: who are the clients? As Abramson (2009) found in a study of a nursing home, staff members often treated the elder patient as a problem to be managed, and the adult children as the "real clients." In private cash-pay settings, clinicians view this as indeed a problematic possibility they must guard against. As Joseph put it at one meeting, "when you feel like you're working for the family something is wrong." With family members paying thousands of dollars, however, team members were accountable to parents or siblings as much as the person who was in treatment. Alienating the family could mean the end of money for the clinic and treatment for the patient.

When I asked Richard what type of scrutiny the state of California placed on them, he explained that they were only accountable to the families. These people, he claimed, knew best whether they were receiving a good product, and he was in effect "audited" every two weeks.

> Yeah, it's called the mother and father are millionaires. You get people who have money, they are much better at watching the efficacy of their money than most people. That's why they've got it, so every few weeks I've got to send a millionaire dad running a major company a bill for a few thousands bucks and he wants to know why is he paying it. The reason he's paying it is cause he's talked to me several times. He's talked to the doctor. He's talked to the son and he feels really lucky to be able to pay the bill. I get audited every two weeks by everybody.

Thus, it was the family that one needed to justify expenses to, rather than the person in treatment, the government, or insurance companies.

Drawing on the vocabulary of family therapy, clinicians described how the "identified patient" was part of a system that was itself sick. Thus, to treat the individual required changing family dynamics. Again, the team did not believe that families themselves generated serious mental illnesses like "schizophrenia." Biological explanation co-existed with the family and psychosocial approach. What was key was that issues of treatment engagement and behavioral change for an underlying pathology like schizophrenia or bipolar disorder, or the meaning of particular symptoms, were linked to the wider family dynamic.

Deirdre, the clinical director of Actualization, had worked as a teacher and a social worker in Children's Services before coming to adult psychiatric care. When discussing a new case manager who had worked primarily with autistic children in Applied Behavioral Analysis, she explained that she believed working with kids was actually great preparation for Actualization's adult program. "So much of what we do," she said, "is actually re-parenting." She explained that some clients had a developmental age much lower than their chronological age, in part because of family dynamics. She pointed, for instance, to a thirty-two year old woman who still expected her father to provide all things for her. For Actualization to do their work, they would need to both address the woman herself and the father, who had enabled the daughter's dependence and pathological behavior.

And yet, there were also serious ethical issues when families were the paying clients. Generally speaking, the team informed clients that they had to sign authorization forms for speaking to parents or other paying relatives, and that they "do not hold secrets." For the case managers, who had trained as therapists and believed in confidentiality, this was potentially problematic. Consider two such instances at the Actualization Clinic illustrate this dynamic, when the quiet consensus was broken and team grappled with how much they were to reveal to those who paid the bills:

One morning case conference the team debated whether a husband should be informed of the content of his wife's therapeutic sessions. The key issue was whether the husband was paying, or they were paying together. Joseph, who coordinated with the families, noted that the wife didn't work, so it was the husband's money, and he was entitled to updates. Marlene, a social worker, responded angrily, "Just because she doesn't work doesn't mean it's not her money too. That's gross Joseph." He responded by looking at it from the husband's angle. "If it was my wife I would want to know [what was going on in treatment]." The team decided it would be best to talk with the wife, the identified client, before relaying the information to her husband.

Generally the case managers agreed with the policy not to "hold secrets," such as reporting if an adult child had stopped taking medication or relapsed on drugs. Yet one particular "secret" sparked a heated debate. A client in her early 20s had been bringing men from Alcoholics Anonymous meetings home for sex, unbeknownst to her parents. Yet when her case manager informed her they couldn't hold secrets from the parents, the patient said that she was scared of her father, who had hit her as a child. The treatment team argued about whether they would have to relay this exchange, as well as the sexual trysts, to a father who might be abusive. Was the client manipulating them? Or was there real danger? The tactic they usually settled on was to try and convince the client to relay the information him or herself.

To be clear, I do not mean to suggest that the paying family member is the "real client" in the sense that they can make nefarious demands that the team will simply adhere to. As I'll describe later, the team often viewed the families as negatively impacting the identified patient. The fact that the team took the ethical issues regarding "holding secrets" seriously shows this is a tension for them, rather than a decided manner. Yet this points to the profoundly different dynamics at play when a family has the cash to pay for and control treatment. While for families like the Tanakas it was a relief to be involved with providers who worked with them, as opposed to their oppositional experience at the hospital, this meant private clinics like Actualization had to serve two masters. From an organizational perspective, there was a simple relation of "resource dependence": if they wanted to continue treating a given client and receive payment, they had to appease those who were footing the bill.

Governing For the Family

In serving the families as the first point of contact and money source, Actualization had a different task than county services. Richard was sympathetic to the difficulties of public mental healthcare, but saw it as a separate undertaking. In orienting to families rather than bureaucratic auditors or city officials, Richard was tasked with reforming individuals rather than managing a population. Part of the difference was the shear scale and number of people to care for, and what possibilities there would be for that care. While he had some ideas for how public services might learn from his approach, he also knew it would be difficult to transfer practices directly.

> I don't have any illusions about that. I don't know what I would do if I had to take care of every mentally ill person in the city. I mean that is a whole different charge than a person coming in one at a time.

Rather than dealing with a mass of people who were a problem for the *city,* the Actualization team focused their case management on highly personalized care for individual people who were of concern to their *families*. With parents, siblings, or spouses as the paying client, and the identified patient often ambivalent or resistant to treatment, Actualization specialized in engaging and treating people on behalf of another party.

Richard explained that there were particular practical problems that arose when serving clientele from wealthy families, related to reputation, social capital, and the actions money itself enabled. The challenge of madness to the social order was different, because patients were recognizable, socially connected, and had the money to make things happen. He asked me to think of it in terms of who or what was affected beyond the individual patient.

> Who can do the most damage? The homeless person [can], to themselves. But it's gonna be one on one. A manic or psychotic person with resources and connections can do so much damage, you wouldn't believe it. To their family business, to their community…

Rather than an eyesore on a gentrifying street corner, here the patient might be a liability for the family's material standing and reputation in the community.

In addressing these specific needs, providers govern the identified client *for* the family. As noted above, there could be ethical conundrums when the treatment team refuses to hold secrets, or pushes courses of action that may be at odds with the desires of the patient. Yet the techniques of governance in a voluntary outpatient program are couched in a language of choice, and an aligning of the identified patient's goals with those of his or her family. We can see both the similarities and differences with Foucault's theorization of early private psychiatric hospitals as disciplinary mechanisms that coercively reformed and reinserted a patient into a family. At Actualization a similar goal of reform obtains, but the technologies of power are necessarily different because only a small number of clients are on legal conservatorships.

Dev, the former Actualization Client who now ran his own practice, explained that private pay services allowed for engagement with people who were, in legal terms, well within their rights to be left alone. In many cases the public sector might stop engaging such a person unless he or she became a danger to self or others. Families with a member who "lacked insight" into his or her illness were frustrated by the enforcement of "patients rights."

> If someone doesn't want to engage in the public mental health system, they're not pushed to engage. So especially with people who aren't aware of illness, they're not gonna come in… I mean, I have parents say, "They [public agencies] tell me unless my child wants to come in to get services, there's nothing I can do." And why is somebody going to believe they need help if they don't believe they have illness?

For those families who could not afford alternatives, the public care would only work when a person sought care voluntarily or eventually crossed a threshold of dangerousness to self or others. A person whose family could pay for private engagement was in a very different situation, however.

Dev believed that people were lucky to have families who could afford to push them through their periods of “insight-less-ness.” Readiness was “in hindsight,” as he’d said regarding himself, and the pushing need not occur in the heavy-handed form of direct coercion. Instead, it was about creative engagement and incentive structures to get people to try treatment. He explained, “In the private mental health system you can *create situations in which the individual is likely to comply* as a result of the work you do with the family [emphasis added].” These situations to generate compliance speak directly to the theoretical orientation of “governance” rather than simple social control. In an advanced liberal social setting that emphasizes rights and choice, and indeed institutionalizes patient choice in law, guiding people toward “compliance” through the structuring of possible action is both normatively appropriate and practical.

What Money Buys

In this section I present a series of paradigmatic cases that illustrate what elite private care can offer. Here clients engage in services voluntarily, or at least choose it over another option. In each I note that Actualization case management has the capability to tie the management of psychiatric crisis to a developmental approach—that is, not only keeping clients from danger, but also cultivating lives and giving people meaningful and respectable activity. I highlight the kinds of issues being problematized in care, as well as the solutions on offer.

A "Second Family" for Your Child

One thing money buys is time and the possibility for intimacy in intensive clinical relationships. For those families that can afford it, the Actualization Clinic had the potential to become a lasting, even permanent part of a person's support network. Like Leonard and Dev pointing to Joseph at the NAMI meeting, clinical relationships here were supposed to feel special. As I'd hear numerous clients say, the case managers were "like family." The following example demonstrates how the team could serve in place of family members, navigating resistance to treatment, emergency situations, and long-term cultivation of a person's life.

Bradley, a 36-year-old white man diagnosed with Bipolar Disorder, recalled his first visit to the Actualization Clinic at age 24. He was in what he described as a manic state and did not agree that he was experiencing an illness. He refused to listen to his psychiatrist and felt his parents were trying to dictate his life from afar, but for some reason the Actualization Clinic was different. Richard, in particular, put Bradley at ease and told him he had choices. Bradley claimed that, although it was years ago, that first encounter was fresh in his mind.

> I felt very controlled and felt like everyone's against me, and I shouldn't be here, and I don't need this. And Richard was like ... I remember the conversation very specifically. We were sitting in his conference room, he was like, "We don't want you to be here unless you wanna be here." And, "I think that there's something

> going on with you, something that we can try to kinda figure out." He really partnered, I don't know if you're familiar with that LEAP method? It's like Listen, Empathize, Agree, and Partner. ... I don't know how they got through to me but they somehow were able to reason with me when I was super irrational…and not having any family here, they're kinda like my second family now.

Notice that Richard's first move was to put Bradley in the proverbial driver's seat. The LEAP method, as described earlier, was designed specifically to work with those who lack insight into their putative illness. Rather than addressing Bradley's "impaired insight" head on by informing him he was mentally ill, Richard acknowledged uncertainty ("I think there's something going on") and partnered with him ("something *we* can try to kind figure out.") Drawing on LEAP, but also his own approach from years of engagement, Richard was able to "reason" with Bradley when he was "super irrational."

In part, Bradley said he was simply more open to working with the Actualization team than having his family members pressure him, because they were a third party. "It's almost like I would listen to Richard or Joseph more than my parents just because they're my parents." For the family living in another state, it was important to have someone watching over their son. This "second family" could offer the support and surveillance without the same feeling of control. When he had a crisis, the team was there to guide him through legal troubles, facilitate inpatient and residential treatment placements, and keep his family in the loop.

Bradley had tried to go off of medication several times, leading to a series of interruptions to his life and career. The “lowest point” of his life, he explained, was when he’d stopped medication, became manic again, and left a stable job in a bid to become an actor. Drinking heavily, he was arrested for driving while under the influence. Richard came to get him out of jail and arranged transfer to a private psychiatric hospital, and then Gateways, a private dual diagnosis residential that had a special program for Bipolar Disorder. There he learned more about his diagnosis and coping skills for both his alcohol use and symptoms, before the Actualization clinic moved him back to the community. Now he saw a psychiatrist he liked, in part because she did psychotherapy in addition to medication management.

When I got to know Bradley he was trying to work in the holistic health industry, and also sought training to be an addiction counselor. The team collaborated with his psychiatrist and parents to keep him moving forward towards self-management and an eventual career. Richard corresponded with Bradley’s parents, who were especially excited about how responsible he was becoming. Regarding their gratitude to the Actualization Clinic, his mother relayed that she and her husband had a recent visit to Los Angeles where he’d been far better at managing the trip than in the past. She noted that he’d picked them up at the airport, and took care of all the details like paying for the parking meters. Then he took them for a meeting with his psychiatrist, to discuss a “breakthrough”—he’d been able to track his own signs of elevation signaling mania, and that he wanted to work with the doctor and the Actualization team to control it. Additionally, she was pleased he was working at getting a job, and was staying on track.

Notice what Bradley's mother orients to. One dimension is medical, namely Bradley's engagement with the psychiatrist and "breakthrough" in recognizing the "elevation" that might signal mania. Yet beyond this psychiatric dimension, she orients to how responsible a *son* and *adult* he is—picking them up, taking care of the parking meter, and looking for a job. The father echoed his satisfaction later, when he suggested that Bradley was finally becoming the person he could be. "His mom and I are tremendously grateful for everything you have done to bring out the "real Bradley."

Bradley's case offers three important points. First, what money buys is the kind of time and relational skill such that treatment providers can become like "a second family." This family can serve as the eyes and ears of the biological family, who may live out of town or be viewed with suspicion by the patient. Second, money buys access to the team's tools to address crises like Bradley's DUI arrest, from their referral network of specialist lawyers, to private hospitals, to residential programs that specialize in Bipolar Disorder. Third, beyond negotiating crisis, the team works on things that might not be problematized in another clinic, such as Bradley's ability or inability to be a responsible son who picks his parents up at the airport. Thus, what money can buy here is treatment that goes far beyond psychiatric care or crisis management. Although Bradley has not been in a psychiatric crisis in several years, the treatment team continues to visit him and help with everyday life, and finding his passion and role in life.

Protecting the Family's Reputation

When I began fieldwork with elite private providers there was a marked concern with privacy, such as talk of non-disclosure agreements regarding client names. My approval from UCLA's institutional review board (IRB) and assurance of confidentiality were only partially assuaging. Conducting research at DMH required passage through bureaucracy, review boards, and allegiance to HIPPA standards, but there was no indication that a person's *name* had particular meaning. In the elite private settings, I encountered family lineages that were not familiar to me, but reportedly were well known in their particular communities. The following case illustrates Richard's claim about the damage highly resourced and socially connected individuals could do to their families. What money purchases here is treatment oriented not only to symptom management, but reputation management.

Adonis was a white man in his early 30s who came to the Actualization Clinic after a series of hospitalizations in the previous year. He was part of the insurance pilot program but his family also had considerable resources to pay for cash services and amenities, and had moved him between different cities and programs for years. Diagnosed with Delusional Disorder, he was convinced that celebrities were talking about him online and others were plotting against him. While the emergency triggering hospitalization had been a suicide attempt, the ongoing problem for the family was reputational.

Adonis had suffered his most recent psychotic episode after taking a large dose of the attention deficit disorder medication Vyvanse, an amphetamine. According to his case manager Norah, Adonis was convinced that people erroneously believed he was gay and possessed a small penis, and were threatening to expose him online for unusual sexual behavior.

> He thought all of these Hollywood people were in cahoots to stop him from being a famous actor because of his sexual deviance. When he started tagging the FBI, and famous people, and people he went to high school with, like "help me, they're trying to destroy me." It was going all up and down Facebook to the point his mom got his access code and was trying to delete stuff.

His mother, from Norah's perspective, was a woman obsessed with beauty, plastic surgery, and propriety. Adonis had previously thought a television was talking to him and saying he'd never make it in his dream job as a model and actor. This precipitated his first attempted suicide, but such crisis remained at the individual level. Norah explained that the family used their resources to keep their dirty laundry private, and had been able to manage other relatives in such a manner.

> They're Southern old money, rich white folks, a lot of mental illness, brother had narcissistic personality disorder. [The mother] clearly had some stuff going on. A couple family members with schizophrenia. But they always had money so they were able to play it off.

The problem, Norah explained, was that in an age of social media it became much more difficult to "play it off." Where other relative's behavior could be managed privately, Adonis' online activity made it all public.

> I think other family members were just sort of tucked away. But Adonis, because of social media, was more difficult to tuck away. Because his was so public and he was attacking people that they knew and he was young and doing drugs and throwing bricks through their window. And [Southern City], I don't know if you know, is a very small town. Everybody knows everybody, especially if you have money. So he would be doing all these behaviors and the whole town would just be like "ooh," aghast at his behavior and he was embarrassing them. And so he got sent away a lot. I mean, when he was younger, he was like a big meathead football player, he got mad at his girlfriend, I guess she was cheating on him. And busted the window of her car and beat up the other dude. And they sent him to a school in Costa Rica. And he should have gone to jail. He almost killed the kid.

For families with a great deal of money, this option of sending people to other states or countries could mitigate public embarrassment, or in this case, even arrest for attempted murder. Where another person might be incarcerated, they'd kept Adonis in the alternate social control circuit of international schools and now elite private psychiatric care.

As a high utilizer for the insurance company, and an embarrassment for his family, Adonis was enveloped in an enormous amount of outpatient care. He attended three days a week of a specialized Thought Disorder program at UCLA, and then transitioned to the Actualization Clinic's IOP. Living in an apartment, the treatment team visited him five days a week, attempting to impose enough structure to keep him on track. Norah worked to "reality check" him and keep him off of social media while symptomatic, responding to his text messages late at night or meeting on weekends.

Notice what is being problematized here, and at what threshold. Adonis' suicide attempt would garner attention in most any setting, but some of these other issues and subsequent interventions would make less sense. Consider the impact of having a *name* that means something in public. Where a homeless mad person's online ranting from a public library computer terminal might elicit a few raised eyebrows or concern, it might very well be ignored. Similarly, a family at a public clinic might be deeply embarrassed about a mad family member's behavior, yet would have a difficult time convincing clinicians to prioritize monitoring a client's Internet usage. Yet both Adonis' family and the Actualization Clinic saw his online behavior as profoundly problematic and worthy of attention. Like Richard said, a well-connected person could do enormous reputational damage in a way a homeless mad person might not.

"Providing that Net" for the Family

In other cases, a family might need the Actualization Clinic to create a buffer zone with the identified patient. Here money buys a net of care and activities to keep a person occupied, and for families in ongoing conflict, the treatment team could manage the contact. The following example is of a person who was no longer in serious crisis, but continued to receive intensive case management to "provide a net" for the family. Here again, serving the family need not mean doing anything oppressive to the client. Instead, what money buys is distraction and companionship to alleviate the stress of familial contact, even when the care might be clinically inappropriate.

Shelly was a forty eight-year old white woman who had been engaged in some form of mental health treatment for the majority of her life. Diagnosed with Bipolar Disorder, she had been in and out of treatment centers for years, with eight voluntary psychiatric hospitalizations when suicidal. She had grown up with luxury, the daughter of philanthropists, but struggled to find her place and had failed to establish her career as an actress. Shelly consumed an enormous amount of health and other services, and the team of people she assembled to attend to her—a renowned university-affiliated psychiatrist, the Actualization Clinic, a relationship therapist, massages, and a psychic—showed just what money could buy when a person voluntarily sought treatment. Yet I'd learn that the Actualization Clinic thought much of Shelly's care unnecessary, and more about distracting her from her loneliness and conflicts with family.

On a sunny LA afternoon Shelly and I sat by the pool in her apartment complex discussing her video reel of dramatic and comedic clips. She longed for the day she could show her brother and his wife, who didn't believe in her, just how talented she was. Shelly said her family had never believed in her, and she was waiting to finally make it big. Only her father, whom she idolized, had supported her and celebrated when she joined the Screen Actors Guild after a handful of minor parts. She was eternally grateful to Richard for telling her family that they didn't understand her and her talent.

When her father died, she wanted crisis care but did not want to go to the mental hospital. "I told Actualization, take me to Forward Steps." This is one of the premier

Dual Diagnosis rehab and mental health centers in Malibu, at around $50,000 a month. Although Shelly did not use drugs or alcohol, she found the mountain air, daily therapy groups, individual therapy session, farm to table food, and kindhearted staff offered her the care she needed outside of a psychiatric institution. “I’m never going back to a mental place,” she told me. “I’ll get 10 massages a week if I have to.” Although this was hyperbole, Shelly indeed had the money to surround herself with whatever companionship she wanted.

Upon exiting Forward Steps Shelly transitioned back to Actualization, who visited her to help with daily living in her apartment. With the money at her disposal, Shelly pursued a variety of avenues to happiness, such as going to Disneyland by herself for three days. More than anything, they believed, she suffered from loneliness and lack of purpose. While she had once been paranoid about people plotting behind her back, and occasionally suicidal, she was no longer seriously symptomatic.

This came to a head at one clinical team meeting, when Deirdre said it might be clinically inappropriate to continue with Shelly. They were not doing much for her beyond companionship, and Actualization services could be used to help others in more need. Yet Richard said that at this point it was no longer about Shelly: they were working for the family. As long as they were “providing that net and containing her” for the family, they should continue. Thus, in offering Shelly the attention and clinical companionship she desired, they were also serving the relatives.

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What does it mean to manage a client for the family? Fifty years ago, this might have meant dropping someone at a locked facility for years. Today, for those with money, there are key immaterial things to be purchased for community care. In Bradley's case, he'd entered care on his own terms, and had developed strong relationships with Actualization. His family uses the team for surveillance, managing the occasional crisis, and helping Bradley develop into a productive man. Adonis had been sent away to various institutional settings, and was now monitored by the Actualization Clinic to keep him off the Internet, occasionally hospitalized during crisis. Tracking his Internet behavior, they can try and keep him from embarrassing the family again. With enough money, Shelly can be in the community with only occasional returns to a higher level of care in residential or hospital settings. Rather than go to the psychiatric hospital when her father died, she voluntarily attended a dual diagnosis center in Malibu, despite not having an addiction. Here the categories that are so crucial to *sorting out the down and out* on the street are actually unimportant, and she receives treatment that is not clinically justified but is important as a buffer zone for the family.

Governing the Non-Compliant Family

On one of my first visits to Actualization, I noted my surprise at the high level of family involvement. A case manager laughed and told me that, ironically, the family involvement and money that facilitated Actualization care were also some of the greatest obstacles to treatment. In the cases of successful and powerful families, they sought expert advice but would not follow it. While at times the Actualization Clinic governs the patient *for* the families, acting as go-between, mediator, or in some cases "enforcers" (as one case manager put it), they also governed the family itself. This was because they saw the family system as largely determinative of the possibilities for treatment.

If, as Dev put it, private care seeks to "create situations in which the person is likely to comply through the work with the family," this ultimately relies on the cooperation of the family members to follow through. Actualization was proud to jointly advertise with success stories like Dev and Leonard, but the productive person with a gradate degree was only one of many outcomes. When they encountered difficulty in getting someone under control, they often attributed this to families who would not restrict money properly, in turn disrupting the carefully orchestrated positive and negative incentives that would help to normalize a person's life.

Thus, to govern the identified patient would necessarily mean altering the entrenched dynamics of the family as a unit. Consider the following discussion of Elon, a white client in his 40's diagnosed with schizophrenia, and his father, who "enabled" his self-destruction. Elon had been using crystal methamphetamine and continually psychotic, and the team first helped arrange for him to go to an intensive treatment program and then a transitional home. Yet with a gambling problem, substance dependence, and a penchant for purchasing sex, Elon often came up short for rent for his transitional setting. The treatment team had developed a system of incentives to keep him on track, such as an allowance predicated on clean urine tests and treatment compliance. Yet they came to believe that the biggest obstacle to change was not Elon, but his father, who "bailed him out" when he ran out of money and continually exposed him to his various triggers. In a team meeting, Joseph relayed their latest conversation.

> "The dad wants Elon to come to a family event with gambling and people who drink too much." Deirdre scoffed. "What a fool." The father apparently planned to give Elon $200 for the day at horse races. "That's like giving someone a heroin needle," said another worker. The therapist who had worked directly with Elon, agreed. "That's very dangerous for him." Elon had missed the annual family event the last year because he was in rehab, and Joseph considered another perspective. "To me it's a normalized thing—he's gonna be with dad and see the horses." Deirdre scoffed again. "Then go to the horse ranch." The therapist turned to Joseph. "I see what you're saying but he doesn't have the addiction under control, he's only 2 or three months clean." Deirdre said that if the family wanted to continue the horse tradition this year, they should just do a "healthy ride at the stables."

Here we see how the team's approach is stymied when the larger ecology, and in particular the family, subverts their incentive structure. Joseph's thought it might be helpful for Elon to resume a family tradition, and to do so without drinking or gambling would be a good step. Yet others saw this as a setup that would ruin Elon's precarious sobriety. They relayed to the father that this was a bad idea.

Later that month Elon gambled away his SSI check at a casino, and his dad planned to pay his rent anyway. One case manager said with a bitter laugh, "This was the guy trying to bring his son to horse gambling and drinking." Deirdre suggested, "Let Elon go to a shelter. Unfortunately, nothing will make a difference. Dad is gonna give him money.” Elon’s primary case manager was worried that Elon seemed suicidal. “I don’t think making him homeless… yeah, it could teach him something.” This time Joseph wasn’t on the fathers’ side. “But you don’t learn when dad bails you out. This has to be broken. Or dad will die and it’ll get broken that way.” They then discussed a plan to have Elon’s psychiatrist make someone else the SSI payee. Yet the next day, they were still scheduled to give Elon his $70 allowance if he met his other benchmarks around sobriety and treatment compliance.

If the providers are relying on shifting family dynamics for their larger intervention, parental “non-compliance” could undermine care as well. Elon’s dad followed instructions in starts and stops, holding the line in some cases, such as getting his son out of the house and into a transitional living, and “caving” in others, such as covering blown rent money. This example reveals both the team’s logic of care and control, and the way that family members could easily subvert this. As I’ll detail later, the team would use the threat of homelessness to teach privileged adult children the importance of compliance with treatment. Yet with a father agreeing to work within the team’s parameters and then repeatedly failing to follow through, the threats became empty. The team’s ability to leverage Elon into more compliant behavior only worked when they had convinced his father to follow treatment recommendations. Here, to govern *for* the family is dependent on governing the family itself. This brings us to the next section, which addresses what happens when both legal interventions and incentive structures fail.

What Money Can’t Buy

I noted above that money could purchase highly personalized care, with service relationships that resemble a "second family," monitoring of a person's behavior to protect the family name, or access to enormous amounts of services to keep a person distracted from their family. In these various cases the client might be ambivalent about treatment but then see it as necessary—Bradley, for instance, looked back on his refusal to cooperate in his 20's as a sign of irrationality. Yet what money ultimately cannot buy is control when the relational work fails, or a family continually funds self-destructive behavior. This also brings us back to the dilemma alluded to by Marsha Tanaka—it is one thing to have access to high end care, but another thing if the person does not believe themselves in need of psychiatric services, or does not like the services offered.

First I consider one family that had come to the Actualization Clinic repeatedly, beginning treatment only to drop out when the team pushed for "leverage." Unlike Elon's father, this family was unable to "hold the line" even temporarily and initiate the kind of intensive treatment oriented to reform and normalization. Second, I consider a case from outside of Actualization that illustrates the limits of the legal conservatorship system, as well as the destructive power of money. Here a man sought to control his brother and periodically had legal control, yet also sent his brother cash that fed an amphetamine addiction that amplified psychosis.

Family Cooperation

Kaye Crawford was a woman in her early 50s. Diagnosed alternately with bipolar disorder and schizophrenia, she had been in and out of psychiatric facilities for much of her life. Her father was a prominent physician, and the family had come to the Actualization clinic numerous times over the years. The case manager Greg reported that the Crawford's had previously secured a legal conservatorship over Kaye that required she take medication, but it was not renewed. The family found they could not control much of her other behavior. For instance, they had arranged for her to have a place to live outside of the family home, but she refused to stay there. She would frequently show up at the family home, asking to be let inside. The family would always "cave," allowing her back in and resuming their longstanding dynamic. Furthermore, they found that while she was inconsistent with her primary psychiatric medications, she had begun to abuse her benzodiazepine and amphetamines.

Greg reported he met with Kaye, and attempted to "align" with her, taking her to museums and simply sitting with her in the family home. He described her as child-like, a 6 year old in an adult's body. He explained that the team coached the family to not let her in. While the mother would agree to this, she always folded. "They might agree to it at first, but what about if she shows up and it's raining and she has a black eye?" For the Actualization clinic, the most important way to initially gain control over people is through "leverage." Patients can only get something they want in exchange for compliance. This might mean predicating housing, money, or something else on agreeing to both medication and behavioral modification. In this case, they wanted her to go into a residential setting that could attend to both the substance use and psychiatric symptoms.

> The recommendation was for them to stop supporting her, to really have it be like, "We will support you in this, which is inpatient recovery and then to sober living, and then moving forward along the spectrum, like we will support you if you participate in recovery." It became really clear that just visits from Actualization was not nearly enough, that she really needed some heavy psychiatric care. She needed to get on the right medicine and consistently, and she really was in a position where she was gonna benefit from really long term care. But she wouldn't do it. She wouldn't do it. She threw a temper tantrum and wouldn't do it, so we were coaching the family to like you have to have this be an either/or situation. You don't have to be angry or mean about it, but you have to say, "It's not good for you to live here. It's not good for us, so you can't live here anymore." The hard part is to get her out of the house.

Kaye's family, however, would not stick to the plan. Each time they agreed yet then folded, taking their daughter back in. The team considered collaboration with an interventionist who specialized in this kind of situation—not to deal with Kaye, who would meet with Greg from Actualization, *but to help the parents be strong*. In the end, the family gave up the plan yet again. Chris expressed concern for the parents, who were entering their 80s yet still trying to manage their daughter.

Like the Tanaka's and other families, the Crawford's were stymied by California's laws, which protected disabled people from abuse of power. Conservatorships could be challenged at the annual renewal. Greg once joked in team meeting, “it’s not like the good old days when you can just stick someone in the state hospital.” Now, without that legal control,

> They tried to take her into treatment, and she would run away and then come back. And then they'd have the police come try to 5150 her, and she would calm down and tell them what they needed to hear, so they wouldn't take her.

Actualization recommended that the family give the ultimatum, but they were trapped in their fear that she would be harmed on the street. Eventually the family followed through enough to get Kaye out of the house, but Greg worried that they would once again let her back in. Then, they might return to Actualization to start over.

Permanent Legal Control

Outside of Actualization I learned of the nightmare scenario for families—the adult relative that, despite financial resources, wound up dead on the street. Family members might hear of successful recovery like those addressed earlier at the NAMI meeting, but also stories of great frustration and despair in the California conservatorship system. Here I relay the perspective of a man strongly critical of California’s civil liberties. To his mind, the inability to permanently conserve his brother led to a homeless-like lifestyle despite wealth, and premature death at 57, run over by a police car.

John was a man entering his golden years, successful in the film industry yet also sitting on family money. We spoke at his home overlooking the ocean when he told me the story of his brother, Todd, who had a psychotic break in his late teens. Living with their parents in a nearby state, Todd stayed at home and was largely dependent on the family elders. When the parents passed away, Todd came to live with John, his wife, and two young children. At first John and his wife were excited to give Todd the freedom and independence that he had not had before.

> We got him a place and got him a car… He didn't wear glasses. We thought he couldn't see. I'm like, "Dude. You need some glasses." So we bought him a pair of glasses and he could see. So we mobilized him. And we thought, "Well, this is gonna be great."

This had unanticipated consequences, however, as Todd eventually drove off in his car, disappearing for long stretches. Tasked with monitoring Todd's portion of the family trust, John soon was unsure what to do beside doling out cash and paying for housing. After a serious car accident and surgery to repair a badly broken leg, Todd disappeared again and walked on it, destroying the pins and requiring a subsequent surgery.

John went to the county court and became appointed as Todd's conservator, and had him sent to a locked Board and Care facility. Yet a few months later Todd returned to court, lucid and advocating for himself. The judge ended the conservatorship, and Todd resumed community life. Yet from there the relationship got more and more strained. Todd got angry when John did not give him his money immediately, setting his room on fire. He was arrested and moved to a mental health wing of LA county jail. John spent $40,000 on lawyers' fees, getting Todd a plea bargain with "two strikes." He once again got conservatorship over his brother and placed Todd in a locked facility for a time. Later he contracted a private conservator, paying $80,000 for a year.

Upon losing the legal authority once again, John and his wife didn't know what to do. They simply continued to give Todd gift cards and cash, and learned to anticipate his long angry rants on their voicemail. A lawyer instructed John that he could not misrepresent the situation to landlords, and so he began to try and house his brother in unlocked Board and Care homes and hotels. Indeed, as he rattled off the names, I recognized some as the "flophouses" that some county clients stayed in. John noted that some of these Board and Care homes were overrun with drugs, with little to no monitoring involved. He would visit his brother's hotel room, and find drug parties that John perceived as composed of "street people."

Todd died when he was running the streets naked, run over by police dispatched to the scene. John explained that, although the police were worried he might sue them, he did not blame them at all. Instead, he believed that Todd should have been locked up in a psychiatric facility through an extended conservatorship. It was not the police, he thought, but the mental health laws that had killed his brother.

> Look, the system is so fucking sideways that people who are mentally ill no matter whether it's schizophrenia or psychotic narcissism, whatever, shouldn't be able to tell the judge, "I wanna go out on the street." The society's not made safer and the patient is not made safer. And if there's a parent or a sibling or any kind of person who's a genuine guardian who's interested in the welfare of that person, they should be able to keep that person in a hospital like they're a child...

John identified as a former California counterculture liberal who had become more politically conservative over time, and saw the mental health system as propounding a false notion of freedom.

> How in the world can a civil libertarian advocate argue that letting someone live on the street where there's no idea what's going on in their head or how dangerous they are, it's somehow freedom. What are they free? They're free to defecate in public. That's not freedom. They're not making a choice. In order to make a free choice you have to have the ability to have a rational thought.

In addition to these more philosophical reflections on the nature of freedom, he believed his family's situation proved the issue was not about money.

The family had access to topflight psychiatrists and treatment programs, but Todd did not want to continue in treatment or take medication. John, on the other hand, had the money to pay for legal representation and a private conservator. Money had at least kept his brother out of state prison, but it could only lead to coercive care for temporary periods of time.

John's statements of frustration are similar to a perspective advocated by some pro-coercion groups, like the Treatment Advocacy Center (TAC). The TAC has argued that, while the inadequacy of public services had to be addressed, even with access to care many people would simply refuse. For the TAC, a primary problem with such laws protecting patient rights is that they presume a person can make a rational decision about their illness. Yet if the illness had made the person too irrational, or prevented knowledge of illness itself, what did it mean to give people choice?

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Cases like Kaye and her parents, or Todd and his brother John, present an opportunity to reflect on what money cannot do. We might imagine a counterfactual scenario in which Kaye or John landed in a DMH program. There they would have little material comfort yet be exposed to a different mentality of intervention. Perhaps they would be offered a place to live, bound to it by lack of money. Instead, they are from the perspective of the Actualization model, "enabled" by the resources without threat for leverage. In such a situation, money and familial indulgence is seen as poisonous, enabling self-destruction.

This is quite different than the kind of leverage presented by the street to those who have already fallen through the cracks. The family that continually offers resources, then retracts them, makes threats, then folds, presents a kind of gradated infantalization. Here the treatment team takes on the role of "enforcer," whereas for the poor the world has already done the enforcing. Unlike the person who is simply abandoned to the street, or lost from family members for years, people like Kaye are continually suspended in a web of promises and seemingly empty threats. Someone like John may have an endless supply of money for crystal methamphetamine, punctuated by psychiatric hospitalizations, arrests, and short-lived guardianships. For the Actualization Clinic, these are toxic family dynamics, but leverage is only possible if *the families* learn to change behavior. For those who could not bear to put their relative onto the street, and could afford to continually fund a destructive lifestyle, the elite treatment resources might go unused.

Who Doesn't Get In?

The above cases have focused on the families and clients who managed to access Actualization or other elite treatment. Yet another way of understanding this service ecology is through considering those people who *don't* get in. How should we think about families and clients who almost access treatment centers like Actualization? These are harder for researchers to find, as I learned primarily of the people who were actually in treatment. These people I could meet at the clinic, or learn of via case conference. Yet where in my public sector fieldwork I could literally see outreach workers decide to stop speaking to a homeless person, or decline to work with a prisoner while visiting court, I did not know about those who tried but could not get in to Actualization. After presenting some preliminary findings in an academic setting, however, a professor named Mary reached out to me to discuss her experiences with her adopted son, Alex, who was twenty-four and incarcerated in county jail. This case helps us better understand the contours of the private care ecology and the way middle class people with serious psychiatric disabilities may slip through the cracks.

Mary invited me to her home and relayed to me her long efforts to secure her son treatment. Mary's husband had died when Alex was still young. Even as a child Alex exhibited behavioral difficulties, particularly in displaying aggression toward other children and adults. Between adoption, his father's death, and being African American among privileged white children, Mary initially thought the stressors were purely environmental, but psychologists soon diagnosed him with both cognitive and psychiatric disabilities. Mary, highly educated and culturally savvy, decided to work every part of the system she could. For instance, she was able to get him tied into the Regional Center, which arranges services for people with developmental disabilities, despite Alex being somewhat "higher functioning" than typically accepted. Although she had a solid income and excellent benefits from her tenured university position, she was not wealthy and could not pay for treatment out of pocket. Her heavy investment in Alex's development was reminiscent of "concerted cultivation" (Lareau 2003), but instead of focused primarily on making her son prepared for upper middle class success, she had devoted these enormous time and social resources to getting him care.

Mary struggled with managing Alex's aggressive behavior at school and home. Thinking like a social constructionist, she told me that he might have thrived in a different social environment, such as a rural society with less emphasis on academic achievement. Yet she also insisted that I understand the material reality to his outbursts, when he would become upset and lash out at her and others. After a series of hospitalizations, a doctor recommended residential treatment, which would be paid for by the school district. Alex went to an out of state residential treatment program for his later teen years, returning to Los Angeles at age 19. The Regional Center helped him get part time work, and he found a routine. Yet now home and smoking marijuana, Alex began to say things his mother interpreted as paranoia.

Mary had always felt he did not quite fit the categories of the major mental illnesses, but she now worried she was seeing the emergence of schizophrenia. He believed the neighbor's son was talking about him, as were others on the bus. Unable to stop him from confronting the neighbor, she decided that she would not let him go alone. Soon he and the neighbor were in a physical fight. Later that night, when Alex would not calm down, Mary had him hospitalized. This time he was given the diagnosis of paranoid schizophrenia, although upon discharge this had been changed to major depressive disorder, closer to his previous mood disorder diagnoses. Having had bad experiences with numerous antipsychotics, mood stabilizers, and others, Alex refused medication but remained open to psychosocial support. Referred to various places, she found Actualization through another provider's recommendation.

Mary was impressed with Actualization, but was hesitant. Joseph the family specialist pushed her to pay for case management alongside the intensive outpatient program. She felt pressured, and was not prepared to pay the thousands of dollars a month. As she explained to me, she didn't want to go through her savings for something that might not even work. Instead, she would try to get her insurance to cover the day treatment. Alex met with Evan, the director of Actualization IOP and therapy groups, and agreed to come in and give it a try. Mary had excellent insurance through the university, paying for the most expensive PPO option, but they refused to cover the Actualization clinic as in-network.

In the meantime, things were deteriorating at home. Mary's nephew, Earl, had decided that he would get Alex in line. Believing that Alex had been newly diagnosed with paranoid schizophrenia, he felt even more that he would have to exert control. Yet this simply generated conflict, and the cousins got into a physical altercation. Alex purportedly acted in self-defense, but then harmed Earl with a weapon. Mary took Alex to the emergency room for a psychiatric admission, but the police came and took him to jail instead. In what Mary and Earl would later argue was a gross over-charge, he was charged with attempted murder. This began a months long saga of hiring a private attorney and convincing a sympathetic prosecutor to consider alternatives. She learned about the Department of Mental Health's diversion program, but heard from a worker that the clients there were quite sick with low prospects. Instead, Mary worked her insurance company to cover a long-term residential treatment program as an alternative to jail, and searched extensively for a program that would accept his particular issues.

Alex was indeed diverted. Yet what was missing was not long-term residential treatment, but high quality care in the community. He had already spent years in residential. She believed that in the asylum era he would have been someone locked away for his whole life, and today, he had been looking at potentially years in prison. What was the community-based option? Her private insurance covered hospitalizations, residential, and outpatient therapy, but not the case management and IOP that Actualization might have provided. Although there is no way to know for sure, Mary speculated that the Actualization Clinic could have kept her son from deteriorating. The worst of the crisis, from the violent encounter, to the incarceration and long-term residential care, might have been averted.

What this case illustrates is the plight of the middle and even upper-middle class family. Mary did not want to move to public insurance. Her private insurance meant Alex could go to top hospitals and actually stay for weeks at a time, rather than be booted out after a 72-hour hold. If she took him off such private insurance, he might get case management services from the county, but might also get no more than a psychiatric appointment. Yet her private insurance would not cover what she was hoping for—the intermediary community care like Actualization. What options Alex will have for community care, after returning from residential, remain to be seen.

Imagining Futures With the Tanaka Family

The last sections outlined the dynamics of governing clients for the family, and governing the family itself. Considering a variety of cases, I've noted both what money can buy and what it cannot. Let's return to the Tanaka family to consider what the situation looks like for a family with moderate assets in the relatively early stages of their son's mental illness "career." Recall Marsha Tanaka's situation and her question at the NAMI meeting that opened the chapter: she had contracted expensive services, but her son did not believe himself mentally ill. Would there be a turning point where he gained insight and agreed to care? Actualization had gotten him back from his Puerto Rican adventure, and into a treatment home and enrolled in community college classes. With the problem of non-compliance and resistance, which Marsha attributed to "lack of insight," they had to project into the future. Would he become a successful recovery story with a Masters degree like Leonard, Dev, and Geraldine, or would he return to homelessness on Venice Beach?

Despite Richard's assessment that they were rich, the Tanakas told me that they were living on credit. They had gone into considerable debt, borrowing from relatives to finance George's treatment. Their home, which I had thought could provide them equity, was in fact owned by the extended family. Already spending $7,000 a month on the mental health and sober home, case management was becoming unaffordable. Marsha told the Actualization Clinic that they provided a great service, but if even the Tanakas could barely afford it, what happens to other families? Trying to offer George the best of the best had depleted their savings. At twenty-five years old, he was also about to lose coverage under their insurance. With their resources dwindling, the Tanakas would not be able to sustain this care.

They had one less gambit: after the presentation we attended at NAMI, they looked into another holistic health home on the beach. Like the current transitional living home, it would cost them thousands more a month than they had. The holistic care appealed to them, as did the healthy structure of exercise and therapeutic work, but they remained unsure of whether it would actually help. Marsha was wary, likening it to a snake oil salesman in an old Western TV show.

After visiting, Arnie believed all of the holistic procedures were good, but George simply didn’t want to do them. They planned a three-month trial to see if it would be helpful. In a dynamic I would come to see at other treatment centers, numerous goods that people saw as luxurious—beach exercise, therapy, and holistic nutrition—could also be seen as oppressive. Arnie explained,

> Yeah the place is nice, it's the fact that he has to give up a lot to do that. Even though it's for his benefit and everything. He's the one who has to think about, "Do I want to wake up in the morning and have to go on these walks?" It's all good stuff, do yoga. Things we would do, but does he wanna do it?

Marsha explained that they were putting all the last of their money into three months for George. After that, they were unsure what they would do.

For Arnie, the brief periods of respite showed that George could be successful. In a telling summation of the parental experience, however, Arnie saw these moments of hope fall by the wayside. “But he went off the meds. So then you have no control, and he has no control over himself.” They lacked the legal authority to force him, yet believed him to lack the volition for self-control in the community. Instead, they would try and ply him with resources and get him into a healthy, disciplined lifestyle.

The Actualization Clinic, for a time, had helped them generate situations where he might comply. Two years later, however, I learned that George had left all treatment and was homeless. He would no longer be covered by his family’s private insurance, and might eventually qualify for something like an FSP program. Whether he will return to comply with the family’s desires, become a client of a public or non-profit clinic, or go it alone remains to be seen.

*

The Tanaka’s story, now situated in the dynamics discussed in the rest of the chapter, can help illustrate the meanings of care, success, and client choice in this ecology. Observing the hopeful stories of recovery, Marsha Tanaka’s question regarding her son’s lack of insight shows the way choice dynamics arise in even elite care. If her son did not want services and did not believe himself mentally ill, what could she do? Dev’s appeal to the LEAP method might find anecdotal evidence of success in cases like Bradley, who said that Richard had reached him while he was in a state of irrationality. Perhaps George would eventually come around. Like Bradley, he might find therapy or medications that worked for him, and begin the pursuit of a respectable career satisfying to his family.

Yet what of these other futures? The Tanaka's had struggled with keeping George out of the house and "holding the line," like Kaye's family, but had successfully gotten him out. Now, however, he had decided he would live on the street. Would he become the kind of horror story that circulated among families, like John's brother Todd, run over in the street?

The conceptualization of "impaired insight" points to the limitations of wealth—even those families who could afford high end care were in a similar situation as poorer people or the county system: people would only be confined when a danger to self or others, and might still not be forcibly medicated. Conservatorships could be challenged, restoring a person's rights. And then, people who "lacked insight" might continue to refuse.

In the next chapter, I move into the DMH and Actualization Clinics, to discuss what a diagnosis of serious mental illness means in such settings. I ask what doors it opens, and the broader network of actors that become assembled around a person and their illness.

Chapter 4

Epistemic Cultures of Care

In chapters three and four I showed how the mental health teams addressed treatment in radically different contexts, bound to larger projects of *urban poverty governance* and *family systems governance*. In this chapter I will examine the everyday practice of community mental health care through the lens of the worker's knowledge and expertise. The treatment teams, I argue, are part of different *epistemic cultures*—that is, their interpretive frameworks, the things they aspire to know, and the actions that such expert knowledge authorizes—diverge in important ways related to their respective ecologies. The notion of such epistemic cultures comes from Karin Knorr Cetina's (1995) research on physics labs and biology laboratories. Although each is engaged in "science," and orient to abstract ideas of scientific method, she shows substantial differences in how the workers actually reason within their settings. In intensive mental health care, the variety of interventions and disjuncture between biological and psychological explanations means that there can be substantial disagreement about proper treatment. This is best captured in Luhrmann's classic (2000) *Of Two Minds,* which illustrates the split in training between biological and psychodynamic psychiatry, and ensuing hegemony of the biological in the United States. Lakoff's (2006) work has shown continued tension in places like Argentina, where psychoanalysts still have influence even in public hospitals.

Here, in a study of unequal community treatment, the question of biological psychiatry *versus* psychotherapy doesn't accurately capture the epistemic cultures I address. Outpatient case management encompasses a person's broader life in the community, and treatment typically involves medicine and a variety of psychosocial interventions, which may or may not be therapeutic per se. Treatment regimens are built on different networks, with different expertise, and with access to different social and physical infrastructures, which in turn enable contrasting assemblages of care. The expertise of treatment providers is necessarily *ecological* in terms of working with clientele in the broader array of services, social networks, material opportunities, and ways of living.

The sociology of psychiatric diagnosis has long focused on construction and medicalization—the way a set of amorphous experiences are relabeled and authoritatively stabilized as an illness (see for instance Conrad 1975). Scholars often criticize the way diagnostic language reduces a complex person to a label, with an implicit critique that medicalization may be inappropriate or at least too far reaching (see Horwitz and Wakefield 2007). Classic labeling theory (e.g. Scheff 1967) aimed to understand how labeling actually *generated* mental illness, and later iterations investigated labeling processes for impacts on stigma and self-concept (e.g. Link et al. 1989). For my purposes, this process of getting a diagnosis can be tremendously important, but it is only one part of the story. What I will illustrate is how these objects are mobilized from this point after diagnosis, and what they do in the world. That is to say, if a diagnosis is a key, what doors does it open? Allow me to illustrate with a brief comparison of the way a singular diagnosis functions for two people linked in to the wider social ecologies.

Two Major Depressions with Psychotic Features

Let's consider two women who are diagnosed with the same disorder, "major depression with psychotic features." From a purely nosological perspective, the disease object should be the same. It describes a person with a combination of depressed mood and psychosis, often manifesting in a belief that something terrible is about to happen. There is a long historical debate as to whether it is its own syndrome or simply an extreme form of depression. Prior to the DSM IV scholars and clinicians mobilized a wealth of clinical and biological research to suggest that it was indeed a separate illness, yet through the current DSM V it has remained a subset of depression. Recent research has focused on how to separate it from both schizophrenia and bipolar disorder, as there is considerable overlap regarding disturbances to affect and thought. The baseline medical intervention is a combined use of antidepressants and antipsychotics, with electro-convulsive therapy increasingly recommended during acute periods.

Here is where seeing two women of similar age, living in the same city, can make visible the stakes of treatment in different circuits. Delilah Jackson is a poor African American woman who entered DMH via street outreach, and Gwen Sennett is a wealthy white woman whose family brought her to the Actualization Clinic after a series of hospitalizations and residential treatment. Each woman experienced mental health crises in mid-life that possibly stemmed from hormonal events, and entered into two very different mental health systems. Their trajectories through those systems help illustrate precisely what doors are opened by a diagnosis of serious mental illness, and the network of actors and institutions assembled on the other side.

LA County DMH: Getting Delilah Housed and Managing Risk

Delilah is a working class African American woman from Watts. As she tells it, she was first diagnosed with a serious mental illness during a difficult pregnancy in her 40s. She yelled at a doctor on a maternity ward, got in a conflict, and was labeled with schizophrenia. With a series of other diagnoses on file, including schizoaffective disorder, and eventually major depression with psychotic features, her medical history illustrates a fundamental sociological insight regarding diagnostic instability. Each diagnosis can describe both affective fluctuations and an altered sense of reality, with overlap. Her medication cocktail included Prozac, Trazadone, and Risperdal. For Delilah's life, the key issue would not necessarily be the specific diagnosis, but whether she could count as "target population" for specialized services and housing.

Delilah's intense depression left her unable to work and she lost her job, and after bouncing between family and friends, ended up living on the street. She lost custody of her kids, yet managed to see them occasionally at church. Her diagnosis helped secure her SSI and therefore a basic survival income. While other programs had outreached her, she said she didn't trust anyone until the DMH team. This was in fact one of the team's chief skills—talking to people on the street who were scared, considered "resistant" by others, and otherwise had fallen through the cracks. She explained,

> Lauren and them came and visited me when I was at King and Crenshaw in front of Albertson's [grocery] and sat and talk with me and ask me what *I wanted to do*. They wanted my opinion on what I wanted them to do for me and I gave them the opinion of what I wanted.

After putting her up in a hotel, and a stint in a Board and Care facility, they helped her secure permanent supportive housing. Delilah was one of a number of DMH clients who had moved into an old notorious Downtown building, and the building's makeover offered a hopeful parallel for the individuals living in it. Once known as the "Hotel from Hell," the building had been retrofitted with a partnership between the SRO Housing Corporation and the Department of Mental Health to have a courtyard, onsite voluntary case management, and small but functional independent units.

The following vignette illustrates how the team conceptualized Delilah and her place in the social ecology, and the resources and actors assembled around her "major depression with psychotic features." Delilah had formerly run a bible study upon moving in, but she had suddenly stopped participating in the life of the building or the clinic. The team worried that she would soon be unable to care for herself, and speculated on what may have happened in her environment. Their available knowledge was limited to recent observation and speculation about Delilah's reticence to come to the clinic area, closer to Skid Row.

> "She can't live on her own," said the social worker Beth. Delilah had purportedly not left the house to buy food. "We might have to go over and put her in [e.g. a

> 5150 emergency hold].” The team speculated on the sudden change and apparent depressive episode, with one worker suggesting she might have been sexually assaulted near the clinic. Although the team noted sadly that this was a real possibility for women downtown, no one actually had any idea. The team planned to visit her and assess whether she reached criteria for the hospital, and try to get her to socialize and eat.
>
> Soon I accompanied the community worker Carlos, and we tracked down the building’s onsite case manager. The man recalled Delilah was doing great when he first started working here, but then not so well the last few months. Although the building offered counseling and job training for residents, services were voluntary and people often flew under the radar. Like the team, he was at a loss in knowing what, if anything, had triggered her apparent downward spiral.
>
> When Carlos and I knocked Delilah came to the door slowly, letting us in without saying anything. Asked if she’d like to come to the Chinese New Years event, she quietly agreed to come, but stared at the ground as we talked. Carlos told her we’d wait for her outside, and I soon drove the three of us back to the clinic for the Panda Express party.

After similar routine visits, the team eventually hospitalized Delilah at LAC-USC when she was, in her words, “not eating, not cleaning up, not doing what I was supposed to do.” She then came out and resumed living in her unit.

The team visited her once or twice a month, and with their encouragement, she began to come in for Friday outings, like picnics. Delilah described a life that was largely isolated and confined to her apartment, some time spent on hobbies, with occasional contact with her family.

> I sit at home and I watch t.v. or listen to some music. I listen to a lot of gospel. I stay in my room singing and…Reading the Bible. Or getting rested. And then I get out. I go downtown sometimes and walk around. Or I eat at Kentucky Fried Chicken. I relax. And there's not too much where to go. 'Cause everybody in my family works so I don't get to see no during the weeks, months, years. It's like on holidays or the weekends, stuff like that.

This point that “there’s not too much where to go” spoke first to her relative isolation, and second, what parts of the ecology were available to her.

Her physical ecology, adjacent to the thriving parts of downtown, potentially offered numerous cultural and consumptive opportunities for those with money. For Delilah, however, it consisted of her building and apartment, those fast food restaurants she could go to, and the DMH clinic. Her social ecology included a family that she saw on rare occasion, clients at the clinic outings, and the DMH staff. These people offered kindness, safety checks, entertainment, but little in the way of processing the trauma of street life and what it meant to now be housed and a county patient.

Let’s compare Delilah’s illness and treatment with Gwen’s, as it was constructed in the Actualization Clinic and surrounding providers, to see what resources are assembled around the same diagnosis in another care ecology with its own epistemic culture.

The Actualization Clinic: Understanding Gwen's Family System and Finding her Voice

Gwen was a white woman in her early 50s who had worked as a journalist before deciding to focus on motherhood. Her husband was a major player in "the industry," and they lived in an exclusive area near the beach. She described herself as a formerly busy, social, and energetic woman. She'd first encountered the Actualization Clinic when her son was diagnosed with Bipolar Disorder, and she'd contracted their case management to help him in the early years. Thus, when she was in crisis, she already knew of and trusted the team. Although she'd been in therapy for years, diagnosed with and medicated for anxiety, it was only recently that she had experienced significant distress, withdrawal, ideation of both self-harm and harm to others, and been diagnosed with major depression with psychotic features. Her diagnostic experience was also marked by variability. She had initially wondered if it was connected to menopause, and hormonally influenced. Her clinicians had at one point suspected she had Bipolar Disorder like her son and brother, as any confluence of affective and altered thoughts could be read multiple ways.

Yet rather than simply note the porousness of diagnosis, I'd like to focus on what was made of her symptoms. Far from falling through the cracks, she had been through an extensive round of elite treatment providers over the past year. "I've had a *lot* of treatment and I'm still battling stuff," she told me. This ranged from multiple hospitalizations at UCLA (a public school yet a hospital that doesn't except Medicaid), to a psychodynamic residential program in the Malibu area, to now doing outpatient care with the help of the Actualization team. Some was covered by her private insurance, and some was funded out of pocket. In a therapy group at Actualization's Intensive

Outpatient Treatment (IOP) program, she relayed what she had learned through her time at Resolve, the psychoanalytic residential treatment center.

> "I had a lot of trauma these last few years, that's what we established at Resolve." She noted how she'd spent much of her life as a mom.
>
> "Three kids," sighed the therapist. "That's a big job."
>
> Gwen agreed. "I did so much for them, now they're all busy. You give up a lot of yourself for other people. I kinda got lost in all of that—lost myself."
>
> The therapist suggested that this moment had potential in it as well. "It's a difficult time but also a very exciting time." Gwen was starting to consider what she might do with herself now that her kids had left the nest, but was wary. "No workplace for 24 years. It's hard."

Gwen's calm narrative belied what was until recently an ongoing crisis. According to her case manger Norah, Gwen was so psychotic and distressed on their first day together that they had her husband immediately drive her back to the hospital. After rotation through various medications, and more than ten bouts of electroshock therapy (ECT), Gwen was no longer experiencing thoughts of self-harm or aggression. She was, however, struggling with basic cognition and memory, which could be attributed to the depression or possibly the treatment.

Let's look at a vignette of a case conference to see how Gwen's illness sits in its ecology and the expertise of the treatment team. At the meeting, the Actualization clinicians debated how to address their next step. Gwen was cutting back on her time at the Actualization Clinic’s Intensive Outpatient Program (IOP), now only attending two rather than three days of therapy groups. She remained in case management, and Norah believed that Gwen’s difficulties were largely in relation to her family, who had expected her to return to being a peppy stay-at-home mom. Helping her recover her “voice” in her family was a key point of tension: the team wanted Gwen to become an active and productive person again, but her family’s expectations were impinging on this.

> Supervisor Deirdre: “She was one of those parents who did everything. Her daughter wants her to wake her up and make breakfast. She doesn't want to go back to being a mother-maid. It's a family issue.”
>
> Evan the IOP director suggested that the family required intervention as well. Norah said that they needed psycho-education to better understand the nature of Gwen’s illness, and she in turn needed to stand up to them. “I tell her she has to say “no” to me at least once a session,” said Norah.
>
> Evan agreed. “That was a goal in IOP. Say no to her family once a week.” Beginning to “say no” to them could indicate empowerment to rediscover herself outside of her mother role. Norah explained that the family still got mad at Gwen when she was symptomatic, rather than understand what was happening to her. Yet she could not stick up for herself. “We had her write a letter to her daughter and her husband. Two weeks ago. But she can't send it. [she said] "I'm too scared to bring any of this back up. "
>
> The team continued to debate whether the problem lay in Gwen herself, or in her family member’s expectations and the overall family system. Stacy, a

therapist who was beginning a PhD in Depth Psychology, brought these strands together with a psychodynamic interpretation.

> "I had a similar patient who had become psychotic after being a super mom and member of the community. Not consciously, but the psychotic issue was an exit strategy from that life. If it's, 'you become this person you used to be or you're disowned,' then she can't progress. She has a sense of what to do, but if the risk is too great then she's stuck."

> …

> "She has no voice," said John, the family specialist. Yet Deirdre responded that it was different at the clinic. "She has voice here." Gwen was doing well in session, but could not transport it to the real world. Norah said it again came down to Gwen's husband and children's understanding of her illness and the slow pace of growth. "She could have voice if the family expectations were different."

With the team's help, Gwen attempted to establish a new routine with her family. In addition, she slowly reduced treatment days, and with the team's help, found a series of volunteer activities. Following the Actualization team's recommended protocol, she could leave a day of IOP groups if she replaced it with a volunteering, work, or other productive activity.

*

Delilah and Gwen's shared diagnosis and vastly divergent life histories offer an opportunity to think about the way an illness can become different objects and bring together an array of different actors. The illness is linked to the women's bodies, psyches, and biographies, certainly, but also different ecologies, networks, and institutions. What is remarkable is that contemporary psychiatry can authorize both of these assemblages for the diagnosis of "major depression with psychotic features"—at DMH: medication, SSI, supportive housing with onsite case management, a treatment team to visit and check for emergency hospitalization, surveillance or lack thereof, the speculation of trauma but minimal investigation or therapeutic work, and the social activity of field trip outings—or, at Actualization: medication, ECT, psychodynamic theorization of trauma, family systems work, finding voice, and translating clinic-based therapy to the outside world.

Given the diversity of such interventions in the treatment regimens to be compared, I will track these not against an established standard of care, but instead document what "treatment" means pragmatically for a given diagnosis. Put simply, treatment is what the contrasting clinical teams *do,* and the significance of a diagnosis is in what kinds of network it can pull together and the actions it authorizes. Since such teams address a "whole person" in a "hospital without walls," the work is deeply tied to the world the client lives in. This is less a question of biological psychiatry versus psychoanalysis, as in Luhrmann (2000) or Lakoff (2006), but of attempting to create a treatment situation that can sustain beyond the hospital out into the world.

DMH: Diagnosis for Qualification and Survival

Here I'll consider the epistemic culture, the network surrounding a diagnosis, and the construction of clients in the day to day routine of case management practice. From the perspective of expertise, I focus on what it is precisely that county mental health workers do, and the broader network configured in executing their tasks. I begin with showing how a diagnosis brings together a doctor, client, and a range of other state agencies, and then show the way ideas of diagnosis travel through the ecology.

Diagnosis as Bureaucratic Objects

At DMH, a client's psychiatric diagnosis was tremendously consequential but primarily from a bureaucratic, rather than scientific perspective. The key issue was about access and appropriateness. Rather than focus on diagnostic specificity, the operative category was whether someone was, as Betty the nurse put it, "one of ours." By this Betty had meant the person was, in lay terms, crazy enough and therefore in need of specialized services. Bureaucratically, it was crucial that clients have official diagnoses of serious mental illness in order to qualify for services, and for the team to bill. Although the California Mental Health Services Act had some resources for open-ended use, agencies must rely on client diagnosis and appropriate categories of medical intervention to bill Medicaid and justify their continued work. One supervisor told me, "95% of what we do is social services," yet it all had to be predicated on medical intervention. Like Dobransky (2012), I found sympathetic clinicians who gave "workaround" diagnoses (see also Wooley 2014) to make an inappropriate person an official client. Team members estimated about 15% of the clients didn’t actually have serious mental illness, and introduced me to some that they’d surreptitiously diagnosed with depression—for instance, a homeless man with AIDS—in order to get them into the program. Here, a degree of diagnostic vagueness rather than specificity could be crucial, given certain worker’s discretion.

The team psychiatrist, Dr. Wong, told me he was not interested in the “academic distinctions” of his profession’s diagnostic system. We once sat in his office discussing the changes in psychiatric science during his lifetime. He thought DSM 3 was important because “it connected the dots and took away homosexuality as a disease.” When asked about DSM 5, the latest manual, he said he thought there were too many categories. Such distinctions did not matter to him. Instead, he thought pragmatically in terms of what a medication would do for someone. He told me, “Does the person have bipolar, schizophrenia or depression? Give someone Abilify [a second generation antipsychotic] and it will help for everything. Just depends on the dosage.” This practice was neither based on a strongly formulated theory of those individual illnesses, nor trying different medications to identify what the underlying illness truly is (see Lakoff 2009). Instead, it was a pragmatic approach to medicating people with various presentations that he’d honed over years as an institutional psychiatrist working in prisons and hospitals.

Some workers took diagnostic categories as discrete scientific objects, wondering why a person might have an unclear record. For instance, a medical caseworker once brought up a new client and the fact that the diagnosis was still unclear, complaining about the referring program. “They’ve had a client for a year with psychotic disorder NOS [Not Otherwise Specified]. One year with a social worker, and still NOS. I can't believe it. How have they not figured it out?" Lauren the team leader, a psychiatric social worker, responded that the Axis 1 (major mental illness) probably did not have a consistent presentation, which must be because of a secondary axis two (personality disorder) issue. Yet she pointed out this wasn't significant. "It doesn't matter for bureaucratic reasons, though." As far as processing people through the DMH system, it could work.

The life of a diagnosis or records of illness at a public safety net clinic like the DMH team goes far beyond the scientific classification of disease and appropriate medication for it. As noted in the outreach chapter, it is the lifeline that links a variety of services, from income, to health insurance, to housing. A diagnosis here could bring together a network of clinicians and other state agencies that were crucial for patient survival and the team's work. Consider the following interaction between Dr. Wong and a client concerned about his SSI.

> Jesse, an African American man, complained that his SSI income was turned off while he was incarcerated. "I just got turned down by Social Security. I had to wait 90 whole days and they just turned me down as of yesterday." Dr. Wong told him they'll need to get the medical records from prison psych and hospitalizations, and asked Jesse to sign a medical information release form. "There is an SSI panel. They don't even look at you. They look at your records."
>
> As they discussed his treatment history, Jesse asked Dr. Wong about the medication he was prescribing. "What's the Haldol for?" Wong replied, "It's for the hallucinations and delusions you have. Remember you have the paranoia?" He

> further suggested that Jesse stop taking his Seroquel, because multiple antipsychotics made it hard to figure out what is working. Jesse interrupted and returned to his chief concern. “What I’m taking right now—is it good enough for social security?”
>
> “What you’re taking right now is not for social security,” Dr. Wong replied. “It’s to treat your delusions—
>
> “I know,” said Jesse. “But is it good enough for social security to approve me?”
>
> “Social security doesn’t look at the quantity of the medication you’re taking. They’re looking at your ability to function in a year’s time.” Dr. Wong looked at Jesse. “You were hospitalized at Silverlake, do you remember? You were hospitalized there for a reason. My concern is to get you to be able to function without hearing voices or paranoid. I want to give you enough medications to control that.” Jesse asked if he could use the phone.
>
> “It’s not like you failed,” Dr. Wong said with kindness. “You have to understand that it’s really a process. It’s not like you failed yourself.”

Here the diagnosis and Dr. Wong’s evaluation of functionality links Jesse’s goal of survival income, Dr. Wong’s goal of medicating psychotic illness, and the Federal government’s means-testing approach to benefits. This interaction also points to the mismatch between the social meanings of a psychiatric diagnosis and medication prescription between DMH clinicians and clientele. Although treatment providers sometimes accuse patients of faking it for money, Dr. Wong believed Jesse to be suffering from psychotic illness. Thus, he wanted to start Jesse on an injectable medication. Yet Jesse understood the appointment in a different way—his primary concern was making sure he got his SSI back. Dr. Wong saw this in terms of Jesse's psychological sense of rejection from the Social Security Administration.

In such cases above, whether clinicians believed the diagnosis correct, false trickery by the client, or collaboration between client and clinician, it points to the fact that diagnosis and treatment are wrapped up in a complex bureaucratic system for access to resources that are not actually about treatment. In this system, the diagnosis and medication are, for some clients, tethered primarily to resources. Jesse was willing to take an injection but wanted Dr. Wong to assure him he would get his income, and that the Haldol was "enough" to convince the SSI panel.

Keeping the Medication Flowing

In the five years I knew them, the DMH team had three psychiatrists. Dr. Wong expressed frustration with working at FSP, stating that he preferred the old-school settings where the doctor was in charge. He relayed to me the way DMH was formerly run by MD's, but was now led by social workers. When he left, the team scrambled to find a new full-time psychiatrist. The caseworker Carlos speculated that it was especially difficult to find medical doctors who wanted this type of work. "Maybe a lot of people don't want to work down here. [Imitates haughty doctor] 'I went to medical school so I can be surrounded by piss and shit?'" In place of a full-time doctor, the team had locum practitioners, who would often rotate through the other clinics. With this instability, the team experienced a number of major difficulties, most notably the inability to renew medication prescriptions.

Miguel, the co-team leader, was especially pleased with a locum doctor who had managed to clear up their backlog. Dr. Usman, who had previously worked in the state mental hospitals for 3.5 years, was now rotating through the county clinics. In the team meeting Miguel noted, “He was crazy. He saw like 17 people. I hope we get him into our locum.” Usman had also completed four new patient evaluations. A psychiatric technician added, “This is how it should be with our clients.” Miguel said, “He was a trooper…It was a big success so we'll have to do it again." Still, he noted, “we have to see who we get.” This was because it was unpredictable whether Dr. Usman would get a more regular rotation at the team.

I soon met Dr. Usman on his visiting day and sat through an afternoon of rapid assessments and prescription renewals. He saw Kineesha, an African American woman in her late 30s. She had been last seen by a doctor over 3 months ago. There was some confusion, but they figured out when her last Abilify injection was. He asked about her last hospitalization, which was several years ago. He then fired a series of quick questions:

Usman: “Do you think someone is against you?”

Kineesha: No

Dr. Usman: Are you hearing voices?

Kineesha: No.

Dr: What is your diagnosis?

Kineesha: Bipolar schizophrenia.

Usman: “No, just bipolar.”

Kineesha: the hospital had told me that it was bipolar and schizophrenia.

Dr Usman: the docs just saw that episode.

He wrote up a prescription to keep her on the Abilify injection.

When Dr. Usman and I sat alone I asked about the work when there are up to 17 clients a day. He says a new patient requires lots of time. It is difficult because patients are not well versed because of the nature of the illness. He says he wants to ask them very specific questions and they bring up all kinds of information. It would take 20 minute to read, and he would like to have 2 hours for new case to get a proper diagnosis. Follow up is fine with fifteen minutes. When I asked about the fact that various doctors have given Kineesha different diagnoses, he said it doesn’t matter if she has it wrong. Furthermore, it’s a misconception that bipolar and schizophrenia are clearly distinct. He says it's not an issue except in inpatient care, where it could change the course of treatment.

Yet he then reversed himself, saying there was a clear distinction. “I can read from the history, and from her behavior, that she’s bipolar. I can see in her behavior that she doesn't have schizophrenia.” He said it is difficult to do such work, because they keep changing the schedule on him, people don’t show up, they move someone else in for an appointment. He says he may never see this patient again, but “my contribution is my note.”

The notion that his contribution is his note, in a long paper trail, points to the role of such doctors—it establishes history, gives the next doctor something to work off of, and keeps the medication flowing (see also Lufety and Freese 2005). The locum doctor called in to do sign-offs to refill medication prescriptions is not in a position to do much else. In the above observation, he checked to see if Kineesha was paranoid or hearing voices, and then if she knew her diagnosis. She did not complain about anything with her current regimen, and he renewed her Abilify injection. There's nothing necessarily suspect about this, but it shows the way care becomes routinized when there isn't more opportunity for dialogue with a clinician.

Thus, when the clinic lost a permanent doctor, the kind of expertise needed changed. Dr. Usman may not have thought getting through cases rapidly and renewing prescriptions assigned by other doctors was the best approach, and wished he'd have hours to evaluate a patient. But in the context, his expertise was the ability to rapidly see patients and get through the paperwork so that there no concerns about people missing their medication. Next I consider a form of psychosocial expertise where a person's diagnosis may lead to stigma in the sense of the dismissal of meaningful speech, but authorizes plans to bring people into various permanent housing situations.

Tracking Schizophrenic Bodies, Dismissing Schizophrenic Speech

One of the team's chief skills—engaging people on the street who were scared, considered "resistant" by others, and otherwise had fallen through the cracks—meant that the early months of work were about simply keeping track of people. Given that many clients may be attuned to the street and uncomfortable moving indoors, and others may simply not know who they are, the team must know the person's ecology and in some cases track them down again. To illustrate these dynamics, consider my afternoon rounds with Vic, the DMH nurse who had worked with the jails, hospital, and emergency team before coming to community care. Vic rejected the idea that workers should listen to the speech of people with serious mental illness, and focused instead on getting people their medication, keeping them indoors, and hospitalizing them when needed. For Vic, the speech of "legitimate schizophrenics" was meaningless. That said, he also tried to interpret their behavior with his own variant of psychodynamics, not for a psychological intervention, but in regards to the practical work of managing whether they would stay in place.

In the clinic, Vic received the following three assignments for recently outreached people currently at the Super 8 hotel: first, check on Valerie, a woman who had left the hotel to return to the flagpole, her longtime sleeping place in a public park. Second, to see if the mysterious woman, Nelly, who had once lived under a bridge, required hospitalization as she was "increasingly disorganized." The team could not find records of her, and she variously described herself as from Canada and Europe, a corporate communications expert, and connected to the Vatican. Third, he was to check on Alan, a man who'd been outreached beside a river.

> As we got ready to go Vic chuckled and stitched them together into a comical story. "Oh, maybe Valerie and Alan were on their way to the Vatican when they stopped at the hospital." As he packed medications into a box I asked him if he thought Alan would understand which pills to take and when. He says, "No, the thing with these people, the thing is I don't even know if he's gonna take all three

of these at once instead of spreading them out." We then drove out to look for Valerie at the flagpole.

Valerie's park was an island in the middle of a busy intersection, with a monument to Vietnam vets. A round woman with white hair and rouged cheeks, Valerie sat on the park bench with a younger homeless man passed out next to her. "So you want to stay out here on the bench?" Vic asked. Valerie replied she was thankful, but didn't want the team's services anymore. "You don't want our services anymore?" She said she'd think about going back to the Super 8. We said goodbye and that the team would check on her again.

When we got back in the car Vic began to tell me how he saw the situation, invoking a Freudian interpretation centered on unconscious fear.

> Yeah, she looked great, smelled great, was on medication, everything going good. You can go forward or backward or stay the same. She's going backwards. And I can relate, people get scared when things are going good. It's all unconscious but that's what's happening. You know, people develop all these resistances.

Vic in fact believed in psychodynamic explanations of human behavior, but did not believe that it could be used in interaction with these clients.

We arrived at the Super 8 motel and went to Alan's room. His door was open, and he was smoking. He's a white man, balding, with a patchy beard. Vic noted that he'd lost some weight after coming out of the hospital. Vic showed him the pillbox, taking one days worth of pills out and showing which ones to take when. “This one is slightly smaller than this thin one, and is more like a tab.” It was actually quite complicated, and I thought to myself I wouldn’t have remembered. Alan nodded his head and said he understood.

Just then we saw Nelly walking into the Super 8 parking lot. She’d come from the library, where she went to get a number for a president of a company she used to work for. Vic asked what she could tell us about who she is, as the team remained unable to figure out her identity. She explained that she had lived in Canada and various places, including Switzerland, which is where she said she grew up. She explains that she is keeping her identity secret for now. She told me about Nortel Communications and the Vatican, and that she needed to protect herself and her identity because she is an important person and in danger.

Vic interrupted, glancing at me as he said, “Oh, so you’re a very important person?” Nelly blushed and averted her eyes, saying “yes.” Vic asked her if she needed anything, and she replied that she doesn’t like being in debt to anyone. He suggested that if she continued panhandling it’s better that she not sit directly on the busy street, as he didn’t want her to get hit by a car. She agreed, and said she’ll see us later. She was far from “hold-able” for a hospitalization.

Back in the car Vic told me he was making a point interrupting her, “that if you just let these people talk they’ll go on forever.” They were, after all, he said, delusional. I had previously mentioned the idea that people might have some form of truth within seemingly delusional talk, and he wanted to return to this. “You said something pretty profound before, but I don’t know if you know how it

> was." There is truth in what such people say, he agreed, but nothing for therapists to make any use of it. When I asked him if he thinks anyone recovers he said, "No, not if you're a "legitimate" schizophrenic. No, no one recovers. Their mind is gone. Their soul is gone. Really, I mean, brain tumor, cancer. None of these is as horrifying as being that gone psychologically."

I use this example to show how, for workers like Vic, a "legitimate" schizophrenic cannot be spoken to in any meaningful way. This is a classic point from the literatures on labeling and stigma, namely that once a person is deemed crazy his or her entire being is suspect. Thus, even though Vic acknowledges they might say something true, it is essentially useless. Vic's interest in psychodynamic theory, I learned, was for "neurotics" in everyday life, but that it would play no substantial role in the treatment for these clients. The major issue of knowledge here is the *lack* of knowledge. Beyond the issue of knowing a person's past to interpret symptoms, is the problem of not even knowing someone's name and basic history. Vic isn't sure that people will take medication on a regular basis or understand their regimen. The intervention, such that it is, is to deal with this homelessness. In essence, there was not tailored care, but an attempt to stabilize people indoors.

Valerie would soon be housed as part of a specialized "Good Samaritan" Housing Program, which connected clients to rapid housing that was fully furnished. She would still on occasion talk about going back to the flagpole, but later learned to stay in her apartment. Alan moved temporarily to a Board and Care home, where staff monitored his oral medication. The treatment team then got in touch with Alan's children, who lived in another part of the state, and sent him there when they agreed to assume responsibility for his care. Nelly presented a more serious difficulty, because there was quite simply no information on her. Lauren the team leader struggled with ways to figure out who she was. She was difficult to hospitalize, as she did not present as "dangerous" or "gravely disabled." They considered fingerprinting her at the police station, but after contacting a police representative learned that they'd have to arrest her if there were outstanding warrants. Eventually I went with the team to an embassy to try and discover if Nelly was who she claimed to be, but they could not help.

One of the community workers put it thusly, regarding the need to fingerprint or otherwise discover the identity of clients. "They need to have a loophole in the HIPAA law for clients like ours. You don't know who these clients belong to, or what they've done." The language of "belonging to" points to a key mindset. Rather than conceive of clients as individuals with complex psychodynamics, such a framing indicates a concern with their keepers e.g. some absent family or custodial institutions. "What they've done," on the other hand, often meant the issue of criminal records, and that the clients might be dangerous to staff.

Some of Vic's colleagues would criticize his suggestion that we not listen carefully to the client's speech. Yet for the tasks at hand, it made little difference—what "legitimate" schizophrenics required was a check-in, a med drop, and evaluation for the hospital.

Paperwork Expertise and Non-Therapeutic Empathy

The following example concerns the work of a DMH "housing specialist," a key role at an urban safety net clinic where residential stability is an omnipresent concern. It follows directly from the above snippet, related to the immediate stabilization and temporary housing of formerly street homeless clientele. This "Community Worker" position typically requires the person have some college education, and they share many case management tasks with the clinical staff. Here the diagnosis includes both that of psychiatric illness, and that of "chronic homelessness"[4] as a way to prioritize people for special vouchers.

I use the following story to show the expert knowledge necessary to make the housing component work, and the way the mental illness (which serves as the disability designation) facilitates access to housing vouchers that a non-disabled, non-homeless person might wait a decade for. The excerpt is of a typical and mundane day, focused on processing a housing voucher and getting a client an ID in preparation for a housing recertification. With a staff made largely of community workers and peers, rather than therapists, DMH treatment was often formulated around basic social services. I spent the day shadowing Pat, an African American woman in her late 30s who had previously worked with homeless youth and at various social service agencies. We had the assignment first to go deal with a Shelter Plus Care housing voucher application at DMH headquarters, with the unit that prepped paperwork for the Housing Authority.

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[4] This designation meant an "1) unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more OR 2) an unaccompanied homeless individual with a disabling condition who has had at least 4 episodes of homelessness in the last 3 years." (HUD Exchange 2007).

We sat with the office worker pouring over an application for a woman with a long history of street homelessness. Small errors, or minor misunderstandings with forms could substantially delay the processing of vouchers. The cover letter certified that the client was homeless "because of her level of functionality," and thus appropriate for this special line of mental health specific housing. Her diagnosis was schizophrenia. The major issue here was that she gave her maiden name in conversation, but had official records tied to her married name. The marriage had not officially been dissolved, leading to inconsistencies in documentation. They would have to commensurate these, or otherwise account for the inconsistencies.

Shelter Plus Care previously required photos of a person living in a place of residence "not designed for human habitation." Luckily, Pat explained, they no longer required this "degrading" aspect of documenting a "homeless history." She further explained to me particular stipulations that trip people up, such as spending their own money on temporary rent, which might disrupt the "homeless clock." For county DMH clients, so long as the program was doing interim funding for a hotel or special room in a shelter, rather than a person's own money, it would not impact qualification. These small details were, as Carlos had explained during the outreach project, crucial, confusing, and only learned via experience. Navigating this bureaucratic work was something one could only learn from doing it over time, as the opaque Housing Authority might send things back for unexpected reasons.

From there we went to the next housing related issue of the day: Fante, an African American man in his 30's had his annual housing recertification coming up. Having lost his ID, they would need to go to the DMV to get a new one. Pat explained to me that Fante was something of a "gangster" in his youth, "but someone got the better of him" in a violent encounter. His issue may have been traumatic brain injury as much as serious mental illness. He came to the front door at his apartment and then joined us in the car. Pat began asking him about whether he wanted to stay in the apartment. I'd learned earlier that the team was hoping he would move, as there were bedbugs and he had been sleeping in the kitchen to avoid them. Fante said he wasn't sure if he wanted to move out, as "my decision-making isn't that great." Pat said that the team was there to help him live a better life, and he should consider moving.

We stood in the first line at the DMV for people with appointments, and Fante walked off, limping and with erratic movements. I went to catch up with him, and we talked about weight lifting. He enjoyed working his upper body, but had harmed his left shoulder so was unable to do so anymore. He said he doesn't do much of anything at all now. We went back inside to have his photo taken. While waiting Fante turned to us, smiling. He observed, "It's ironic that I'm deaf in my left ear, and burned on my left hand." I reminded him that he'd hurt his left shoulder weightlifting, too, and he laughed at the coincidence. Pat asked about his hand, and Fante told us that his cousin had burned him with an iron. He said, "I've been thinking about my people. You know, they didn't love me. My own family." Pat looked at him sympathetically, and told him he'd "been through a

> lot." He then got his picture taken and we left, eventually dropping him off at a 99-cent store where he would buy food.
>
> While driving in the car, Pat shared her pessimistic perspective on county services. Unlike Vic, who saw this in terms of the patients being too far gone to recover, she blamed it on the county. She had been hopeful when the Mental Health Services Act money came in, and about the switch to a "Recovery instead of the Medication Model" but it didn't really go anywhere. When I asked why she said it was because of bureaucracy, and that the team really "goes around putting out fires" and making things "look right for billing." She further criticized workers who had bias and stigma around mental illness, in terms of "dehumanizing, othering, and just labeling someone crazy and then minimizing what else is going on with them."

For community workers like Pat, the task is ensuring the basic housing needs of clients remain met. Client histories of both serious mental illness and homelessness stitch together an array of non-medical services like income and housing. I'd go on similar outings with Carlos, where we would take paperwork to different agencies, bring clients to the Social Security Office or DMV, and meet with landlords to prepare for Housing Authority inspections. The whole system was in flux when the county began working with the Coordinated Entry System (CES), which centralized the housing resources through the area. Carlos, Pat, and others would have to learn new paperwork, and learn to "game" a new ranking system that prioritized vulnerability on an alternate scale.

For clients like Fante, much of his experience of the FSP team is through these interactions. The context of his speech is, arguably, ripe for talk therapy of either a psychodynamic or family systems nature. Pat offered sympathetic encouragement when he opened up about his family not loving him, but she did not address this therapeutically. In contrast with Vic, who said that one should avoid listening to the seriously mentally ill, Pat's righteous anger at the system, labeling, and stigma is striking. Still, she does not really talk to Fante about his experience, perhaps in part because she lacks training as a therapist. What she does do is mobilize his disability and diagnosis to ensure he will not lose his housing voucher, and subtly try to persuade him to choose to leave his unit for one without bed bugs.

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In sum, diagnosis at DMH FSP is oriented to the question of whether a person is "one of ours," that is, ill enough or *appearing* ill enough to qualify for services. For psychiatrists, diagnostic specificity is relatively unimportant in terms of treatment. For some workers, this operative category of "legitimate" crazy people means that some people can be ignored, yet helped in terms of getting them access to resources. Others may criticize this, yet their role is also primarily about helping people survive. Client's traumas may be acknowledged, but not addressed therapeutically, in part because there is no proper resource for addressing it, like going to a trauma therapy center. This becomes clearer by contrast with the Actualization Clinic.

Actualization Clinic: Diagnostic Specificity and a Life Beyond Diagnosis

Diagnosis as Scientific Object

Diagnosis held a paradoxical importance at the Actualization Clinic. On the one hand, the team strongly emphasized that they were interested in treating a person holistically, and that this diverged from a medical model. As Deirdre explained it to me,

> We're not interested in how many hospitalizations have you had and you know, what are your umpteen diagnoses? It's basically where do you want to go from here and how can we help you make a better life?... I think people get stuck in living their illness and it's all about their illness and what they can't do and all of those things. And here it's the complete opposite. Like we don't care what your diagnosis is. What do you want to do? You know, do you wanna make friends? Do you want to recreate? Do you want to go to school? Let's do it.

On the other hand, proper diagnosis and medication was a key issue, and the team often did not trust the psychiatric diagnoses that their clients had come in with. In their system of “life domains,” the first to be addressed would have to be psychiatric and medical stability. Before they could move *beyond* diagnosis and the medical model, they had to make sure people were properly medicated.

When I began fieldwork at the Actualization Clinic, they insisted I speak with Dr. Myrdal. Affiliated with a university, and respected for his research on differentiating schizoaffective from other overlapping psychotic and affective illness, Dr. Myrdal was the psychiatrist the team turned to whenever clients were struggling with medication. With his multi-hour diagnostic evaluation, he drew on various ratings scales, a thorough medical history, and neurological testing. It cost $750. The team members were especially impressed with his use of genetics, which John said is “where the field is going.”

In an illustrative instance, the team reached out to Dr. Myrdal to evaluate Bobby, a white man in his 50’s who had been working successfully before he relapsed with drug use and had a return of severe compulsions. Currently diagnosed as a case of severe Obsessive Compulsive Disorder (OCD), he’d had a string of secondary diagnoses including bipolar with psychotic features, an eating disorder, and borderline personality disorder. He had been referred to Actualization as part of their pilot program with Breyer Insurance. He’d been through a specialized clinic for OCD that had not managed to get his symptoms under control. While some of his behaviors fell largely under this diagnostic category, such as compulsively eating mayonnaise until he’d become sick, some of his rituals struck Actualization case managers as particularly bizarre. Furthermore, the medications he was taking seemed not to be working. They convinced the insurance company to send Bobby to Dr. Myrdal, who could give a second opinion and clarify the diagnosis.

The team was thrilled when the doctor re-diagnosed Bobby with schizophrenia and prescribed him Clozaril, often seen as the antipsychotic of last resort due to its efficacy but potentially life threatening side effects. For Deirdre, this was a testament to Myrdal’s diagnostic perception: “Can you believe that, out of all that time, no one saw the schizophrenia?" Dr. Myrdal was also the first to try Clozaril, and the case managers reported it seemed to be working—Bobby was lessening his compulsive behaviors. Furthermore, Myrdal told the insurance company that Bobby needed some form of residential treatment, as opposed to living independently with home visits. Here, the scientific authority worked also as a bureaucratic object within the insurance regime to try and authorize a specialized residential. This was precisely what Actualization had hoped for, and would be especially important as Bobby transitioned onto the Clozaril and need consistent blood work. This remains a reason that Clozaril is reserved for people in very stable situations. If not monitored closely, it can compromise the immune system and potentially be deadly. In fact, the DMH psychiatrists downtown would not prescribe it, because client's lives were too chaotic, and they couldn't get the appropriate lab work done. This medication itself requires a particular ecology.

Unlike the doctors I shadowed at DMH, Dr. Myrdal's approach involved significant testing and collaboration with neuropsychologists. Consider this discussion of Myrdal's work with Bethany, a young African American woman diagnosed with bipolar disorder. From the team's perspective, he offered a level of precision and thoroughness that people simply didn't receive elsewhere. This included his use of the genetic testing, psychological scales, as well as attentiveness to people's social situations. In this case, he was measuring her depression relative to her boyfriend's deployment with the military, to distinguish the situational from the pathological.

> Deirdre: Dr. Myrdal did the report on Bethany. He rocked it.
>
> Norah: he's awesome. I was in session.

> Deirdre: now she's on a therapeutic dose of meds
>
> Norah: she said things that sounded really psychotic
>
> Deirdre: He ruled out schizoaffective [disorder]
>
> Norah: he did a Beck Depression Inventory. She back peddled saying she’s not doing better. Had a [score of] 21, now a 19. But her boyfriend deployed. It was interesting to see. Then mom came in.

In previous weeks team discussed how Bethany’s moods seemed to wax and wane with her boyfriend’s presence and familial dynamics.

Both Bethany’s parents were physicians, and Norah theorized that Bethany was under immense pressure as the identified patient in an elite Black family. They attempted to integrate such psychosocial information for Dr. Myrdal’s evaluation. In the end, he decided to raise her Lithium and Gabapentin, and added the antipsychotic Seroquel at night to help Bethany sleep. The team celebrated his expertise, noting that Bethany’s previous doctor seemed to have the dosages wrong. Hence, they believed that it was important to bring clients to Dr. Myrdal, as he could offer a scientific approach that they could be confident with.

When I met with Doctor Myrdal at his office near the university, he explained that much of what he did was simply proper work ups. This ranged from the evaluation forms to doing enough physical testing to rule out an organic cause to apparent mental illness.

> You can see the evaluation formats patients have to fill out, which is very comprehensive. I just think about things *dimensionally*. How much depression do you have? How much mania? How much do you have it right now? How much do

> you have it lifetime? The same with psychosis …And because the more I see trauma in someone's life, the more I'll be aggressive in trying to make sure they're in some form of psychotherapy, or some kind of psychosocial support system.

In this sense, he asserted he was simply practicing thorough psychiatry, looking at dimensions of need, and suggesting psychosocial or psychotherapeutic work alongside the biological intervention. He insisted that the Actualization workers had misinterpreted his use of genetics and neurological testing. Although he used it to rule out organic causes, he did not use it diagnostically. Primarily, he used genetics to try and get a sense of people's metabolism to figure out medication dosage. He asserted that genetic diagnosis was the quackery of others in the area.

> There are people, including the guy across the street and Dr. Amen and whatnot, who will claim that they can do an FMRI and predict what medicine you'll respond to and what your diagnosis is. And that's BS. You can't do that. And even if you have someone with schizophrenia, you can get a pretty picture of their default network activity and connectivity, and the guy across the street will talk patients into doing this…It's interesting, and usually it's in the direction you would expect for a diagnosis of schizophrenia, but it's not diagnostic.

For Dr. Myrdal, these were important research tools, and he was interested in them for his academic work. Yet he was against other psychiatrists who upsold patients with scientifically faulty or premature workups. The man he criticized, Dr. Amen, was a Southern California based psychiatrist who had become famous, and infamous, for his claims that he could get accurate diagnostics and precision medication based on FMRI.

In fact, Dr. Myrdal echoed some of the points that DMH psychiatrists made regarding the problems with diagnostic specificity. Yet where Dr. Wong claimed not to be interested in "academic distinctions" and might treat everything with Abilify, and Dr. Usman stated there would be no significant difference if Kineesha had schizophrenia or bipolar disorder, Dr. Myrdal framed this in terms of overlapping pathologies. Precisely interested in academic distinctions in his research, he acknowledged that the actual treatment response was a "shotgun" approach rather than a medication targeted to specific diagnoses.

> These things [different illnesses and substance abuse] all sort of feed on one another…our medicines are really a shotgun approach, 'cause they affect the whole brain and they go everywhere in the brain. It explains why a medication like Cryptopine or, which is Seroquel, or Tudolorazodone, why they might work for psychosis, why they might work for mania, why they might work for depression by themselves as monotherapy ... and we don't probably even know why the same drug works for all three conditions. It's probably doing different things in each condition, almost for sure.

Thus, for Dr. Myrdal, he simultaneously worked to stabilize a diagnosis for clinical purposes and deconstruct those categories for scientific purposes. Here diagnostic specificity was a first step, and then key to a variety of specialized interventions beyond the medication itself.

After such workups, clients who did not have the money to continue seeing someone like Myrdal might return to a doctor who primarily monitored and renewed prescriptions. For some Actualization clients, this might be a resident in training at UCLA, as the sort of equivalent to Dr. Usman or other locum doctors at DMH. Yet the major difference made of evaluation, beyond medication changes, was the way that it could funnel people toward specialist services.

Gerald, a therapist who had formerly worked on a DMH-funded community treatment team, explained the way diagnostic workups and a "profile" connected to individualized treatment.

> [Actualization] is probably the closest to the FSP model I've seen [in the private sector]. But way less clients, way less bureaucracy, way less oversight... the other thing we've done really well is we have a really good network of providers... if we need trauma specialty … I'm gonna send you to a trauma expert. I'm gonna send you to an expert who's good at diagnostics to make sure we get the right kinds of differential diagnosis. I know the best place to treat somebody with your profile… And once we get that profile, we can say okay, this is what you need now. This person, this person, and this.

Thus, differential diagnosis and a proper profile could facilitate numerous focused treatments for those who could afford it.

Therapeutic Specificity and Referral Expertise

Diagnostic specificity could matter at Actualization in a way that it did not at DMH FSP, because a diagnosis might map on to a very particular set of therapies beyond medication. A key aspect of case management at the Actualization Clinic is that they are embedded in a different ecology—their institutional circuit and referral network is not shelters, supportive housing buildings, jails, and the Institutes of Mental Disease. Instead, it is a series of elite providers that specialize in various transformative therapies that can be diagnostically specific, such as places that address OCD, thought disorder, or eating disorders.

The following story illustrates how therapeutic case management and "getting a life" in this setting is often in conjunction with more explicitly therapeutic work at specialized centers—connections and referrals that typically do not exist for poorer people. Treating another man with bizarre rituals that seemed to overlap OCD and psychotic illness, the team turns to Dr. Myrdal to clarify a plan and then move the man into specialized care.

> The case manager Zach introduced a new case, a man in his early 30s who lived with his mother near the beach. "Connectedness is an important issue," Zach explained. "Stellan hasn't touched anyone in years."
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> The mother contracted the Actualization clinic because Stellan experienced strange bodily sensations like tingling in his fingers related to "an

entity," and refused to be touched. His inability to tolerate contact had gotten so bad now that he was avoiding the water droplets in a shower, and had stopped bathing. The family employed a psychiatrist, a therapist, and a shaman. The shaman had advised Stellan reduce the use of psychiatric medications, which troubled the team, given their perception of a serious psychotic disorder. This issue of "connectedness" with his mother and others was an important relational issue, but was secondary further down the hierarchy of domains than the psychiatric.

"What's the problem?" John the psychologist asked. In the team's parlance, this was a way to understand symptoms in a person's life context. Deirdre, however, scoffed and jumped directly to what she saw as the obvious pathology at hand.

"He is floridly psychotic."

"He has severe OCD and is delusional," Zach followed.

Deirdre reported that Stellan insisted his symptoms were somatic in origin. She then returned to the "connectedness" dynamic. Here it was not that the relational or psychodynamic had necessarily caused the illness, but the illness had powerfully impacted the family in a negative way. Apparently Stellan's inability to touch started before his father's recent death, and that had created a powerful regret. "He feels remorse he couldn't hug his dad before he died."

Cassie, a social worker, asked, "Does he have right dx?" Deirdre shook her head "no."

Ian, who had spoken with Stellan’s doctor, added, “The psychiatrist needs some help here. He doesn't see it as classic OCD.”

Deirdre noted, “I have classic OCD, and the difference is I know it is irrational. But for him there's not even… it's delusional. He's not medicated properly.”

John added, “We asked the doc to increase the antipsychotic and he's considering it.”

Deirdre expanded on the family dynamic. “Mom hugs the air around him. She says, "I know it's his illness but sometimes I still feel rejected".

John sighed, “It's just so typical that the family doesn't know what to do. They go with what the doctor says year after year.”

“The SWAT Team is here,” someone called out with a laugh.

Deirdre concluded, “He needs to go to Dr. Myrdal. We're not gonna be able to help him w out the right meds.″

Notice in this case formulation is how the Actualization team orients to a client’s needs. First is the emphasis on the relational dynamic: the initial framing is in terms of “connectedness” and Stellan’s inability to hug his father or his mother. Yet the psychological formulation is entangled with a psychiatric one: Deirdre says they cannot help him without the right medication, and their first task was to take the young man to Dr. Myrdal for a potential re-diagnosis and medication switch. The “SWAT Team” analogy, while a joke, was also apt in the team’s vision of itself. Like a special police unit, the team believed they were equipped to do the work when standard mental health care failed. Their therapeutic plan was for the new psychiatric evaluation and then transfer to specialized, focused psychological care.

Zach began meeting with Stellan in the community and pulling him from his routine. At a subsequent team meting he excitedly announced the breakthrough that, "Stellan wants to try something different." Deirdre replied, "that will be major when it happens. And it will. Cause *that's what we do*." They took him to see Dr. Myrdal, who prescribed Clozaril. They developed a plan for Stellan to attend a residential OCD clinic in the LA area to address his rituals. This program cost approximately $40,000 a month and did not directly bill insurance, although families could attempt to be reimbursed. The residential OCD curriculum involved four hours of psychotherapy a day, consisting of three hours of individual cognitive therapy and Exposure and Response Prevention (ERP) and one daily group hour.

I visited the center, and while I could not observe treatment, I spoke with a clinical psychologist and read over their materials. Their ERP approach focuses on a stimulus that would normally trigger a person, such as crowds or contamination, and then supports the patient in refraining from the compulsive behavior. They work with both "imaginal exposure hierarchies" and "in-vivo" activities, and gradually work to lessen the compulsions and avoidances. They also engaged in family systems work, not necessarily because families caused the distress, but because of "the behavioral accommodation family members develop over time to cope with their family member's OCD." Thus, the behaviors themselves were supported in a family environment. "OCD invariably involves an entire family system that requires education and support to help the OCD sufferer overcome their symptoms and comply with exposure work."[5]

The team continued with weekly visits during the months Stellan was in residential, collaborating with the other program to do "in vivo" expansions of the exposure therapy in community settings. His mother decided that paying for Actualization in addition to the residential center was too expensive. Thus, over the period of one year, the "SWAT Team" had rearranged Stellan's care system, prepared him for outside activity, and enrolled him in specialist care.

The Relational Work of Getting to Treatment

The possibilities afforded by money, such as second opinions, diagnostic specificity, and access to specialized treatment centers, might all flounder if a person could not leave the house to get to the therapy. Cassie, one of the social workers in the above excerpt, revealed that she had been a former Actualization client in precisely that position. She had been in various forms of therapy through her childhood and "was the identified patient of the family." After several suicide attempts, and a series of hospitalizations, she felt hopeless. Diagnosed with Bipolar Disorder II and a profound body dysmorphia, she had tried nearly twenty medications and was unable to hold down a job. At the age of 24 she was living on disability and her family had locked her out of the home. They did not have the money to pay for out of pocket care, but when Cassie

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[5] https://iocdf.org/wp-content/uploads/2018/05/Psychological-Care-Healing-OCD-Intensive-Treatment-Program.pdf

began to live out of her car, her wealthy aunt stepped in and paid for private psychiatric services from a famous university doctor.

Cassie came to believe, however, that this prominent psychiatrist had misdiagnosed and overmedicated her. During another hospitalization she was diagnosed with Borderline Personality Disorder, which she initially resisted because of stigma associated with the category. Her family hired Dev, the peer coach social worker and Actualization affiliate, and they planned for her to attend a clinic that specialized in "Mentalization Therapy," a cutting edge approach to Borderline. Yet even though Cassie had access to this therapy, she was unable to go. Her body dysmorphia was so severe that she was unable to stop staring at herself in the mirror and couldn't leave the house. Having the "right" diagnosis and the access to specialized treatment might not matter if a person could not participate. To address this, Deirdre worked to get her out of the house. She recalled such tasks as getting her mail, and going outside to places she was uncomfortable with. Soon the team got her a plant to take care of, and then a dog, which required she take it outside twice a day and walk down the street. She described Deirdre as like a friend gently coaxing her, "Let's not wear sweats today. Let's do your hair." Through months of slowly building her capacity to leave home, Actualization helped her get to the specialized therapy center.

The theoretical base of Mentalization treatment is that people with Borderline Personality Disorder lack the ability to understand how another person's behavior is related to internal mental states. Mentalization is "the process by which we implicitly and explicitly interpret the actions of oneself and others as meaningful on the basis of intentional mental states" (Bateman and Fonagy 2010). Cassie explained to me that they worked to help her understand and properly attribute motivations to others that had previously elicited massive emotional outbursts. In a major turning point, for instance, she'd been out to a dinner celebration at a restaurant where she'd gotten a cake slice that was smaller than others at the table. Cassie believed that it must have been a sleight, but when a woman suggested that they must have run out of cake, she found her mentalization therapy kicking in.

According to Cassie, without Actualization getting her to the mentalization clinic, "I'd be dead or on the streets." Getting the right diagnosis, and then having access to specialized care might not be enough. It also required the Actualization team and close relationship with Deirdre to help her get to the point of not simply living in an apartment (which she was doing with her family's support, albeit poorly), but able to go and do the psychotherapeutic work that changed her life.

Rationalizing the Disordered Self

Actualization's own IOP curriculum consisted of cognitive behavioral (CBT) and dialectical behavioral therapies (DBT) with workbooks and homework assignments, alongside art and experiential groups. The psychotherapies, broadly concerned with "self-management," are industry standards for both mental health and addiction and not restricted to the wealthy. Yet the emphasis stands out when contrasted with the relative absence at the county team, where groups focused on things like basic check-ins, money management, and information on medication. As Evan the IOP director explained during a session, "At Actualization we do the 'opposite action.' So if you feel like staying in bed, you should go to the gym." This was because people's thinking was considered disordered yet open to rational reflection and change. By learning to name emotions, rate them, and work on being "mindful" through difficult experiences, clients could hope to have greater choosing capacity. This required symptom rating, as the inscription of such ratings would allow tracking of emotions and cognitions. The director elaborated, "When we look at things [e.g. anxiety] and rate them on scales, they tend to go down after awhile."

Similarly, Dawn the Dialectical Behavioral Therapist implored clients to "name it to tame it." By this she meant that articulating emotions and bodily states allowed people to "know what they're working with." Consider the following example where Dawn and Evan coach a client to disentangle his emotions and interpretations from facts, and symptoms from reality. Anthony, a white man in his early fifties who had come as a medical tourist for schizophrenia treatment, expressed his fears that his family would send him back to his country. He had been attending IOP and begun with an individual therapist, and had a night vision of his therapist disclosing his childhood trauma to his parents.

> Anthony: I had an emotional thought. Because of what I told my therapist my parents will send me back.
>
> Dawn: the emotion?
>
> Anthony: fear and panic.
>
> Dawn: these are your interpretations. Remember thoughts aren't facts.

Another client speculated that it would be illegal for the therapist to reveal his secrets, and Evan asks why the therapist would disclose these things to his family.

> Anthony: I guess because the stakes are so high, I have an irrational fear.
>
> Alex: I like that you can see that. When the downside is so big…recognizing it as irrational is important because there's no reason for her to tell.
>
> Anthony: I wrote in my notebook that she said she wouldn't tell. And my case manager says I won't have to go back until I'm well and working. We are going to start the medical Visa in August.

Evan asked what Anthony would tell a friend who had an irrational fear. "I'd say it's irrational and has no basis in reality," he responded. As a next step, Anthony could simply ask the therapist if she in fact revealed what they'd discussed.

> Anthony: I have all kinds of hallucinations at night. Since she broke my confidence, my family and doctor talk at night.
>
> Evan: And you know those are symptoms, not really happening. You've run off with it in your symptoms.

By disentangling bodily feeling states, emotions, thoughts, and hallucinations from reality, clients might slowly gain some control over their internal world.

Here Anthony's fear that his therapist is not trustworthy, and that his family will not support him in his treatment, are addressed through the lens of correcting distortions and accepting that which cannot be known. Alongside the past-oriented individual therapeutic work, which may address the *meaning* of such fears and identify things like "childhood trauma," the Actualization IOP aims to help Anthony cope with and name them as irrational.

Working With Schizophrenic Subjectivity

In contrast to DMH workers like Vic, who suggested that "legitimate schizophrenics" had essentially lost their souls, Actualization workers engaged people with thought disorders with a sense of possibility. Some of the workers at Actualization were inspired by the humanistic psychology traditions that viewed psychosis as meaningful. Both the Buddhist psychology MFT Ian and the nutritionally focused social worker Zach had connections to an additional, if unofficial, part of the Southern California holistic healthcare ecology: psychedelic drugs as a spiritual practice. Indeed, Ian had been synthesizing his own DMT (the active ingredient in Ayuhuasca) and invited Zach, another Actualization therapist, and me over for trips. I declined, but began to speak with Ian about how his experiences shaped his work.

Ian believed that the more time he spent with people experiencing positive states of psychosis (e.g. hallucination) the more he realized those were states he had already approached through his drug experimentation. Some people, he believed, are genetically disposed to such experiences. Others learned about them through sacred plant medicines. Currently he was case manager for Omar, a twenty-five year old man diagnosed with schizophrenia who also attended UCLA's Intensive Outpatient Program. He was another

Breyer Insurance client, although his family also began to pay for services privately. He'd been conserved with his parents having a guardianship, but Ian reported that Omar was now engaging enthusiastically in their sessions. Omar was having trouble physically tolerating antipsychotic medications and was thus unmedicated, and he persistently experienced visual light and pattern constellations, as well as wordless chanting.

When guiding Omar through meditation, they came to states Ian said he was not experienced enough to facilitate. Fortunately Omar seemed to be able to walk back from the edge. According to Ian, Omar initially allowed the sounds to become voices, which began to say "its you, it's you." Then later they said, "it's god, it's god." Then the voices told Omar not to let the voices through, and they returned to chanting. The young man became involved in posting about his experiences in online forums for people experiencing psychosis. In this way, Ian was attempting to engage with some of the alternative approaches to psychosis. For instance, he tried to find a "Hearing Voices" group for another client, who was already connected to a PhD clinical psychologist with training in the Finnish Open Dialogue method. These are considered "progressive" forms of peer support and family therapy that seek to counterbalance medical model approaches to psychosis.

These alternative approaches to healing schizophrenia, however, generated tension at the clinic. In a broader discussion of medication and people's ability to titrate down, they noted that Omar had been doing well without medication because he had an enormous amount of support from family, the UCLA IOP, and Actualization. Deirdre believed he would need to try antipsychotics again now that his highly intensive structure was coming undone, as the insurance stopped paying for IOP. "Mark my words," she said. “Omar is going to lose it eventually.” Ian responded, “I’ll prove you wrong as long as I’m here!”

In some cases, workers took an approach that was neither psychodynamic nor a spiritual interpretation of altered states, but a slow attempt to poke at the delusion when the most powerful antipsychotics failed to alter it. Here odd beliefs are still medicalized, but the relationship centered on helping people slowly question whether the delusions were real. Consider the following treatment interaction, when I accompanied Dev, Actualization’s affiliated peer coach social worker, to meet with a client diagnosed with schizophrenia who was still unsure if he was in purgatory.

Daniel was a white man in his early 40’s who’d had a late onset psychotic break in his 30’s. Previously a CPA who also had a JD from a private university, he became convinced he was in purgatory. He had been hospitalized when he stopped eating, believing he could escape purgatory by fasting for 14 days. He had briefly met with Actualization, but ultimately felt closer to Dev and decided to have him as case manager. One evening we met up with him to have dinner and a casual therapeutic session.

While they had previously met three days a week for sessions, Daniel had moved out of his aunt’s house in LA and back to another city to be with his wife and children again. His wife hadn’t wanted him around the kids, because he’d continually ask them, “Can you help me get out of purgatory?” Now he met with Dev monthly for check-ins. We met in a mall and ate at a Yardhouse chain restaurant.

> As we walked over, Dev asked how sure Daniel was in purgatory. He responded that he was 90% sure, which was an increase over before. Dev asked if the doctor

had lowered the Clozaril dose, and Daniel said he had. He believed that the Clozaril was acting not medically, but through Dev and his powers.

Daniel told me that he believed Dev was a supernatural being, maybe Jesus, “placed here to help me through this process.” When he’d first met Richard, the owner of the Actualization clinic, he’d wondered if the man was God. “He’s a pretty charismatic dude,” I agreed. Now Daniel said he felt more and more like his everyday experience was real, but he couldn’t account for the last five years of his life.

While we waited for dinner to arrive, Dev pulls out his Cognitive Behavioral Therapy for serious mental illness illustrated guide, and flipped to a scale on delusions. He then measured Daniel on such issues as how preoccupied he is, his conviction that the delusion is real, distress, and disruption to life. Daniel stated that on distress and disruption to life, his numbers had gone down considerably over time. He was now trying to work again.

The big thing, Daniel explained, is that it can be hard when he goes for a job interview and he’s worried that maybe the guy is reading his mind. Dev points to a part of his CBT book on how there’s been lots of research debunking ESP and telepathy. “What do you think of this book saying there is no telepathy?’ For Daniel, this didn’t prove anything about his experience. On the contrary, the fact that he encountered telepathy proved his belief he was in purgatory. “I agree. That means I'm not on earth.” I laughed at his clever logic, and we began eating.

*

In sum, the Actualization Clinic emphasized that they treat a whole person in their broader life, which means moving beyond thing like a person's diagnosis. And yet, in order to do so, they feel they must get the diagnosis and medication correct. From there, a diagnosis can draw together a network of practitioners in a variety of frameworks, from psychodynamic theory, to family systems, to spiritual, and cognitive approaches to serious mental illness. The clinics expertise may be in referral, connecting people to specialized centers that can address particular symptoms with targeted therapies.

Conclusion: Diagnostic Networks, Ecological Affordances and Treatment Expertise

In this chapter I've outlined different epistemic cultures in the DMH and Actualization clinics. My strategy was to follow how the clinics work diagnostically and then the types of actions such categorization in turn authorizes. I've shown how, despite both operating under general psychiatric rubrics, the diagnoses and approaches to mental illness then get connected to myriad other institutions, actors, and discourses that treat patients very differently. This is because contemporary psychiatric diagnosis is a boundary object that can pull together numerous projects and authorize a variety of interventions.

If we look at this from the perspective of the diagnosis, consider a typical trajectory for a DMH client: a diagnosis of "crazy-enough" may serve to connect a doctor and patient interacting in a clinic with an SSI panel, to a medication prescription, to a housing application and worker who keeps the housing paperwork in order, to a nurse who dismisses patient speech as nonsense, and checks to make sure people are alive. What is missing here is also striking: tailored therapeutic techniques for the psychological dimensions of illnesses, trauma, or a more general engagement with client's subjectivity.

Consider instead a trajectory of a person at a place like Actualization: a diagnosis of schizophrenia versus OCD, Bipolar versus borderline, might connect the person to specialized treatment, to psychedelic loving therapists with an interest in exploring altered states, to workers who insist on moving past diagnosis to making a life, and a processing of trauma. The issue of qualifying and recertifying things like housing based on disability status are beside the point.

Within these epistemic cultures workers must *know* certain things in order to *intervene* in different ecological systems, but what is knowable, and therefore actionable, is in turn relative to the system. To paraphrase Bruno Latour, they must also *make the world a clinic,* altering the environment and enrolling other actors—family members, laboratories, therapists, landlords, board and care home operators, housing authority bureaucrats—to make therapeutic interventions translate out into "real life." In turn, they are responsive to those same actors, who have their own projects that sometimes align and diverge.

Chapter 5

Between Tolerant Containment and Concerted Constraint

In the previous chapter I illustrated the profound difference in the meaning of an illness classification at the DMH clinic and Actualization, and the way a similar diagnosis may open up vastly different possibilities. In each case, community psychiatry focuses on life management beyond medication, but the two worlds feature divergent interventions for vastly different lives. Downtown, DMH focuses primarily on ending homelessness and the "institutional circuit" of jails and brief emergency hospitalizations. I described the difficulties compounded by the shifting resources, lack of information, and clients who had dispositions oriented to street life. At the Actualization clinic, clients' basic safety and necessities are already secured, allowing the treatment team to focus on transformation, such as connection to elite psychiatrists to reevaluate medication regimens, specialized psychotherapies or linked programs for particular diagnoses, and daily routines involving intensive group therapy, volunteering, or school.

This vast inequality in resources in the clinics and the clients' broader lives, however, can lead to some ironic contrasts in the forms of governance and what the teams try to make people do. Numerous scholars have noted that there is a potential for conflict between institutional logics of "empowerment" and providers' task of managing mental illness (Estroff 1981, Dobransky 2014, Myers 2015). This is most obvious when a person outright refuses to engage with providers, but may also come in various gradations, from the legally loaded issues of medication adherence and drug use, to less politicized questions like whether a person wants to go outside or do things. Precisely because the

DMH clinic has less to offer beyond survival basics, and they recognize that their service users have enormous needs, they have developed a tolerant approach with low behavioral expectations. On the other hand, because the Actualization clinic has great therapeutic capacity, works with and for well-off families, and believes in the potential for clients to do better, they attempt to cultivate class appropriate behavior and health.

This chapter focuses on people who are involved in voluntary care, yet are failing to self-govern in prescribed ways. Strategies to address this may range from shaping people's thought processes, to limiting their choices, to accepting deviance, with coercion as a possibility lurking in the background. With client choice both legally institutionalized and normatively valued, the team's work with the resources at their disposal to achieve different visions of recovery. I elaborate on Rose's (1999) notion of governing people *through* their freedom, with authorities offering and structuring choices more than overriding them. The tension arises when the governed do not appear to meet standards of rationality, but are also in a legal position to choose or refuse aspects of their care. Each team works in a terrain where outright coercion is only one tool in a larger system of incentives, nudges, and shifting ideas of acceptable outcomes—in other words, different choice architectures (Thaler and Sunstein 2009) surrounding madness. Consider the governance strategies for two men who reject aspects of their treatment.

Two Models of Governing Through Freedom

DMH: Tolerating Hugo Castro

Hugo was a Cuban American man in his mid-20s. Diagnosed with schizophrenia, Hugo had aged out of Hollywood's programs for street kids, and recently received a subsidized apartment through a non-profit. The treatment team began to worry when he said could hear predatory men's whispers and thoughts, as his goal of protecting his female friends might turn into conflict. He'd begun to take homeless youth in, and Hugo's neighbors grew angry when he held a party and emergency medical services were called for a possible overdose. Between the possibility of eviction and the potential for violence, the team decided to evaluate him.

In the team meeting the nurse Vic stated that it was important to talk to Hugo about his plans, but to remember, "trying to understand what schizophrenics are thinking is impossible." Lauren the team leader agreed that they were not trying to "understand deeply" but to listen practically—for if they did not address the potential for danger, "this is how we get sued." Betty the nurse, with her many years as a psychiatric emergency team [PET] worker, would be ready for a potential 5150 hold. In the following field note, I traveled with Betty and Beth the social worker, who worked with Hugo to minimize his risk of eviction after deciding he is not a danger to self or others.

> We drove to the apartment building and found Hugo with a group of teenagers. He was all skin and bones, with his hair in messy dreadlocks. Hugo clutched his arm, having hurt his shoulder skateboarding. A young woman of about 15 came out of the bathroom. The kitchen was a mess, with overflowing dishes in the sink and the smell of cat urine wafting through the air. After asking the youth to step out, Beth told Hugo she was concerned. She acknowledged that Hugo was trying

> to do the right thing, but it looked bad to have underage girls in the house. Also, he might see any man, “even Neil,” she said pointing to me, and think I’m talking about hurting a woman.
>
> Hugo responded that men “can talk all the shit they want,” but until they “lay hands” he won’t do anything. I looked at Betty for her reaction, and she didn’t shift her expression. They then discussed how he could keep the things he wanted, like the cat, if he went through the proper channels and got it approved as a therapy animal. His SSI was coming through soon, and Beth said he could perhaps find another place with a different management company. Then he could have friends over and party late “because it will be in a shitty building.”
>
> When Betty asked if he’d like a medication appointment he replied that he’d rather have his friends, instead of being “zonked out on meds.” He scrunched his face up imitating a zombie, and we all laughed together. When Beth moved some trash around he said, “Don’t do that, Mom.” She replied, “I’m not your mom.” As we left Betty noted, “He said the right thing about not reacting until men ‘laid hands’ on a girl.” They decided they couldn’t put him in the hospital, but would concentrate on making sure he didn’t get kicked out.

Note some of the key features of the interaction in Hugo’s apartment.

First, Betty honored his right to not be hospitalized, as well as his right to refuse a medication appointment. Like many subject to evaluation for the hospital, Hugo seemed to know what to say to avoid it. Because of his strongly institutionalized civil liberties, Beth and Betty’s best option was to try and limit his and their liability. They explained to

Hugo that it looked bad to have underage girls around, even though he was trying to protect them. On their end, they could document they'd evaluated him. Far from an intensive behavioral regimen, or medication to "zonk" him, or understand him through therapy, the plan was to try and save his housing. One way to do this was to get him to move to a "shitty building" where no one would complain about his partying. Indeed, six months later and under threat of eviction, Hugo left that apartment to move to a Downtown hotel that had been converted into small permanent units.

Second, consider the issue of Hugo's speech and the use the team makes of it. Hugo called Beth "mom," and relayed that his mother had been murdered. Later, however, Beth learned that his mother was alive, and Hugo had gotten her phone number and began saying sexual things to her. For the team, the issue with Hugo's speech was not the Freudian or family system interpretation of this psychosexual content, although at one point they joked about "psychotic transference." Instead they focused on whether he would agree to the terms to help save his housing, and whether he was technically appropriate for hospitalization. Here, what in the last chapter I noted as an anti-therapeutic lack of engagement with client subjectivity, might be reconceived as leaving a person alone.

Working in such situations, with clients whose psychiatric histories were matched by social trauma and precariousness, the team aimed to achieve stability, loosely defined. The temporal, material, and institutional restrictions of working Downtown meant that whatever one's position on autonomy versus control, the work tended to become laissez faire until the point of dangerousness. Then, a heavy-handed hospitalization might be in order.

Actualization: Constraining and Cultivating Tom Burton

At the Actualization Clinic I found something quite different than the laissez faire until point of dangerousness model at DMH. Given higher status clientele who appeared to have substantial potential based on their familial and educational pedigree, Actualization sought to generate hopeful futures and help clients achieve their life goals. This required some forms of constraint and therapeutic control in order to help cultivate the person and get them to high functioning, a therapeutic constraint that was not enacted on poor patients. While the team tried to align their work with the client's projects, therapeutic work often meant the reduction of choice in order to facilitate growth and normative behavior. Here, amidst privilege and opportunity, the team utilized subtle forms of discipline in the name of health.

As an illustrative case, consider the experience of Tom Burton, a white man in his mid-20s who came to the Actualization clinic after a month in a Northern California hospital. He'd studied computer science at a prestigious university before attempting a career in Silicon Valley, where Tom became convinced that the Singularity, or the melding of human consciousness with that of artificial intelligence, was unfolding before his eyes. As he joked with me, his friends steeped in tech culture first believed his claim before realizing that he was in an episode. He'd been diagnosed with bipolar disorder previously, but hoped he could manage without Western medical interventions. Referred by Breyer Insurance as a high utilizer, Tom would receive the team's full suite of case management, IOP group therapies, and family meetings.

Tom came from an upper middle class family who had encouraged his education and were themselves high achieving. His mother was an attorney in Northern California and his father worked in business and now the mental health field in LA. Like many in Actualization care, a subtle form of leverage facilitated participation. I got to know Tom at the IOP, where he told me that he was there to appease his "investors," namely, his parents. Living with his father, he spent his afternoons after groups researching Bitcoin and other blockchain technologies, hoping to find an angle for getting rich.

Tom reported to me that he liked his case managers Ian and Zach a lot, as they were also interested in Eastern spirituality. In the IOP, when Tom grappled with whether his ecstatic spiritual experiences were just delusions, the therapy pushed back against all or none thinking. Evan, the leader of the IOP didn't think it should be reduced to just mental illness. He was worried, however, when Tom condemned "Western medicine," believing this indicated another plan to go off of medication. The team hoped to equip Tom with coping skills and address his family dynamics, and help him recognize the need for psychotropic medication alongside holistic health.

Consider the following treatment interaction in Dialectical Behavioral Therapy group. Tom was addressing his conflict with his father, who doubted Tom's business ideas and wanted him to do something else with his life. Here Tom speaks the language of DBT and how the therapy was helping him live with his father and make better choices. The skills of DBT addressed previously, such as naming and reflecting on feeling states, appeared to help him turn reaction into purposeful action.

> Tom: [In the past] he'd say I was full of shit. I'd say f-you dad. But I stayed mindful during the trigger and he gave me the best advice—I don't have to be an entrepreneur to be happy. I could do other things and be just as happy.
>
> Therapist: You're so much more open.
>
> Tom: yes, more growthful. DBT gave me the skills to *choose*.
>
> Another group member: Choose what?
>
> Therapist: The choice to remain calm and present. What did "emotional mind" say?
>
> Tom: He's going to judge the last two years of my life.
>
> Therapist: You're making assumptions.
>
> Tom: Yes I felt afraid. Fear and hurt.
>
> Therapist: "rational mind" said what?
>
> Tom: maybe I should listen to my dad, he pays my bills.
>
> Therapist: "Wise mind" is a melding of the emotional and rational.

Thus, the therapy presented Tom with a new way of conducting himself in relation to his father, the ability to choose his actions versus simple emotional reaction, and the wisdom of understanding his financial situation with his father. Learning to stay "mindful" through fear and anger could generate new forms of choice.

Yet when I spoke to Tom outside of IOP I came to wonder whether he was performing for the therapists. He told me that he'd discovered a system called "Bipolar Advantage," which suggested that extreme states could be harnessed rather than eliminated. From this perspective, some of his heroes in the tech world may well have had similar experiences. “Steve Jobs was probably bipolar,” Tom said. He began to denigrate the IOP, and said he was only coming to Actualization so his parents would support him.

All of this expensive treatment, then, could feel like control. He disengaged, began smoking pot again, went off medication while at an Eclipse festival, and became psychotic. He reportedly entered UCLA psych voluntarily but was then held against his will, and a Riese hearing (legal order for forced medication) overrode his refusal of an antipsychotic injection. After the case manager Ian visited the hospital, the team debated whether to push for a legal guardianship. Ian and Zach, who believed in the wisdom of altered states, saw possibility for growth *through* the crisis.

> Deirdre: his mom and I talked about possible conservatorship. We gave the number of our mental health attorney.
>
> Ian: you think a conservatorship is necessary?
>
> Claire: yes for now…until he understands that the antipsychotic will be part of his life, he needs to be on an injectable.
>
> Ian: I’ve never seen anything like it. It was beautiful to behold actually. I could see it (psychosis) peaking. All the same stuff, with AI, the world ending…
>
> They continue to discuss the logistics of the discharge.
>
> Zach: and he’ll learn from it.
>
> Deirdre: I wouldn’t go there.
>
> Zach: (points to an inspirational quote written on the white board) “A man’s errors are his portal to discovery.”

The above case conference points to a tension I addressed in the last chapter, between Ian's kind of Laingian interpretive model of psychosis and spirituality and Deirdre's insistence on the need for antipsychotic medication. For Zach, the crisis presented an opportunity for learning. Yet for Deirdre, they had to take advantage of this opportunity to revoke Tom's rights.

After stabilizing on an injection of the antipsychotic Invega, he was discharged to Resolve, the psychoanalytic residential treatment center. Here they would try a different form of therapy, working to get to the childhood roots of Tom's experience. When Evan the IOP director and I met with Resolve staff on a tour of the facility, they noted that Tom was coming to see how his sense of insignificance as a child fed his desire for grandiosity.

Yet after a month at Resolve, Tom was heading to Northern California to live with his mother. The team would continue with phone contact, but were unsure how well they could work with him from afar. Tom told them he planned to go off the injection. Deirdre said, "his mom should have conserved his butt," but Ian relayed that the mother said it wouldn't go through. "He seemed on board and was doing really good analytic work on the source of the psychosis. They've got a cool program [at Resolve]." Yet Deirdre was still upset about the lack of conservatorship. "How many times does it take? It's not enough to be at UCLA for five weeks?" Traveling through the elite institutional circuit, Tom would soon move on to another treatment provider up north.

*

These two young men present a similar problem, but one shaped by vastly different life situations and treatment options. Both agree to comply with certain aspects of treatment, such as help with housing and benefits, on the one hand, and some therapy groups, on the other. Each is resistant to antipsychotic medication. There are differences of course, for instance, of diagnosis—schizophrenia versus bipolar disorder with psychotic features. Hugo's street punk and Tom's Silicon Valley worlds are also substantially different, but brought together in the question of what it means to govern a person who is intermittently or partially "non-compliant." Building off the last chapter, which pointed to radically different options for treatment, I address here what those models mean when it comes to the question of shaping people's actions. These stories illustrate what is at stake and how the providers understand their role in the world, and who their clients are or can be.

At DMH, the goal is to keep Hugo safe, housed, and ensure he does not do anything destructive. Rather than interpret his psychosis, they orient to Hugo's speech through the lens of legal liability and attempt to make sure both he and they are covered. Ironically, the team's lack of interest/capacity in getting to know his thoughts and control his everyday actions means Hugo has a kind of surprising freedom. His rough experiences as a homeless street youth have now facilitated him having access to independent housing and logistical support with few rules or behavioral expectations. The hope is that he will either eventually engage in medication treatment on his own eventually, or will cross a threshold at which they can put him back in the hospital. In effect, he has latitude until dangerous or gravely disabled.

At Actualization, Tom's leverage dynamic and class status—participating to appease his family who have money and good private insurance—facilitated a substantial amount of treatment, from case management, family work, to group therapy, that served in part as a form of governance. The depth of penetration into his psyche, as a form of both care and an attempt to foster self-control, contrasts markedly with the way Hugo is left alone. They are building different types of subjects—it's assumed Hugo will be a continued SSI recipient who hangs on the streets, while Tom may very well return to work, although his father wants him out of Silicon Valley entrepreneurial world. Yet the leverage relationship to push intensive treatment only goes so far, as he came to believe the care and cultivation of his potential was controlling, and he rejected a pathological view of his experiences. This heavy investment in understanding Tom's psyche to get him back on track, may or may not be effective. Expressing his plan to go off the antipsychotic again, his family has no legal recourse.

Theorizing Governance Logics

Precisely because treatment is both a *care resource* and form of *social control*, it complicates typical associations of poverty with constraint and wealth with freedom, as well as recent theories of neoliberal governance. A wide literature observes the disciplining of the poor, who must comply with therapeutics to avoid arrest (Stuart 2016), work to receive welfare (Soss, Fording, and Schram 2011), and become responsible self-governing subjects in a larger context of hyper-incarceration (Wacquant 2009). Comparative research across class echoes the intuitive domination of the poor and a tolerance of the rich. In addiction services, for instance, McKim (2017) finds that the poor are subject to intensive surveillance and discipline via criminal justice rehab while the better off receive less invasive care and avoid stigmatized "addict identities" in private insurance programs. Similarly, the literature on white-collar crime shows the general "kid gloves" applied to the class privileged and highly educated (Madden et al. 2012).

Why, then, does tolerance emerge amidst the material constraint of poverty, while disciplinary power manifests itself with the material freedom of wealth? My answer is that these forms of governance are dialectically related to clients' experiences of constraint and indulgence. The clinical regimes are embedded in social ecologies that have markedly different goals and resources to achieve them, and thus different practices.

In the context of *urban poverty governance*, the public safety net team engages in *tolerant containment* of deviant behavior. Rather than surveillance and the transformation of subjects via disciplinary tactics (e.g. Foucault 1977), the team aims for basic management of harm. With a key goal of housing homeless clients and ending the institutional circuit, providers concede a degree of medication "non-compliance," continued substance use, and idleness as inevitable. In the context of *family systems governance,* the private treatment team engages in *concerted constraint* of clients' behavior to transform them into responsible adults. Here I bring the social control scholarship into dialogue with the literature on family class socialization. Drawing on Lareau's (2004) notion of "concerted cultivation" of privileged children, which emphasizes scheduling of activities, surveillance, and development of individual capabilities, I theorize *concerted constraint* as the mobilization of therapeutic resources to develop and control adult-children.

These governance styles are not primarily about domination and coercion, but about shaping people's freedom. Foucault (1982 789) defined the art of government in liberal societies as

> …a set of actions brought to bear upon possible actions; it operates on the field of possibilities in which the behavior of the acting subjects is inscribed: it incites, it induces, it diverts, it makes easier or more difficult, it broadens or restricts, it makes more or less probable.

In mental health services after deinstitutionalization, we can trace the development of such a "governmentality" as well as deep ambivalence about its appropriateness for people with serious mental illness. Alongside more outright relations of coercion, such as hospitalization or guardianship, voluntary mental health care must act upon the freedom of its subjects to ensure both "empowerment" and acceptable behavior.

Governing authorities may shape "choice architectures" to "nudge" people in various directions, eschewing force for the guiding of choice. As noted throughout this dissertation, neither clinical regime's strategy works all of the time. This chapter examines the construction of such choice architectures in highly stratified spaces, and the way each clinical regime aims to craft subjects in line with its institutional requirements. Such broadening or restricting, inducing and diverting, takes on different forms when oriented to different goals, and is suited for producing different types of people. The following table summarizes these projects, tools, and logics of care and control.

Tolerant Containment and Concerted Constraint

	County DMH	Actualization and Network
Governance Project[6]	*Urban Poverty Governance*	*Family Systems Governance*
Practical Goal and Tools	*Neutralization* of public nuisance through medication, housing, and disability benefits for the homeless or formerly incarcerated mad person.	*Normalization* of wealthy patient and strained family relations through medication, specialized psychotherapy, and rehabilitative activity.
Logic of Care and Control	*Tolerant Containment* (e.g. contra Foucault 1977 on disciplinary power) of deviant behaviors, such as "non-compliance," substance use, and idleness.	*Concerted Constraint* (e.g. Lareau 2011 on privileged childrearing) of deviant behaviors, leveraging resources and therapeutically reforming wayward adult children.

Bridging Foucault and Lareau

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[6] A note on the "governance projects": marginalized urban patients may have family involvement, and rich patients may occasionally create problems in public space for the city. My analytic separation of *urban poverty governance* and *family systems governance* points to the way the overarching clinical logics are linked to these broader organizational and institutional dynamics.

The main theoretical contribution of this chapter is to bring the Foucaultian study of governance into dialogue with what at first seems distant—the sociology of childrearing. Lareau's (2000, 2003) classic comparative ethnography of social class and parenting offers an account of differential logics of raising children that is particularly useful here. Working class and poor families engage in an "accomplishment of natural growth" model of parenting, believing "as long as they provide love, food, and safety, their children will grow and thrive." (2000, p.749). Lareau notes little structured activity, and less emphasis on talk. Her middle and upper-middle-class families, in contrast, engaged in a "concerted cultivation" to develop talents and capacity in individual children, "a deliberate and sustained effort to stimulate children's development…" (2003, p. 238). This required "organized activities that dominate family life and create enormous labor…" (2000, p. 748). Furthermore, they attempted to reason with children, with talking as their preferred method of discipline.

These styles were rooted in part in material class factors, as only the wealthier could afford to pay for things like violin and karate lessons. Yet it was also linked to different ideals, such as middle-class parents seeing their children as "projects," or a working class parent's criticism of forcing a child to play piano. Lareau (2003) further argued that these forms of socialization reproduce class advantage through differentially rewarded dispositions—the poorer children lacked tools for navigating middle class institutions like school, and the more privileged children began to feel entitled to resources or speaking with authority figures, such as doctors or teachers. Recent extensions, such as Sherman's (2016) work with elite parents, finds a concern that too much material privilege may spoil a child morally. Thus, properly cultivating a child may also require retraction of goods or “symbolic deprivation” (Pugh 2009) to ensure proper moral characteristics.

This “concerted cultivation” with emphasis on scheduling, achievement, highly verbal interactions, and the development of individual talents and interests, offers a possible hypothesis for how child-rearing logics might arise in clinical care oriented to the privileged family. Would community treatment providers attempt to schedule the time of the “adult child,” cultivate his or her interests into productive talents, and expect therapeutic achievement? When put into dialogue with the social control literature, we also begin to see intriguing parallels unexplored by Lareau herself. Most notably for the following analysis is the intersection between “concerted cultivation” and the techniques of Foucaultian (1977) disciplinary power. With each aiming to develop self-efficacious subjects for participation in modern social institutions, and sharing such tools as surveillance, the time schedule, and controlled activity, we may find reading Lareau alongside Foucault offers tools for theorizing governance far beyond childhood.[7]

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[7] The opportunity for theoretical synergy here is considerable. Foucault’s writings (2008) on the family in disciplinary societies, such as the surveillance of childhood masturbation, offer a rich and suggestive avenue for exploration. Yet as feminist scholars like Bradley (2012) have pointed out, he offered only “fragments” of a genealogy, alternately conceiving of the family as a sovereign or disciplinary institution, and he failed to theorize maternal power at all. Thus, empirical sociological works like Lareau (2003), with ethnographic observations and grounded theorization of actual familial governance practices, offers ripe material for contemporary Foucaultian theorists. When Foucault (2008) did address families of means and their management of deviant members, he addressed a historical era where the solution was long-term institutionalization—a different problematic than the one presented here.

Tolerant Containment at DMH

Housing the Homeless Mad Person

As noted in chapter 3, public psychiatric services in Downtown LA respond to a particular yet not uncommon context: urban redevelopment of a gentrifying area and the need to clear problematic people from the street via either policing or services. In contrast to but also conjunction with the "zero tolerance" policing of street corners (Stuart 2016), mental health and housing providers work to move people into apartments or Board and Care homes. This approach is oriented to madness as an urban problem: the management of people who are homeless, recently discharged, or at risk of being a disturbance in public. Its goal is *neutralization* of problematic public behavior, not by incapacitating people via incarceration, but by bringing people indoors and manipulating environments such that behaviors that cannot be fully changed can be tolerated or redirected while contained in housing.

As a form of social control, this "tolerant containment" is characterized by an acceptance that rehabilitation is unlikely, eschewing the attempts to create the docile and productive subjects that Foucault (1977) theorized in the prison and asylum, or the responsible consumer of neoliberalism (Rose 1999). Yet unlike post-disciplinary strategies that would simply exclude problem people from public spaces, this "post-disciplinary tolerance" creates spaces for people to be deviant. It focuses on "harm reduction" in the broadest sense, from codified and concrete strategies regarding medication and substance use, to minor alterations of problematic behaviors such that they do not lead to client eviction and arrest. Put simply, tolerant containment is more than neglect or social abandonment, but less than robust care and treatment.

Lowering Behavioral Requirements to Get People Off the Street

The first step of a tolerant containment approach to managing empowered madness is to relax behavioral expectations. In line with a broader movement toward low-barrier housing, DMH placed outreached homeless people up in hotels or special shelters and applied for vouchers for permanent supportive housing. The quickest route to stable housing is typically placement in a Board and Care home, with shared rooms, medication monitoring, and onsite staff who cook and clean. Yet it was precisely those "difficult" clients that refused or were refused by Board and Care homes that might get permanent apartments, because specialized vouchers were tied to length of homelessness and "vulnerability" scores. Thus, one way to govern through seemingly irrational or pathological choices was to simply accept the behaviors that were previously unacceptable.

Clients deemed too difficult for other agencies or who had done poorly in structured settings were offered independence, and a surprising freedom to engage in ostensibly problematic behaviors. For those who had been booted from stricter settings outside of DMH, the team's relative tolerance was remarkable. As Vincent, an African American man in his early fifties said to me upon first entering his subsidized apartment, "Am I dreaming? I can't believe this." He explained that he had been in and out of prison, kicked out of a Board and Care home for drug and alcohol use, lost an apartment, and lived on the streets and in the shelter. Although constrained by poverty, he could now make everyday choices in his subsidized unit. As Lauren the team leader put it later with a smile and shrug, "He's still housed, still drinking, and still defying gravity!" Given that he was alive and indoors, his alcohol consumption was tolerated.

To see the key features of this practical logic, consider a debate over the appropriateness of such housing placements. Melena, a licensed practical nurse who had previously worked in hospital settings, broached this at one morning meeting. "We know they were sick. Why did we put them in these apartments?" She relayed her latest contact with a woman who glared menacingly and intentionally broke the key to the door. The team debated whether the woman could stay in structured settings. Lauren concluded,

> They were this way on the street. At least they are safe. People like them are not gonna do what we want. But what can we do? These are the behaviors that kept them in the streets.

Notice the disjuncture between Melena's suggestion that people who are "sick" do not belong in independent living, and Lauren's high tolerance of the woman's behavior. With the belief that people will not "do what we want," Lauren prioritizes the basic *safety* that comes with a roof and a locked door.

Daniel, another team leader, explained his ambivalence about the Housing First model. He had found through experience that some people did not do well or were not prepared for that level of independence, and lived in conditions that he saw as detrimental

> Some clients are, Housing First model is perfect for you. You stick them in, you get them the rest of the resources and moves forward. A lot of clients are not ready to be in housing.

> I don't think we like to admit that, "He's really not ready to be in a place." If you've seen some of the units that we've seen, you'll realize, "We knew he wasn't ready for this." Or this person really needed to be in inpatient care. He's got trash stacked up high to the doors. We see a lot of that stuff. The staff, if you talk to us, we go back and forth on the Housing First model. Because we get to see the other side of when you put into housing and they're getting evicted.

An eviction on a person's record would impact their ability to secure a lease at a future time. Yet Daniel took pride in trying to honor a client's wishes and give them a chance to try and independent living.

> Here's the funny thing. If a client tells us they wanna be in permanent housing, we will do it. At the end of the day, we will do it. Even if we don't think it's—we will do it. Try to give them the support that they need and hope for the best. We still end up doing it because that's what the client really wants. We try to provide that support and the help to be successful. We're trying to figure out a graceful exit so that they don't get an eviction.

Here the aim of keeping people away from the dangers of street life, or giving people a chance to fail, dovetails with the urban development need to bring the most disruptive homeless people out of public sight. Neutralized as a problem of visible disorder, behaviors could then be tolerated until reaching a point of "danger" or eviction.

"Sitting Back" and Keeping People In Place

With client's legal rights to refuse care unless "dangerous" or "gravely disabled," workers were often laissez faire until a person became "hold-able." For the DMH psychiatrist Dr. Wong, ideas like harm reduction and rapid housing made sense in terms of engagement, but he found some people continued to refuse his treatment after they had safety. Having worked in hospitals and prisons, however, he was used to greater control than in community care. He was frustrated that there was little to be done coercively until a person crossed a "danger to self or others" threshold.

> Gone are the days where we tie them [mental patients] to a post and beat them…But now we're too far over to the other side, the pendulum swung over. Now they're saying my job is to educate a person about their mental illness, and their options, and you have to sit back and hope that the person chooses the right choice…Until something bad happens.

When the team hospitalized people who had passed "danger to self or others" thresholds, they prepared for a quick release. Yet rapid discharges did not result in a completely passive "sitting back," as Dr. Wong put it. Instead, there were different interventions related to voluntary care and the continual evaluation of risk. Like the opening vignette with Hugo, the team often worked to bring neighborly tensions down to a simmer.

Lola Avila was a Salvadorean woman in her forties who had been outreached near a politician's office, where she had reportedly screamed at passersby and thrown feces. Utilizing a Shelter Plus Care voucher, the team found her an apartment with Mr. Kwan, one of two Korean landlords who, as Carlos the housing specialist put it, "know the nature of our clients." Lola refused to take medication. The team was not surprised when she got into conflict with her neighbors over the shared backyard garden space, where she had supposedly cut down someone else's tree. I traveled with Beth and the psychiatric technician Buck, who wondered if they might need to hospitalize her. Yet when we arrived at Lola's apartment, they were able to facilitate a conversation between her and Mr. Kwan.

> Mr. Kwan asked Lola to stay away from the backyard, and just garden in the front. Lola explained that a man had thrown his trash water onto *her* tomato plant. Acting out the scene, she told us that she then confronted him. Buck told her that he understands why she would get angry, and it is totally understandable. She responded, "Not just angry, like I want to *kill* him." She began to shake her fist. Buck calmly responded, "When you shake your fist, I can't hear your words, I just see your fist." Mr. Kwan said that she sometimes waves an object in front of people, and even thought it's not a knife, it is threatening. He turned to me and said that she is a strong woman.

> Buck asked if she could promise to talk to Mr. Kwan instead of getting into it with people. Lola responded that she couldn't promise, because she is human. But she said she wouldn't put her hands on anyone unless they do this to her first. Before we left Beth told Lola that she had planned to hospitalize her based on the initial call, but was glad they could work it out. They scheduled to have some anger management work next week. Lola and Mr. Kwan embraced.

The team would continue to monitor Lola and others like her, honoring the right to refuse treatment until they either tried voluntary care or could be hospitalized.

This form of surveillance does not aim at the deep internalization of norms, as in a Foucaultian model. It is driven primarily by the dynamics of legal liability, as workers must both try to prevent danger and avoid violating patient rights. While some people indeed became more open to medication or addressing substance use once safely housed, such "natural growth" was sometimes secondary to the main goal of getting people indoors.

This emphasis on keeping people housed meant workers might simply "lay eyes" on a person to see if they were staying in place. This is well illustrated by a routine visit to an older man living in a Board and Care home. When the client decided he didn't want to talk that day, the nurse Vic said this was fine. As we left Vic said to me, "Well, we made eye contact, so we can bill for it. Last week he didn't even want to come back to stay here, so hey." In a model oriented to urban poverty governance*,* keeping people in place was a victory. If Dobransky (2014) identified a clash between empowerment and paternalistic care, the worker here embraces the client's stated choice to be left alone unless in crisis. While Vic could have sought to draw out another discussion of choice—the client's apparent interest in living elsewhere—that would have created a problem where there temporarily was none.

Idle Bodies in the Board and Care

The Board and Care system, as noted in the historical chapter, arose in the wake of deinstitutionalization. Harvesting SSI checks, they offered people room, board, meals, and a kind of minimal care in terms of medication management. For the DMH team, clients coming out of a long-term hospitalization would typically require this level of monitoring, rather than independence. As noted previously, Board and Cares are anti-rehabilitative by design, as the only way to generate profit is to stock more bodies or eliminate programming. Such spaces aimed to ensure a kind of general order in which people did not make trouble, with staff ordering the day around meds and meals, and otherwise leaving people alone. Critics have long argued that such spaces produced dependence and hopelessness, as people become idle or wander blighted neighborhoods with nothing to do. As one family member noted in chapter 3, some of these places were known for tolerating alcohol and drug use. Yet this could be a reframed as a form of choice as well, since some clients claimed they didn't want to do anything. Most importantly, the Board and Care required almost nothing of clients through the day.

Consider the following intake interview at a Board and Care home. Carlie, a woman in her early thirties, had been hospitalized in the past for depression, and was a homeless client of the walk-in clinic until they transferred her to the intensive team. I went with Carlie and Francesca the social worker to a building with grass and trees in Highland Park, and a fountain in the courtyard. An Asian woman sat on the ground with two large bottles of Cola. Several others milled around. The director, a chubby Latino man with a ponytail, smiled warmly and invited us into his office.

> "Are you ready to live in a place like this?" he asks. When Carlie doesn't respond he asks her where she's living. She tells him the street corner she's been staying on. He asks if that is a facility, she explains that she's on the street. He asks if she knows what meds she takes, and she says that she can take her meds.
>
> He tells her that people need to sign in and out in a Board and Care setting. "Everyone here is sick and disabled, we *technically* are taking care of you." He draws the word out, and his tone turns apologetic. "You're clearly independent, living on the street but still looking good, so I know you are a survivor." Still, he says that the laws require that they keep track of and take care of people. "It's like kids, a little bit, but you don't look like a kid." He explains, "we're not doctors, we're not a medical facility." So if she chooses to disobey the doctor, he says that is between her and doctor. He then explains that they have a nighttime curfew, but they don't really enforce it.
>
> "How're you guys gonna follow up?" he asks Francesca. "What's her day gonna be like?" Francesca says that Carlie likes to go to groups, and the team's goal is,

> "Help Carlie maintain independence, eat three meals a day, take care of herself better."

At this Board and Care the operator claims that Carlie would be given a great deal of independence, but they must make it *look* like she's more disabled for the state regulations. Having survived street life, Carlie doesn't need to be treated "like a kid," the operator insists that there won't be many requirements of her, and they'll stay out of her business if she "disobeys" her doctor. The team's plan for her—to maintain independence and eat three meals a day—is reference to the fact that Carlie had in the past stopped eating, and speaks to the minimal goals of the treatment at hand.

In this vein, the Board and Care was great precisely because there was low demand. Melena the LPN described a client in his late twenties whose family wanted him to do more. She suggested he move to a Board and Care home, where he could sit around all day if he wanted. When, in another instance I said it was sad to see people sit all day smoking cigarettes, she shrugged. "They don't want to do nothing else." In fact, I met some clients who seemed to agree.

Bernardo, a Latino client in his late thirties, told me he loved the Board and Care he'd been living at for 9 years. He said he didn't want the responsibility of his own apartment. "It's too much hassle cooking and cleaning." He said he'd had to do those chores when living with his family. "I'm very happy there [the Board and Care]," he said. "They do everything for us." His home's schedule included med dispensing, and then three meals a day. Once a week they had an "arts and crafts" activity. He'd hang out, or go to the DMH clinic and outings. Despite a curfew they'd let him leave when he wanted.

Lauren noted this facility as a good place to put drinkers, and Bernardo said that he used to smoke pot every day when he first arrived, but then he quit because he wanted to save some money. The staff there was very tolerant, but would intervene when there were conflicts or emergencies.

Other clients who wanted more fought to get out of the Board and Care situation, and the team had to strategize with how to make this happen logistically. Consider Christina, a white woman in her fifties who had previously lived on her own in an SRO, but lost it when she was psychotic and wandered away. After having lived in a Board and Care for two years, she decided she needed to get out. I went with the team to help move her into the same Downtown hotel as Hugo, which she could afford with her SSDI and still have just enough to cover living costs. The team worked with Christina on ideas like getting food from the food bank, and other ways to budget. She said she was happy to be on her own again, and planned to go back to school and began looking for community college classes, as she had once pursued graduate level studies in natural sciences.

Yet soon after Christina stopped taking medication, and became empowered in a way that the team resented. Also partially deaf, she claimed that the doctor wasn't doing ADA [Americans with Disabilities Act] compliant work and needed to help her with her hearing aid. Francesca the social worker told another worker, "Don't get caught up in all this stuff (gestures in the air with her hands), the hearing aid and school. We need to keep saying "meds, meds meds." If she falls back, that's okay, that's part of the process. She'll get hospitalized then, and put back on medication."

In fact, Francesca's plan to wait until Christina reached the threshold didn't seem to go anywhere. When I later went with Francesca to check in, we heard Christina behind her door but she wouldn’t answer. They’d previously had to drill through the lock to do a safety check, and Christina was simply sitting there, and said she didn’t want to come to the door. Managing now in her apartment unit, at a threshold just below hospitalization, Christina was a different kind of client than the idle Board and Care client—instead, she was a resistant person who would be tolerated until crisis.

Redirecting Behaviors to Prevent Eviction

When a person was symptomatic, or seemed to replicate elements of street life, the team worked to redirect problematic behaviors. People might be relatively stable and safe yet disruptive to the broader public. Thus, the treatment team frequently responded to landlords, with intervention aimed to prevent eviction. Consider the way apparent symptoms and deviant behavior were not eliminated, but creatively redirected when a client was disturbing her neighbors. Sandy was a white woman in her forties who had been found on the streets and placed in a women’s center before coming to the treatment team and getting her own apartment. Diagnosed with schizophrenia, she refused medication and repetitively banged her head against the wall.

I went with Beth to check up on Sandy, who had been housed in a new apartment outside of Downtown. Her building manager called to say that she had angered her adjacent neighbor by head banging against the wall shared between their apartments. We first spoke to the building manager, who also wanted to make sure the unit was cleaned. Although landlords may generate or embellish accusations to evict undesirable tenants (Desmond 2015), the DMH workers initially took the manager at her word. When we went to Sandy's room Beth gave a series of instructions that would be necessary to keep living in that building. The plan was for Sandy to clean the apartment more, and to bang her head on the *other wall* that went out to the street.

Rather than seek the internalization of norms through therapy, or attempt to fully eliminate problem behaviors, this approach redirects behaviors so as to minimize the harm to clientele and nuisance to the public. The team's highly creative plan honored Sandy's compulsion to head bang, while keeping her housed. Soon the team came to believe that the building manager was exaggerating Sandy's troublemaking, and worried that an eviction was immanent. Although Sandy liked her area an eviction could jeopardize her housing access in the future, and they convinced her to move to a building Downtown that would be more accepting of such behavior. This highlights the fact that tolerant containment is not only a feature of the treatment team, but of particular ecologies.

In other cases I learned that helping people find tolerant environments was not without external consequence. Regarding Lola, the explosively angry but largely non-violent Salvadorian immigrant previously mentioned, she eventually moved to a building owned by another Korean landlord who liked to contract with DMH. A man in the new building stopped the case manager Carlos and said, "Please help us." Carlos wondered why they didn't simply call for authorities that might either arrest her or make a 5150 when she menaced people in the hallways. After speaking to the neighbors, Carlos, a child of Mexican immigrants, concluded that much of the building was made up of undocumented people. Calling the police could bring unwanted scrutiny and the threat of Immigration Customs Enforcement and deportation. Although Los Angeles would later become an official Sanctuary City in 2019, meaning that municipal services would not collaborate with ICE, Lola's neighbors may have felt forced to put up with her behavior. Outside of Downtown, and in a building with families, the team unintentionally found a setting where Lola could be tolerated because people *had to* tolerate her.

Reducing Harm and Delaying Death

When a person was unlikely to get sober, workers suggested moderate use or choosing some drugs over others. Bobby, a white man in his fifties who enjoyed uppers and refused medication for his bipolar disorder diagnosis, relayed how Beth had instructed him to "smoke crack [cocaine] instead of injecting crystal [meth]" because there had been some fake methamphetamine floating around Downtown. He had failed to follow her advice, and showed me an infection in his legs seemingly due to the bad product. Theorists of harm reduction have argued that it can function as a disciplinary project to turn drug users into docile patients (see Bourgois and Schoenberg 2011). Beth's approach, however, was practical. Bobby would go on to lose his subsidized apartment, get arrested, and end up in a locked rehab before coming back to the team, who helped him enter another subsidized unit. Choosing "crack over crystal" was simply about survival in the meantime.

In other cases, this harm reduction approach was seen as delaying the inevitable. Consider Vanessa, an African American woman in her fifties and long-term street drinker. Diagnosed with major depressive disorder, she was housed in collaboration with a non-profit agency, and I accompanied her case manager Carlos to check in. After making sure she had food, Carlos would remind her that the doctors said more drinking could kill her, which Vanessa acknowledged. One day Carlos confided in me that they had wanted to schedule her for more visits, to try and connect with her and encourage her to drink less. Yet with other "fires" to put out, and with the departure of some staff that had yet to be replaced, they were reduced to seeing her every two weeks. He feared that he would find her dead, and indeed, a year after my fieldwork they found her unresponsive.

As a visiting psychiatrist stated regarding another client's passing from alcoholism, "You're dealing with a societal group where premature death is enormous. And you're pushing it in the other direction." Keeping people alive for the time being, housed, and away from the most dangerous drugs was a significant task unto itself, and required a different set of expectations.

The Limits of Social Services as Treatment

The DMH team's low-barrier approach to engagement, and their commitment to honoring non-dangerous choice, meant that clients who were deemed "resistant" in other programs could be served effectively. Yet when a client was "compliant" and doing well in terms of medication, housing, and survival, the team had less to offer. Lauren the team leader explained that they were good at getting people stable, and getting them into housing, "but not so good at the rehabilitative side." "It's no one's fault," she said to me. "It's just once we've covered the basics with one person we have to move on to the next person to get them housed."

Let’s consider this in the case of a Jamaican man in his early thirties who had been psychotic and homeless in Downtown Los Angeles. I first met Jeremiah on the team’s initial outreach response near a courthouse, where he stood drawing messages in the dirt. He was given a hotel room, and then hospitalized, responding well to an antipsychotic. Scared of a return to the street, Jeremiah decided to stay in the Board and Care until he felt stable enough for an apartment. As one social worker later said, “that’s what hope looks like.” Jeremiah’s treatment opportunities remained limited.

> You get housing, which is good. I think that's a very good thing. Housing, food, clothes. That is a big plus, but I think it can be more too. It should be more too, right? ... When Laura took care of my Green Card that was a big plus too… I think a big part of it is like when you've gotten the persons on the meds and they're doing fine, you want to get them to the point where they're working and it makes more sense instead of just not having anything to do or feeling that you can't do anything, you know?

Note that the things offered here besides medication are basic provisions of the welfare state and help with immigration. Jeremiah was hesitant to criticize the program given how much they’d helped him, but also believed “there should be more.” From an urban governance perspective, however, Jeremiah was already a success story in that he had been neutralized as a public disturbance. No longer psychotic on the street, he was indoors and not bothering anybody.

The other limit to tolerance was when team members suspected clients were addicts taking resources away from the “truly ill.” For instance, I watched a middle-aged white client named Gary ask why the team wasn't doing more to appeal his failed SSI claim. A supervisor later told me that Gary's psychiatric hospitalizations were related to his heroin addiction and they had mistakenly enrolled him. He might have a formal psychiatric label, but the workers informally labeled him as not-seriously-ill and therefore less deserving (see Dobransky 2014). When I visited Gary at his new single-room-occupancy unit he complained that he'd had to fill out the housing paperwork without help from the staff. Ironically, such institutional competence might affirm the team's suspicion that they need not prioritize him. Like Jeremiah, he was now housed and relatively stable, allowing workers to move on to the next client.

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In short, in the logic of *tolerant containment,* care and control was exercised by relaxing behavioral expectations. This tolerance coexists alongside "zero-tolerance" policing and other forms of intensive social control. If the housed client fails to meet the most basic forms of behavioral comportment, the treatment team and authorities like landlords can still attempt to invoke the coercive power of the state via eviction, psychiatric holds, and incarceration. Neighbors may engage in "third party policing" (e.g. Desmond and Valdez 2013, Stuart 2016), and when evicted from independent housing a person might return to intolerant settings like shelters. Yet within the clinical regime, everyday treatment was marked by the expectation and partial acceptance of deviance and compromised choices.

What the team does *not* do is equally important and worth highlighting here. For these clients who retain their legal rights, the team does not demand medication compliance or sobriety.[8] The team rarely utilizes formal talk therapy, and generally does not push idle clients to be more active and find meaningful roles in the community. When clients did live with family, the team could mediate conflict, hospitalize, or facilitate moving to a Board and Care home or to supportive housing. They were not, however, positioned for therapeutic interventions.

Concerted Constraint at the Actualization Clinic

Re-Parenting the Adult-Child

While the logic of tolerant containment frames interactions between clients and service providers on Skid Row, the logic of "concerted constraint" organizes treatment relations in the wealthy private psychiatric settings. This care and control style is characterized by a belief that clients have the potential to improve clinically, engage in activities in the community, and achieve sobriety, requiring both positive and negative incentives. Practices unfold in a project of family systems governance: an intervention to reform an "identified patient" and his or her relationships with kin. Therapeutic work is tied to a larger project of teaching people how to be adults. Rather than intervening into

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[8] Even when the DMH team was a representative payee for a person's SSI, they did not take away funds based on medication compliance or sobriety. In line with the general logic of tolerant containment, they often anticipated discretionary money would be spent on drugs or alcohol. This may vary regionally—Brodwin (2013), for instance, observed a Midwest urban clinic directly tie spending money to accepting psychiatric treatment and behavioral compliance. That city and region furthermore had a robust outpatient commitment system, whereas LA County only recently piloted such programs, so there may be larger differences in approaches to control.

problems of urban poverty like removing the mad homeless person from a business district, they work with families to alter relations and longstanding dynamics.

Akin to Lareau's (2003) privileged parenting style of "concerted cultivation," this psychiatric rehabilitation strategy utilizes surveillance, scheduling, and a variety of therapies to create a self-efficacious individual and stimulate their hidden talents and desires. It is "concerted" in that it requires resources and energy, engaging in costly rehabilitative services. It is "constraining" of choice, but not coercive per se—instead, it creates webs of incentives to *normalize* behavior. If tolerant containment creates space for impoverished patients poorly served by a cruel environment, concerted constraint seeks to generate conditions of compliance for those whose mental illness has been "enabled" by privilege.

Dev, the former Actualization client turned social worker, had interned at the Village, a famous non-profit mental health center in Long Beach that served as a model for the California Mental Health Service Act's FSP programs. He understood the logic of high tolerance and harm reduction, and eloquently articulated why tolerant containment was undesirable from a private care perspective.

> I think the Village does it in a good way. But the Village is also fine if you don't take meds, even if you do drugs to a certain extent, they're more kind of about keeping you of out of prison, keeping you out of the revolving door of hospitalizations. That's ultimately their goal. It saves the county a lot of money. But what if you want more than that for your loved one?"

Harm reduction, safe housing, and keeping people out of the institutional circuit might make sense from the perspective of the local state, but not necessarily for families who could invest resources in their loved one's future.

Leveraging Resources to Motivate Compliance

As explored earlier, a key dynamic in Actualization's concerted constraint of a "non-compliant" patient was *leveraging* resources, which could both positively and negatively incentivize behavior. In contrast to DMH's immense struggle to secure housing vouchers or qualify clients for benefits, the Actualization workers had to coach well off families on how to restrict resources. Cash was not only seen as an asset, but also as a liability. Flush with money, clients had little incentive to engage in treatment. It pointed to a different set of difficulties when families had long funded destructive lifestyles, and the very privilege that bought access to elite care could ironically constitute an obstacle when a person did not respond to the team's friendly overtures. As Richard the owner put it,

> Would you rather try to deal with someone that's psychotic, but homeless and broke and desperate, or someone that's psychotic and got a lot of money in the bank?"

He explained that families often enabled problematic behavior, as they didn't know what to do besides giving more. This made it difficult to motivate people, because they "didn't have a problem." Thus, Actualization could help families learn how to use their leverage by making financial resources into both a carrot and a stick.[9]

During a team meeting to address a young man who refused an antipsychotic medication, Richard said, "I don't care how disorganized you are [psychologically]. When you see it [budget] in black and white, you'll get on board." Here we see a clear formulation of governing through choices: in the absence of coercion, even psychotic people understood the meaning of money and would comport their choices appropriately. This meant creating a gradated set of incentives, with cash attached to "healthy" behaviors that might be internalized over time. The team called this *contributions and expectations*, where team members would mediate a deal between families and adult children. These tactics are distinguished from simple coercion, encouraging rather than forcing compliance and engagement.

The positive leverage provided by disposable income is illustrated in the following example. Nora, a white woman in her fifties diagnosed with both psychiatric and developmental disabilities, didn't want to take her assortment of medications. The treatment team worked with her elderly mother to develop an allowance system, paying her to take pills and engage in healthy behaviors. For instance, she received a dollar for every minute she walked outside. In some cases, the team would propose paying people extra money to take antipsychotics. The carrot can easily become a stick, in turn, when providers threaten "non-compliant" people with retraction of money and social support.

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[9] In some cases it was not the family driving the middle-class values of concerted constraint, but the Actualization Clinic itself. While upper middle class families seemed primed for ideals of cultivation, productive living, and structure, the team reported that some very wealthy families did not necessarily have the same values as middle and upper middle class staff.

To be sure, the bouts of deprivation or "homelessness" were controlled, and could be almost comical from the team's perspective, as they worked to ensure that clients would not be especially vulnerable to actual harm. For instance, they coached one family to kick the daughter out in order to get her to go to an eating disorder residential treatment center. She was not a psychotic person suffering from "anosognosia" impairing her insight, but from their perspective, stubborn and spoiled.

> Supervisor: she spent two hours on the street in the middle of the day (group laughter)
>
> Case manager: I was so impressed with her parents that they kicked her out. And she spent 24 hour in the car in her driveway. I told her dad, "I bet she's in your neighborhood" and he saw her when he walked the dogs.

With safety in a car, and remaining in the family's upscale neighborhood, such minimal deprivation was enough for this woman. Soon she agreed to go to residential treatment.

In other cases, a stronger scare might be in order. Steven, an Asian American and Jewish man in his mid-twenties told me that he had previously resisted going to treatment to address his psychosis and drug use. After being released from the hospital, he refused to attend a residential program, and was within his rights to do so. He planned to continue using drugs and even thought he could make it as a homeless person, until he learned what this might mean.

> When I was using, and my mom really wanted me to stop because I found out I had schizophrenia, my case manager took me down to Skid Row and was like 'this could easily be you.'

Steven had never seen such poverty, and agreed to treatment. Thus, if providers could work with families to leverage resources, the money and support that was previously "enabling" could also become a disciplinary tool.

Deirdre explained that such leveraging became most necessary when people did not understand that they were mentally ill. The key issue was that of "insight," for if a person did not know they were sick, they would not rationally choose treatment.

> Most people who have a lack of insight need leverage. You know, it's not like they wake up one day and go, 'oh yeah, I *am* psychotic.' It really is through leverage like, "Do, you want to be supported? Well then you got to see a doctor and follow their recommendations. And if not, you can choose what you want to do." And there's a risk either way. We tell families there's a risk of them on the street, but there's also a risk being un-medicated where they could die either way.

Indeed, such leveraging could easily backfire and generate the kinds of crises that families were hoping to avoid. For instance, one man reacted by signing up for General Relief from the city, selling his plasma, and using the money to live out of his car. He soon drove off to Texas in a psychotic episode, where he was arrested for marijuana possession. When a different man diagnosed with schizophrenia went off antipsychotic medication and refused to come back to treatment, the clinic recommended his family threaten to evict him as leverage. In response, he set the family guesthouse on fire and was arrested for felony arson of an inhabited building.

Thus, teaching these privileged adults a lesson was a tightrope walk. The point was not to make these clients suffer, but to create enough of a threat to constrain behavior and encourage participation. Whereas for poorer people the world had already generated difficulties, and being kicked out of the family home might simply mean homelessness, here leverage backed by significant resources could facilitate myriad possibilities of care. This external control in the concerted constraint model aimed to get people into treatment, where medication, specialized therapies, and scheduled activity might generate the internal control needed for self-governance.

"Controlling the Environment" in the "Bubble" Sober Living

At the Actualization Clinic, it would be wasting a therapeutic opportunity for a symptomatic or substance abusing person to live in an unstructured setting with an idle lifestyle, contrasting markedly with the harm reduction model at DMH. According to an Actualization therapist who had once worked in non-profit services for the poor, "Harm reduction is all the county *can* do. They can't control the environment like we can." This meant keeping people in the right housing situations and away from the wrong people, in relatively closed environments. As a step-down from private residential therapy centers or upscale rehab, the team sought placements that offered surveillance but also community activity. Actualization worked with a series of dual diagnosis sober living and transitional homes, preferring those that had a great deal of programming and structure. They introduced me to one they considered exemplary, Namaste Gardens, a Buddhist themed house near the beach.

Namaste served men in their twenties, thirties, and occasionally forties. It boasted a highly regimented schedule with daily therapeutics, exercise, a meat-less diet, multiple urine tests a week, and 12 step meetings. Residents spent the first six months attending an Intensive Outpatient Program (IOP) at a nearby center—in some cases this might be Actualization's mental health IOP, or the adjacent addiction facility. Sometimes treatment was paid for by insurance, but the sober homes themselves usually required cash.[i] Residents explained to me that Namaste was a "bubble" sober living, structured and semi-removed from the real world, in contrast to the "flophouses" attended by poor people.

Geoffrey, the owner of Namaste Gardens, contrasted the intensive scheduling of healthy activities with two poles of treatment: settings that let people choose idleness, and those that used shame-based control inappropriate for mental illness.

> [Some residences] allow the person to just take their meds, sleep in…kind of shuffle through life. That's not going to happen here, I'm not going to want it…we're doing so much together, meditating every day, surfing every day, going to the gym every day…I feel like those bipolar and the schizoaffective clients, they can't handle any kind of confrontation or stress. It exacerbates it, but they flourish in a healthy rhythm.

Neither allowing people to “shuffle through life,” nor relying on punitive “confrontation,” Geoffrey delivered the “healthy rhythm” of scheduled time, therapies, and an active California lifestyle.

Justin, in his early thirties and diagnosed with schizophrenia, illustrates how this can nonetheless be experienced as excessive control. Justin was on a large dose of Clozaril, a powerful antipsychotic that quieted the voices but left him tired throughout the days. When I would see him at Actualization’s IOP therapy in the mornings, he would begin dozing and ask to lie down. He participated in terms of medication, trying to stay sober, and meeting with his Actualization case manager who was “like family,” but he resisted the intensive schedule and lack of privacy. Justin believed himself ready for more autonomy, but the Namaste Gardens house manager confided in me that he was worried Justin could very well end up as a psychotic street person, and they would not allow him to transition to more privileges.

I observed Justin’s request in front of the 11 other residents, three of whom also had a schizophrenia diagnosis, for the ability to walk around alone, and call his mother without staff listening in. This would be from moving from Phase 1, with few privileges, to Phase 2, with more. Another resident, also diagnosed with schizophrenia, said that Justin wasn’t ready. “In Phase 1 you’ve got the managers looking over. When you’re in Phase 1 you’re safe. But it makes me worried with you out there on your own. I’m not trying to be a dick. Your health is the most important thing.” Others soon piled on. Justin saw the tide turning, and turned to the house manager to plead for a chance. When he asked for “a leap of faith,” the man said, “We can’t take a leap of faith with people’s lives.” Justin sat down against a wall, crying silently. That night he ran away and got high on the beach. He was later found by the police and hospitalized when he said he felt suicidal. He returned to Namaste Gardens, beginning his cycle towards privileges over again. When I later accompanied him to do volunteer work, he said with resignation, "You kinda can't get out of Namaste." Although a voluntary residence, he believed himself trapped.

Such settings offer a level of monitoring and scheduled activity otherwise difficult to achieve in the community. Unlike the Board and Care system or the "flophouse" sober livings for the poor, which allowed residents to leave during the day or remain idle, "bubble" residences like Namaste sought to cultivate residents. Although the providers questioned whether someone like Justin could indeed live on his own, the rehabilitative machinery of Actualization and Namaste kept him safe and engaged in activities oriented to recovery.

A mother explained to me the importance of these transitional living situations, and the contrast with settings she'd seen for the poor. Her son, in his early thirties and diagnosed with schizoaffective disorder, had once asked that she leave him alone and let him live in a Board and Care. She despaired at the hopelessness of the people living there, especially given her son's intelligence. She had explained to me, for instance, that he had graduated college at twenty and started graduate school in England. She couldn't let him enter "the system."

> What if we stopped fighting? What if we put him into a Board and Care? I'll tell you what, I can't. I wouldn't put my dog. I don't want him in the system like that. I think once you're in like that, you are not out. Once you're in the Board and Care

> system, you are in it. Because I believe that it's very easy to sink to the lowest common denominator.

For this upper middle class mother, the idea of her talented child sitting idly in a setting with few activities, often surrounded by drugs and “lowest common denominator” people, was simply unacceptable. With money and the know-how to battle her private insurance company, she tried to keep him in private hospitals and treatment programs and then in high-end sober living homes when he was released.

Crafting Self-Efficacious Subjects

As noted in the opening vignette with Tom, the therapeutic groups work on self-control and self-management. Unlike the urban safety net clinic whose time is dominated by addressing homelessness or mitigating basic harms, Actualization could focus on specialized psychiatric, psychological, and behavioral treatment. When I spoke with therapists in such settings, they insisted that even people with serious mental illness could engage in talk therapies, given the right circumstances. In addition to the depth-therapies or cognitive work of IOP or the residential treatments, some clients also participated in skill-based groups. Actualization and Dev referred me to an ongoing “Social Skills” group at UCLA, run by a psychiatrist that they collaborated with.

Dr. Till was well known for his research into psychiatric rehabilitation, and had designed these modules especially for people experiencing the negative symptoms of schizophrenia. Like the DBT and CBT addressed previously, such care is in principle widely available. Dr. Till's group had participants who were not rich. And yet, pushing people to engage in time-consuming and sometimes unpleasant therapies often required a case manager or highly involved family member to facilitate. I accompanied Dev, for instance, as he helped a client complete his socialization homework assignments out in the community. I was struck by the intensity of behavioral modification, in contrast to the tolerance of people being idle or acting in socially inappropriate ways.

In the following field-note, Dr. Till works with Ryan, a young man diagnosed with schizophrenia who generally remained silent. Ryan's mother, a TV executive, reportedly sent him to Dr. Till's group to acquire skills with a long-term goal of getting a job. Ryan, on the other hand, was ambivalent about working. Dr. Till enlisted a recent college graduate to accompany Ryan to the weekly course, and help him practice his social and behavior skills "in vivo" at home. Here they do role-play, with Dr. Till asking Ryan to demonstrate how he'd done his homework assignment, which was to thank the assistant for teaching him how to make the bed.

> Dr. Till says to show him exactly how he did the thanking. Ryan hesitates, and Till modeled his version, saying, "Thank you for teaching me how to make my bed. Now I feel more independent. I don't have to rely on the housekeepers, and it makes me feel good."
>
> Ryan began to speak, but stumbled. Dr. Till went phrase by phrase and made him repeat after him. Ryan scrunched his face, and looked away, and Dr. Till

> instructed him to look forward at his role-play companion in the eye. Ryan broke eye contact again and looked at the ground.
>
> Another participant turned to me and whispered, “ugh, a nightmare.” Ryan eventually finished the sentence.

This struggle to complete the drill, and Dr. Till’s insistent attention, shows the aim of minute behavioral control of speech, bodily comportment, and eye contact.

Note that I am not critiquing this as coercive or bad, per se. Even the critical participant who called it a “nightmare” told me he kept coming back to the group because he believed it had made him more self-efficacious. The point is that this is a classic form of disciplinary power that is here used for psychiatric rehabilitation and to prepare Ryan for the job his mother insists upon. It is *concerted* in that it requires a level of observation and care that is resource and time intensive. Its *constraint* comes from the use of such skill development as a form of normalization of the body and psyche. In addition to the depth therapy that seeks answers in the past, and the cognitive restructuring that rationalizes thoughts and emotions, here we see a type of intensive behavioral conditioning that might scare clients, yet be precisely rehabilitative in the generation of normative social interaction.

“Get Well Jobs” and Meaningful Activity

The Actualization team worked to schedule client lives with non-clinical activity. Far from mere safety checks or redirecting someone to bang their head on the other wall, Actualization insisted on getting people busy in the community. Since there was little concern with basic survival, home visits could be oriented to different goals. Here behaviors that would be low priority at DMH, like idleness and staying at home, became a site of clinical intervention.

As Deirdre explained, it was doing people a disservice to give them too much choice in what to do. The case manager Denise had asked for clinical advice on how to engage Roy, a white man in his late thirties diagnosed with schizophrenia. His father had brought him to the clinic because he spent all day reading comics and watching TV. Although Roy took an antipsychotic and was not experiencing "positive" symptoms of psychosis like hallucination, he had purportedly exhibited "negative symptoms" such as flat affect and self-isolation in the past. When Denise asked him what he wanted to work on, he was resistant to new activities, suggesting a potentially pathological withdrawal. Deirdre said that Denise was giving too much choice, and revealed her logic drawn from parenting.

> We don't want to infantalize our clients. But it's like with my kids: if I ask them what they want to do, they want to be on their phone. "You want a bike ride or get something to eat?" If they want something else, "sorry that's not an option."

Notice that she warns against infantilizing clientele, then suggests reducing their choices like one would treat a child. Yet by narrowing the range of activities, Roy would have choice among acceptable activities. Denise soon began taking Roy to busy restaurants in an attempt to increase his tolerance for discomfort. Roy would later tell me that this work, while difficult, was "better than any medication" he'd received, and he soon began to pursue more daily activities by himself.

As people reduced treatment days in the therapy groups or home visits, Actualization insisted that they go to school, work, or volunteer. In some cases, this required enormous support. One woman in her thirties, diagnosed alternately with bipolar and borderline personality disorder, received multi-day-a-week psychoanalytic treatment as well as Actualization case management. As Richard put it with a grin, she was getting "$1000 of therapy to keep a $500 job" at a bookstore. Yet while there was a tone of humor, the point was that the work was psychosocial care—rather than a means to make a living, it served as a "get-well job." With such resources at the family's disposal, privileged clients could pursue employment activity without the fear poorer disabled people had of work impacting benefit provision (see Estroff 1981, Padwa et al. 2016).

In some cases, however, the pursuit of meaningful activity meant insisting on community engagement even when it terrified clients. Kayvon was a Persian man in his early sixties who lived at home with his mother. Diagnosed with schizophrenia, he had been in various forms of treatment since his twenties, and now saw the worker Dev on the weekends. I sat with them one morning in Starbucks after playing soccer, an activity that Kayvon previously believed would cause a catastrophic event in his brain. Now Dev was insisting on additional activities, but Kayvon was scared a new destructive event was imminent.

Kayvon: "Dev, I'm not going to risk my sanity for doing things that I *know*—

Dev: “I would never put you at risk. You know that.”

After some back and forth, with Kayvon relaying his fear of a brain malfunction, Dev finally put his foot down.

Dev: “It would be a disservice if I allowed this to continue, because it impacts the quality of your life.”

Later that day he explained his reasoning, and linked it to differences between private and public sector services and ideals of client choice. In most public settings, they would accept Kayvon’s refusal and delusion as a form of choice.

> With the private [sector], I don’t know if the right word is *you can get away with more*, but for instance, with Kayvon, we push through things, do things. But in the public [sector] I might not be able to do that. They could think that *that’s not ethical*. (Emphasis added).

For Dev, on the other hand, it was unethical to allow people to live small lives, sitting at home and doing nothing all day. He’d been hired by Kayvon’s brothers to give him a wider array of activities, and improve his quality of life.

The Limits of Leverage Based On Resource Control

I earlier noted situations where resource “leverage” resulted in crises, such as a person running away or setting the house on fire when threatened with homelessness. In other cases, adults who retain control of their own money may subvert concerted constraint by simply refusing to comply. The reliance on families can also become a weakness, as when “non-compliant” families agree to leverage but then recant and disrupt the incentive structure. Here I consider cases where Actualization must reorient the trajectory of care when their resource control strategies are inoperative.

Will was a white man in his forties diagnosed with bipolar disorder and alcohol dependence. He was successful in the movie industry, so while his parents were involved in treatment, he was not financially beholden to anyone. Will saw the team’s favored psychiatrist, enlisted two Actualization case managers, and also hired “sober companions” to accompany him throughout the day. Notably, he used these people precisely to constrain his own behavior when he felt he could not do it on his own. Yet Will soon decided to drink again and fired his treatment team.

After an alcohol related health scare sent him to the hospital, his psychiatrist reached out to the team. Will would be coming out of a residential rehab program and need community-based support. Yet Deirdre declined to take him on again as a client. She pointed out that “he has his own money,” and therefore would be immune to the team’s attempts to leverage him into sobriety. When she saw him on TV some months later, she remarked, “I can’t believe that guy is still alive.” Unlike a safety net clinic that might support a client with risk of death due to serious addiction, private providers may find such a person outside of their scope. This reveals that concerted constraint can be rendered inoperable without leverage dynamics, and that elite settings are less obliged to tolerate certain forms of risk.

Next, consider an unusual but revealing case in which a homeless woman briefly received services at Actualization. Carolyn, in her forties, was diagnosed with schizophrenia and heroin dependence. From a well-off family, she had been cut off and fallen through the cracks, going through a series of psychiatric hospitalizations before homelessness. Her brother, however, was paying for Breyer Insurance. Carolyn was one of the initial test cases.

Put simply, Actualization didn't know what to do with Carolyn. They could not figure out how to get her housed, for the insurer would not pay for non-medical housing and her brother would not assist. Spending hours at court hearings, and finding her when she disappeared, the treatment team struggled to implement their therapeutic procedures. In the end, Deirdre decided they couldn't help the woman and requested that the insurance company not send them any more homeless people. This case reveals how concerted constraint is reliant on a baseline of financial resources and family involvement, and elite therapeutic expertise may not translate without that structure in place.

Even for those who had homes but were not well off, this would be a struggle. Another Breyer Insurance patient came out of dual diagnosis rehab but could not afford a transitional sober living space, and the insurance refused to cover the housing. Returning to her old living situation, she began smoking marijuana and became psychotic again. Unable to mobilize their normal network of providers and "control the environment," Actualization found that they could not engage in transformative work.

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In sum, in the logic of *concerted constraint,* providers exercise care and control via resource leverage with extensive treatment to transform clientele. These forms of therapeutic discipline aim to avoid both excessive choice, on the one hand, and punitive confrontation, on the other. Far beyond simple offers of medication and housing, the providers mobilize a variety of therapies and social activities to cultivate a client's self and design a new life. In cases where a person does not "recover" to the point of independent living or employment, workers may still push for hobbies and the appearance of health over tolerance of idleness and socially deviant behavior. Should a person prove too self-destructive, immune to resource leverage, or lack the social and financial resources for treatment, however, they may fall outside the team's purview.

Chapter Conclusion

Given the need to govern clients "through their choices" rather than coercively, how do the DMH and Actualization treatment teams manage mental illness in voluntary community settings? I identified a series of techniques and tools oriented to the respective practical problems of the two treatment ecologies. At county DMH, the response to clients who are poor, disposed to street life, and in some cases "non-compliant" is to reduce behavioral expectations, offer safe housing, redirect problem behaviors, and reduce harm. At the Actualization Clinic, the response to privileged adult patients who resist but are not "dangerous" is to "leverage" them, exposing them to both positive incentives and gradated material deprivation to generate treatment engagement, "control the environment" through luxurious and structured residences, get people in disciplinary therapies to change behavior and thought processes, and guide people to "healthy" activities.

To make sense of the tolerance for indigent psychiatric service users, I've shown how shifts in urban poverty governance prioritized low-barrier housing for certain costly populations, and how limited therapeutic capacity relative to need alters the threshold at which behaviors are problematized. This can disrupt the disciplinary aims of psychiatric services (e.g. Foucault 1977) and attempts to develop appropriate choices characteristic of neoliberal governance (e.g. Rose 1999). To analyze the behavioral constraint of the privileged, I looked outside of the social control literature to a situation where highly directive and intensive socialization is a mark of prestige and class development. In the case of parenting, the style of "concerted cultivation" is indeed only possible with considerable resources, and linked to values of social reproduction (see Lareau 2003). This style may be repurposed in therapeutic projects precisely to keep the well off from downward mobility or entering other control institutions like penal settings.

Conclusion

This dissertation has sought to understand how class distinctions, and particularly the poles of poverty and privilege, shape the management of serious mental illness. I examined this through a comparative case study of community-based mental health treatment teams for the rich and poor, and situated their care and control practices in broader ecologies that reach beyond the clinics themselves. As I noted in the introduction, the ethnographic picture of American mental health care in community settings is largely oriented to the difficulties of public and state funded non-profit services. Analytically, this leaves much unexamined regarding what better resourcing can and cannot do.

As anthropologist Paul Brodwin (2012) noted in his study of a non-profit treatment team in the urban Midwest, anything beyond baseline survival is nearly unimaginable in everyday care. He wrote,

> Controlling people's symptoms and avoiding evictions dominate the agenda of ordinary clinicians. The imperatives are so pressing that clinicians rarely imagine alternative goals of treatment. Given what the system expects of Eastside Services, how could case managers ever refigure their task as fulfilling human needs…?

No doubt this sentiment would resonate with some of the clinical staff and case managers I got know at DMH, for whom the goals of transformative care or self-actualization would seem utopian.

Such statements as Brodwin's beg for comparison. Looking across the proverbial tracks at the "Actualization Clinic," I found a clinical environment for the privileged where the need to "control symptoms" was familiar, but where addressing human needs and transforming people was, in some cases, a real goal. There, with financial resources, access to a referral network of expert clinicians, and heavily involved families, it would seem that wealth could make all the difference. The privileged clientele of Actualization need not face the precariousness of the public mental patient. Yet in looking closely at the organization of care in each setting, we find a more complicated picture than hopelessness versus the fulfillment of human need. The providers offer divergent expertise and forms of empowerment that amount to different visions of recovery and, in some sense, what it means to be a person. Each struggles with intervening into poorly understood illnesses, and dilemmas around choice and control, with different successes and failures relative to different standards.

In this conclusion I situate the dissertation's interventions around three main topics. First, is my argument that we can better understand variation in forms of community metal health care by analytically separating projects for different social institutions: here the city and the privileged family. Second, I position my chapter on diagnosis and networks of care within the sociological literature on labeling and social construction. Third, I address the overarching logics for governing people who are not "dangerous" and the different kinds of subjects produced. Here I also suggest that the categories I’ve developed throughout have theoretical generalizability beyond the cases at hand, and beyond the substantive topic itself.

Intervention One: The Social Institutions of Madness

The classic sociological statements regarding the management of madness came largely from studies of singular physical institutions. Goffman’s (1963) *Asylums* was particularly audacious for taking a singular hospital to theorize not only psychiatric hospitals in general, but also the “total institution.” By ignoring regional, class, and other variation, such an approach potentially lacks empirical generalizability, yet can be enormously productive in its attempt at theoretical generalizability. With the move from asylum care to community care, the psychiatric hospital became one of many physical locations and social institutions for the management of madness. My historical chapter situated the contemporary agenda and dilemmas of care in a longer sequence of problem solving, setting the stage for the comparative analysis of community based service.

The social scientific study of deinstitutionalization has typically focused on a specific version of care in “the community,” namely the publicly funded community mental health center or treatment team situated in impoverished neighborhoods. We find this in such ethnographies as Estroff (1985), Brodwin (2012), Dobransky (2012), and Myers (2015). Analysts have further described the “institutional circuit” (Hopper 1997) of short hospitalizations, jails and shelters, and then the other total institution of prison (Rhodes 2004). My intervention here is to specify what is going in such care settings via the contrast with elite care, and what I conceive of as governance projects for different social institutions. To be clear, these are not the *only* projects possible, and future work can certainly address variation.

My second chapter focused on mental health and homeless outreach to situate treatment in a broader project of *urban poverty governance*. Many of the features of the above-cited works would look familiar to DMH team, the outreach providers they collaborate with, and the broader array of providers and law enforcement managing urban space. The benefit of conceiving of this as a distinct governance project is that we start to see how one cannot separate the work of addressing mental illness from the larger ecology. The meaning of psychiatric labels changes in a *diagnostic economy* that can bring crucial survival resources, and issues of choice have a specific meaning when people have a right *to* homelessness or freedom *from* forcible treatment, but not a right to resources. It also shows how psychiatric scrutiny may be spatially focused, as when outreach workers stop their engagement once a person moves around the corner. Housing resources address the most "vulnerable" people, calculated in clinical terms but also cost to hospitalizations or jail contact, and may dry up with shifts in federal budgets. Even the way workers come to interpret referrals is tied to these larger structural features.

The specificity becomes clearer by contrast. In my third chapter we find Actualization and an elite institutional circuit, with a somewhat distinct set of problems. Here providers orient to some similar issues, such as a person who has been repeatedly hospitalized, or who doesn't believe him or herself to be mentally ill. Yet other elements take different forms, such as protecting family reputation, attempting to govern and change the families who are paying for the care, or getting someone who is safe and relatively non-symptomatic to achieve more in their life. Far from attempts to clear a street, secure housing, or screen out people who are not quite ill enough, we find a project of *family systems governance.* Analytically we can see how the possibilities of care are bound up with familial resources, classed expectations, and the willingness of families to follow directions, in a way contrasting to care in the context of urban poverty governance.

The separation of these governance forms is, of course, somewhat schematic. Some people served by the DMH team have family involvement, and some of the Actualization clients cause public disturbance in urban environments. But the point is that we understand the stakes, goals, and tools of care better when we see the overarching project at hand. There may be other projects, and I do not claim these are exhaustive. Using critical cases means I can hardly expect to capture all forms of community-based psychiatric service. Various private insurance schemes, pilot public programs for "first episode psychosis," rural community centers, or forensic treatment teams may differ in ways that limit the applicability of these models. Moreover, many people continue to receive no services at all. Still, these cases remain highly significant both theoretically and for people's lives. Outlining these projects, and separating them analytically, also helps point the way for the following interventions.

Intervention Two: The Functioning of Psychiatric Labels

The sociology of psychiatric labels has typically focused on two dimensions: first, the effects of labels on self-concept and the progression of mental illness, and second, the related question of social construction and the reality of illness categories.

Labeling theory, once a thriving research program in the 1960s, lost much credibility in the context of mental illness. The strong etiological claims that diagnosis and societal reaction sustained or even generated mental illness (e.g. Scheff 1967) has not stood up to scrutiny. Few today would argue that labels *create* psychopathology, and the second generation of labeling theory focused primarily on the way labeling impacted stigma and self-concept, while taking mental illness as a given (e.g. Link et al 1989).

The second component, of the social construction of illness categories, has often taken the form of investigations into particular categories. Examples include Horwitz' (2007) historical argument that sadness has become inappropriately medicalized as "depression," or ethnographic study of the construction of illness in particular settings like Lakoff's (2006) study of research into bipolar disorder, and the different constructions of illness in a psychoanalytic versus bio-psychiatric ward in Argentina. Others have aimed to show how classifications help to "make up people" (Hacking 1995), generating identities around real but historically shifting illnesses. In a more subtle argument than labeling theory, Hacking has argued that there are "looping effects" whereby classification affects the classified, who change their behavior and thereby cause the classification to shift.

My chapter 4 builds on such research, but orients instead to the way diagnosis builds different networks, and the contrasting epistemic cultures of the treatment teams. Working with the notion of diagnosis as a key that opens different doors, I follow what a diagnosis comes to mean in the different clinics. Whether the two women diagnosed with "major depression with psychotic features" share the same illness is in some sense unanswerable. My interest is in showing how the classification can pull together a network of actors and resources, setting the stage for both different treatment protocols and constructions of illness. With the team's respective skills, treatments, and referral networks, the person becomes enveloped in different visions also of personhood.

At DMH, this network includes psychiatric intervention, but also benefit claims, specialized housing access, and a treatment team to offer basic monitoring. Psychiatric diagnosis may be a component of classifications like "chronic homelessness," pushing people into divergent resource categories and trajectories. In some cases labels like schizophrenia, and specifically long-term untreated schizophrenia, may allow workers to help with basic case management but ignore a person's speech. Here the chief question is one of access to the team and its survival resources, with classification really coming down to *crazy versus not crazy* and *"one of ours" versus "not one of ours."*

At Actualization, diagnostic specificity has very different effects because it can bring together a different network. First, while the team may hope to move past diagnosis to a holistic and humanistic life intervention, they rely on elite psychiatric and psychological testing for differential diagnosis to facilitate the planning of specialized interventions. Separating out OCD from schizophrenia may mean different medication regimens, but also placements in the elite circuit of residential treatments for OCD, or referral to the university Thought Disorder program. In the intensive outpatient program, and in certain specialized programs, therapists focus alternately on the meaning of symptoms, offering coping mechanisms, or rationalizing the self by separating thoughts from emotions from symptoms.

In so doing, the networks generate different kinds of patients—not only from identification with the labels, but through radically different treatment protocols in the different life worlds. Labeling a person with “major depression with psychotic features” may certainly impact one’s self-concept, but with different ways of living such an illness in these treatment networks and ecologies. Whether these coalesce into ways of being that have “looping effects” in the longue duree is outside the scope of this study.

Intervention Three: Governance Below the Threshold of Coercion

Theorists of psychiatric care as a form of social control often generate controversy because they appear to denigrate the helping professions. For instance, Foucault’s (1961) claim that Pinel removed physical chains but put patients in a giant moral imprisonment remains striking, and perhaps even offensive. Debates as to whether a particular form of treatment was *really* about care or control are often unproductive, because in many cases they go together. For the study at hand, I’ve suggested that we think less in terms of coercion than in terms of the structuring of choices. Deinstitutionalization in effect meant the introduction of liberal choice to people who were once deemed outside of liberalism because of insufficient Reason. My aim in this chapter was to understand not the moment at which a person’s rights are revoked and they are hospitalized (although this happens), but the work to govern them below that threshold.

What I found in the two clinical regimes was in fact alternative forms of choice architecture: one, oriented to the city’s need to keep people off the streets, and another, oriented to the privileged family’s aim of making a loved one lead a fulfilling, respectable life. At DMH, the strategy of “tolerant containment” is to essentially create situations in which people avoid crisis, whether that means being safely housed independently or idle in a Board and Care home. Here spatially specific acceptance of deviance may serve as a release valve in a context of abandonment and punitive poverty management, with precarious freedom is marked less by robust inclusion than mere tolerance. At Actualization, the strategy of "concerted constraint" is to leverage behavior, control the environment, and mobilize therapeutic and lifestyle resources to try and change people. This shows how the disciplinary elements of intensive therapeutic control can work alongside indulgence, serving as an investment in substantive change, self-efficacy, and respectability.

Broader Contributions

Reflecting on the contrasting logics and the overarching dissertation, I make three contributions.

First, I show that mental health recovery has different targets, mechanisms, and strategies depending on a person's class situation and the institutional backdrop of care. Here I draw inspiration from research on inequity in the production of subjectivity, social roles, and life chances. If Goffman (1963) theorized hospitalized patient "careers" in the singular, a comparison of community careers shows these to be as stratified as occupational ones. Like Lareau's (2003) parenting styles or Paul Willis' (1977) differential job preparation by class, programs encounter and mold different kinds of patients-in-recovery. For DMH's formerly abandoned or criminalized patient, a tolerant approach to housing and safety may relieve suffering and serve as a foundation for mental health improvement. Yet in this non-developmental project, some people will self-destruct, return to punitive circuits of social control, or sit idly in poverty. If there is freedom it is to be “mad” in ghettoized housing, and if there is “natural growth” it is largely incidental. Actualization’s approach, on the other hand, may act as an extension of concerted cultivation, especially given the younger age, financial resources, and general social advantage of clientele. It is an explicitly developmental project that can generate resentment or even crisis, yet also facilitate meaningful social activities, therapeutic transformation, and class-respectable roles. Here discipline is not the opposite of freedom, but one of its conditions when coupled with material opportunity. In effect, the same diagnoses may be lived as radically different illness and recovery experiences.

Second, the theoretical categories can illuminate a range of governance projects in advanced liberal societies oriented to “freedom.” Abstracted from the cases at hand, *tolerant containment* is a general strategy to stem costs and mitigate disruption when corrective social control is ineffective or too expensive. Elements may appear in such cases as safe injection sites, decriminalization, penal diversion programs without substantive treatment, sanctioned homeless encampments, universal basic income, and any situation where it becomes cheaper or politically expedient to accept or redefine previously problematic behavior. *Concerted constraint,* on the other hand, is a component of elite socialization to ensure wellbeing and maintain privilege in private circuits. Rather than opposed to luxury, therapeutic discipline may be necessary for generating self-efficacy, reputation management, and respectability. This is a general strategy of reforming elite deviance rather than merely tolerating or punishing it. We might see this in boarding schools for problem children, wilderness programs for teenagers, residential sex therapy for disgraced celebrity harassers, and other efforts to keep privileged people from criminal responsibility or downward social mobility.

Third, these findings point to some ironies for the bioethics and politics of mental health care. Disability studies scholars and activists have long criticized the "hegemony of normalcy" (1995 Davis) and disciplinary attempts to "fix" different bodies or psyches. Ironically, the local state's tolerant containment may avoid this disciplinary normalization, precisely because it cannot afford therapeutic transformation. Yet a person's "choice" to head-bang in a subsidized apartment, to drink oneself into a stupor, or sit idly might easily be reframed as the state's abdication of responsibility for profound need and social defeat. This echoes the perspective of advocates wary of the way "independence" and "choice" rhetoric can justify inadequate support (e.g. Braslow 2013, Howell and Voronka 2012). Familial investment in concerted constraint, in turn, shows the way love, control, and opportunity may go hand in hand. Here class privilege and family expectation may bring a kind of normalization that the marginal urban patient avoids by default.

As a final note, and returning to the contemporary legacy of deinstitutionalization, we find fierce struggles to reform civil commitment law, expand outpatient commitment, and even "bring back the asylum" (Sisti, Segal, and Emanuel 2015) to address the criminalization and social abandonment of mental illness. In California, current efforts to reform the definition of "grave disability" may lead to an uptick in community guardianships, should resources also be made available to back it up. Yet even if such thresholds change, many care decisions will still take place in community settings where choice is both legally institutionalized and normatively valued. In Los Angeles, for instance, a recent bond measure authorized over a billion dollars towards tolerant interventions like harm reduction-oriented supportive housing. Thus, understanding the contemporary management of psychiatric disability means not only the political flashpoints of overriding choices, as in emergency hospitalization or criminalization, but also governing *through* choices when people do not present "danger." Whether one sees tolerant containment as a civil libertarian achievement or neglect, and concerted constraint as loving treatment or familial control, each offers a form of liberal governance that cannot be reduced to questions of simple domination. Here a politics of coercion versus freedom may prove less useful than one that considers the material roots of unequal illnesses and stratified choice architectures.

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