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IRVINE

Managing the Mentally Ill in Los Angeles

DISSERTATION

submitted in partial satisfaction of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

in Criminology, Law and Society

by

Natalie Ann Pifer

Dissertation Committee:
Professor Elliott Currie, Co-Chair
Assistant Professor Keramet Reiter, Co-Chair
Professor Mona Lynch
Professor George Tita
Professor Kaaryn Gustafson

2017

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Dedication

To those fierce women who have enabled me to nevertheless persist.

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Acknowledgments

First and foremost, I would like to acknowledge my committee co-chairs, Elliott Currie and Keramet Reiter, who have been instrumental in helping me navigate both this dissertation project and my path through academia. You have both provided me with invaluable feedback on a countless number of drafts and incalculable support during every stage of this project and of my journey through graduate school. I am grateful to be your student.

I would also like to thank my committee members, Mona Lynch, George Tita, and Kaaryn Gustafson. You have each shared your unique expertise and approaches to scholarship with me throughout this project. Together, you have provided me with new and more layered ways to understand my work. I am grateful for your mentorship.

Each of these five scholars have supported me and my work through their formal service on my dissertation committee and through countless informal moments of mentorship throughout graduate school. I am grateful to have been mentored by this engaged and interdisciplinary group. Your generosity of knowledge and of time has made this dissertation project both possible and better. The errors that remain are my own.

I also acknowledge the personal relationships that have unfolded during my time at the University of California, Irvine. Each one has made my work and my life infinitely richer. Through them, I have grown and grown up. In particular, to the village that I have built during this journey, may we enjoy a lifetime of writing retreats in the desert, at the shore, or wherever we can conspire to converge.

Financial support for my dissertation project was provided by the John Randolph Haynes and Dora Haynes Foundation, the Office of the Graduate Dean at the University of California, Irvine, and by the University of California, Irvine's Public Impact Fellowship Program.

Finally, I am grateful to the Los Angeles Police Department (LAPD) for providing me with access for the fieldwork component of this project. The Office of Constitutional Policing and Policy was instrumental in helping me to navigate the LAPD and I am especially grateful to the individual members of the LAPD who allowed me access to their daily lives on the job.

Curriculum Vitae

Natalie A. Pifer

RESEARCH AND TEACHING INTERESTS

criminology, extreme punishments, law and society, legal categories, legal change, qualitative methods, mental disabilities and illness, policing, punishment and social control

EDUCATION

2017 **Ph.D.**, Criminology, Law and Society, University of California, Irvine
Dissertation: *Managing the Mentally Ill in Los Angeles*
Committee: Elliott Currie (co-chair), Keramet Reiter (co-chair), Kaaryn Gustafson (Law) Mona Lynch, George Tita
Comprehensive Exam Fields: Criminology; Law & Society (emphasis in Legal Consciousness and Punishment)

2014 **M.A.**, Social Ecology, University of California, Irvine
Thesis: *Implementing* Atkins*: Reconstructing and Reinforcing Intellectual Disability through Capital Punishment*
Committee: Elliott Currie (chair), Mona Lynch, Keramet Reiter

2011 **J.D.,** Loyola Law School, Los Angeles, CA
Cum Laude & *Order of the Coif* / Class Rank - Top 5%

2008 **B.A.,** Journalism and Politics, New York University, New York, NY
Cum Laude

ACADEMIC APPOINTMENTS

2017 **University of Rhode Island**
Assistant Professor of Criminology and Criminal Justice
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2016 **University of California, Irvine**
Graduate Student Instructor, Department of Criminology, Law and Society

PUBLICATIONS

Journal Articles, Peer-Reviewed

2016 (forthcoming) "Not an Iron Pipeline, but Many Iron Capillaries: Regulating Passive Gun Transactions in Los Angeles' Secondary & Illegal Markets." Kelsie Chesnut, Melissa Barragan, Jason Gravel, **Natalie A. Pifer**, Keramet Reiter, Nicole Sherman, and George Tita. *Injury Prevention*.

2016 **Pifer, Natalie A.** The Scientific and the Social in Implementing *Atkins v. Virginia*." *Law & Social Inquiry* (41)4: 1036-1060.

Law Review Articles

2016 **Pifer, Natalie A.** "Re-Entrenchment Through Reform: The Promises and Perils of Categorical Exemptions for Extreme Punishment Policy." *Alabama Civil Rights & Civil Liberties Law Review* (7)2" 171-218.

2011 **Pifer, Natalie A.** "*Berghuis v. Smith*: Continuing Ambiguity in Fair-Cross Section Claims." *Loyola of Los Angeles Law Review* 44(3): 1035-1048.

2010 **Pifer, Natalie A.** "Is Life the Same As Death?: Implications of *Graham v. Florida*, *Roper v. Simmons*, and *Atkins v. Virginia* on Life Without Parole Sentences for Juvenile and Mentally Retarded Offenders." *Loyola of Los Angeles Law Review* 43(4): 1495-1532.

Book Chapters, Peer-Reviewed

2015 Reiter, Keramet & **Natalie A. Pifer**. *Plata v. Brown*. In *Oxford Handbooks Online in Criminology and Criminal Justice*, Michael Tonry, ed. Oxford University Press.

Book Reviews

2016 **Pifer, Natalie A.** (forthcoming) Review of the book *Mass Incarceration on Trial: A Remarkable Decision and the Future of Prisons in America* [by Jonathan Simon] *Punishment & Society*.

2013 **Pifer, Natalie A.** Review of the book *Life without Parole: America's New Death Penalty?* [edited by Charles J. Ogletree, Jr. and Austin Sarat] *Punishment & Society*, 15(5): 583-585.

Manuscripts under Review

"Prohibited Possessors and the Law: How Inmates in Los Angeles Jails Understand Firearm and Ammunition Regulations." Melissa Barragan, Kelsie Chesnut, Jason Gravel, **Natalie A. Pifer**, Keramet Reiter, Nicole Sherman, and George Tita. Revise and Resubmit at *The Russell Sage Foundation Journal of the Social Sciences*.

GRANTS & FELLOWSHIPS

External

2017	Law and Society Association Graduate Student Travel Subsidy ($500)
2016-17	Haynes Lindley Doctoral Dissertation Fellowship ($20,000)

2013-14 California Wellness Foundation (sub-grant) Lead Graduate Student Researcher on *Gun Violence in America: Understanding Illegal Gun Markets, A Multi-City, Multi-Method Study* (Co-PIs: George Tita and Keramet Reiter)

Internal

2017 UC Irvine Public Impact Fellow ($1,000)
2016 UC Irvine Graduate Dean's Dissertation Fellowship ($11,498.50)
2015 Associated Graduate Students Travel Grant, UC Irvine ($800)
2015 Summer Research Funding, UC Irvine ($1,450)
2014 Summer Research Funding, UC Irvine ($1,550)
2013-14 Peterson/Microsemi Fellowship in Law, Society and Culture, UC Irvine ($10,745)
2013 Associated Graduate Students Travel Grant, UC Irvine ($400)
2012 Summer Research Funding, UC Irvine ($3,200)
2011-16 Conference Travel Support, UC Irvine ($5000)
2011 Summer Research Funding, UC Irvine ($3,000)
2011-12 Social Ecology Stipend and Fee Fellowship, UC Irvine ($21,490)

SELECTED HONORS & AWARDS

2016 Michelle Smith-Pontell Outstanding Accomplishment in Graduate Study Award, Department of Criminology, Law and Society
2016 Honorable Mention, UC Center Sacramento's Emerging Scholars Award for Excellence in Research and Public Policy
2014, 2015 Department of Criminology, Law and Society Commendation Award
2011 Alpha Sigma Nu Honor Society
2011 St. Thomas More Law Honor Society
2009-11 Faculty Academic Honors Scholarship, Loyola Law School
2011 Election Law and Law of the Political Process, Loyola Law School First Honors
2011 Advanced Topics in Criminal Justice, Loyola Law School First Honors
2011 Habeas Corpus and Prisoner Civil Rights Litigation, Loyola Law School First Honors
2010 Administrative Law, Loyola Law School First Honors

SELECTED PRESENTATIONS

Invited Lectures

2017 "The Promises and Perils of Categorical Exemptions in Punishment Policy." Emerging Scholars Series, UC Center Sacramento, February 9, 2017.

Public Presentations

2015 "Los Angeles' Underground Gun Market." Festival of Discovery, Irvine, CA October 3, 2015.

Campus Presentations & Guest Lectures

2016 Invited Panelist, "Why Graduate School," Justice Research Symposium, Irvine, CA, May 20, 2016.

2016 Guest Lecturer "Punishment and Inequality," in Macro Criminology (graduate course • Charis Kubrin), Department of Criminology, Law and Society, UC Irvine, May 17, 2016.

2016 Invited Panelist, "Translational Research Panel," Department of Criminology, Law and Society, Irvine, CA January 11, 2016.

2015 Panelist, "Prospective Student Research Panel," Department of Criminology, Law and Society, Irvine, CA January 26, 2015.

2014 Presenter, "Implementing *Atkins*: Reconstructing and Reinforcing Intellectual Disability through Capital Punishment." Socio-Legal Workshop, Irvine, CA May 2, 2014.

2014 Panelist, "Comprehensive Exam Q&A Panel," Department of Criminology, Law and Society, Irvine, CA December 11, 2014.

2014 Invited Panelist, "Colloquium Series: Surviving and Thriving as a Graduate Student," Department of Criminology, Law and Society, Irvine, CA November 3, 2014.

2013 Panelist "Foreshadowing Atkins: National Consensus Contradictions in Capital Cases Involving Intellectual Disability." Department of Criminology, Law & Society Graduate Student Colloquium, Irvine, CA, May 21, 2013.

2010 "Is Life the Same as Death?: What's Next for Juvenile and Mentally Retarded Life Without Parole Sentences." Loyola of Los Angeles Law Review Annual Student Symposium, Los Angeles, CA, April 2010.

Conference Presentations

2016 "Policing the Mentally in Los Angeles." Annual Meeting of the American Society of Criminology, New Orleans, LA.

2016 "Policing the Mentally Ill in Los Angeles: The Development and Deployment of Specialized Policing Units in Penal Reform." Annual Meeting of the Law & Society Association, New Orleans, LA.

2016 Invited Paper Session Chair and Discussant, "The Punitive State III: Death Penalty, Wrongful Convictions, and Punishing Violent Crimes." Annual Meeting of the Law & Society Association, New Orleans, LA.

2016 "Managing the Mentally Ill." West Coast Law and Society Retreat Graduate Student Workshop, Irvine, CA.

2015 Paper Session Organizer and Chair, "Researching Extreme Conditions of Confinement: Solitary Confinement, Ad-Seg, and the SHU." Annual Meeting of the American Society of Criminology, Washington, DC.

2015 Roundtable Session Organizer and Chair, "The Law and Practice of Solitary Confinement and Extreme Prison Conditions." Annual Meeting of the American Society of Criminology, Washington, DC.

2015 "Pulling the Trigger: Prohibited Possessors and Deciding to Buy in Los Angeles' Underground Gun Market." Annual Meeting of the American Society of Criminology, with Kelsie Chesnut and Melissa Barragan, Washington, DC.

2015 "Categorically Restricting Extreme Conditions of Confinement." Annual Meeting of the American Society of Criminology, Washington, DC.

2015 Invited Panelist, "Categorical Restrictions: Exempting the Mentally Ill from California's Extreme Conditions of Confinement." Annual Meeting of the Law & Society Association, Seattle, WA.

2015 Paper Session Organizer and Chair, "Bearing Arms from Behind Bars: Examining Gun Laws and the Gun Offender." Annual Meeting of the Law & Society Association, Seattle, WA.

2015 "Missing the Mark with Deterrence: Understanding the Legal Consciousness of LA Gun Offenders." Annual Meeting of the Law & Society Association, with Kelsie Chesnut, Seattle, WA.

2015 "The *Atkins* Category: Revealing the Science of Illusion in Death Penalty Adaptations." Annual Meeting of the Western Society of Criminology, Phoenix, AZ.

2014 "A Qualitative Understanding of LA's Illegal Gun Market." Annual Meeting of the American Society of Criminology, with Kelsie Chesnut and Melissa Barragan, San Francisco, CA.

2014 "Implementing *Atkins*: Reconstructing and Reinforcing Intellectual Disability through Capital Punishment." Annual Meeting of the Law & Society Association, Minneapolis, MN.

2013 "A Space Between: Capital Defendants Alleging Intellectual Disability and Constructions of the Penal Subject." Annual Meeting of the American Society of Criminology, Atlanta, GA.

2013 "Targeting Los Angeles's Underground Gun Market: An Exploratory Multi-Method Approach." Annual Meeting of the American Society of Criminology, with Keramet Reiter, Atlanta, GA.

2013 "Implementing *Atkins*: Interrogating the National Consensus." Annual Meeting of the Law & Society Association, Boston, MA.

Conference Posters Presented

2016 "Influential Factors on Transaction Level Gun-Involved Behavior Among Adults in Los Angeles, CA." Annual Meeting of the American Sociological Association, with Kelsie Chesnut and Melissa Barragan, Seattle, WA

2015 "Missing the Mark with Deterrence: Criminal Law and Legal Consciousness in the County Jail." University of California Conference on Social Science and Law, with Kelsie Chesnut, UC Irvine, CA.

TEACHING EXPERIENCE

Undergraduate

- *Introduction to Criminology, Law & Society**, Instructor, UC Irvine (Summer 2016)
  * online course
- *American Law*, Instructor, UC Irvine, upper division course (Spring 2016)

ACADEMIC SERVICE

Professional Service

Anonymous Reviewer for: *Punishment & Society*, *Criminology, Criminal Justice, Law & Society*

2016-17	Associate Editor, *Punishment & Society*
2010-11	Note & Comment Editor, LOYOLA OF LOS ANGELES LAW REVIEW
2009-10	Staff Member, LOYOLA OF LOS ANGELES LAW REVIEW

University Service

2016	Co-Supervisor (with Keramet Reiter), UC Irvine Law School's Pro Bono Clemency Project
Fall 2014	Co-organized a film screening featuring Gabriel London, Director of "The Life and Mind of Mark DeFriest", sponsored by the Department of Criminology, Law and Society, the Center for Law, Society and Culture, and the Newkirk Center for Science and Society.
2013-14	Co-Organizer of the Critical Justice Working Group An interdisciplinary group of graduate students facilitating reading discussions and paper workshops, sponsored by the UC Irvine Center for Law, Society and Culture.
2013-2017	Affiliated graduate student, UC Irvine Center for Law Society and Culture.

Departmental and School Service

Fall 2015	Graduate Student Representative, Faculty Hiring Committee, Department of Criminology, Law and Society.
Spring 2015	Co-organized a colloquium featuring Professor Meda Chesney-Lind (University of Hawaii at Manoa) as the Annual CLS Graduate Student Invited Speaker, sponsored by the Department of Criminology, Law and Society.
2014-15	Co-Graduate Student Representative, Department of Criminology, Law and Society. Attended faculty meetings, coordinated graduate student community events, liaison for faculty-graduate issues and managed $5000 budget.
2014-15	Member, Ad-Hoc Comps Committee, Department of Criminology, Law and Society.
2013-15	Co-Chair, Social Committee, Department of Criminology, Law and Society.
2012-13	Member, Social Committee, Department of Criminology, Law and Society.
2013-14	Member, Peer Mentoring Committee, Department of Criminology, Law and Society.

PROFESSIONAL MEMBERSHIPS

American Sociological Association
- Crime, Law and Deviance Section
- Sociology of Law Section

American Society of Criminology

Law and Society Association
- Punishment and Social Control collaborative research network
- Law and Ethnography collaborative research network

SELECTED LEGAL EXPERIENCE

2010-11	Certified Law Student, Youth Education Advocacy Clinic, Center for Juvenile Law and Policy, represented juvenile delinquents and their educational rights holders at school disciplinary and expulsion hearings and during actions related to special education rights, including Individual Education Plan meetings and due process hearings.
2007	Legal Intern, Manhattan Borough President's Office, Office of the General Counsel, assisted in policy and legislative analysis at the city, state and federal level, evaluated political legal situations, especially conflict of interest and public access cases, assisted Borough's Immigrant Rights Task Force, including community organizing around the DREAM Act.

Abstract of the Dissertation

Managing the Mentally Ill in Los Angeles

By

Natalie Ann Pifer

Doctor of Philosophy in Criminology, Law and Society

University of California, Irvine, 2017

Professor Elliott Currie, Co- Chair
Assistant Professor Keramet Reiter, Co-Chair

This project uses the case of Los Angeles to analyze how the criminal justice system has evolved to ostensibly better manage the mentally ill in the wake of transinstitutionalization and in reaction to federal civil rights litigation demanding reform. I use original qualitative data to analyze two criminal justice reforms designed to create safer parameters for police encounters with the mentally ill, improve the conditions of confinement for those who are arrested, and divert the mentally ill from the system to treatment: the Los Angeles Police Department's (LAPD) Mental Evaluation Unit (MEU) and the county's decision to replace its Men's Central Jail with the Consolidated Correctional Treatment Facility (CCTF), a state-of-the-art jail facility that will primarily focus on mental health treatment.

Chapter 1 uses archival and legal analysis to trace how the MEU and the CCTF unfolded as specialized policy solutions designed to improve the criminal justice system's management of the mentally ill by hybridizing care and control logics. These reforms constitute a novel form of "specialized justice" and represent the next turn of transinstitutionalization in which the criminal justice system's management of the mentally ill shifts from a de facto to an explicit responsibility. Chapters 2 and 3 use original data collected through field observations of and

open-ended conversations with LAPD officers to examine how specialized justice reforms are implemented on the ground by analyzing how frontline workers navigate the task of policing the mentally ill. Chapter 2 identifies the processes through which patrol officers filter individuals in and out of the category of mental illness and how MEU resources unfold on the ground. Chapter 3 describes how patrol officers understand their role on the frontlines of transinstitutionalization and navigate the line between care and control. These chapters reveal the pitfalls of entrenching the management of the mentally ill in the criminal justice system by identifying how the on-the-ground meaning of specialized justice reforms like the MEU fall short of their formal promise to better police the mentally ill. The dissertation concludes by discussing the case study's implications for understanding the system's place on the frontlines of managing social problems through specialized justice.

Introduction

Early on a Tuesday morning in June 2016, people began to gather at the Caltrans Building in downtown Los Angeles' civic core, which is home to a host of city, state, and federal government entities. City Hall is, for example, just a block up Main Street, while the Clara Shortridge Foltz Criminal Justice Center— the Los Angeles County courthouse that also houses the county offices of both the District Attorney and the Public Defender—is just two blocks northwest on Temple Street. And, the Los Angeles Police Department's (LAPD) Police Administration Building (PBA) is just across the street.

The ten-story, 500,000 square-foot PBA houses not only the Office of the Chief of Police but also specialized units like the Mental Evaluation Unit (MEU), which occupies a suite of offices on the building's 6th floor. The MEU's various components—the Triage Desk, the Systemwide Mental Assessment Response Team (SMART), the Case Management Program (CAMP), and the Training Unit—work together to assist LAPD officers who encounter people with mental illness in the field.

That morning, three members of the MEU's Training Unit had crossed Main Street to convert a large room in the CalTrans building into a classroom with a projector screen and groups of chairs organized around six large tables, each flanked by a blank flip chart on an easel. They would spend the next four days running the MEU's Mental Health Intervention Training (MHIT) series. The training is mandatory for all LAPD patrol officers and the MEU's Training Unit runs the course every other week, outlining over thirty-six hours of hands-on training on how the police can better navigate their interactions with the mentally ill. I waited in the hallway along with some thirty LAPD officers wearing their street clothes to receive a number from a MEU member that would correspond to our assigned group for the training. At 0700 hours, the

MHIT began with a series of brief introductions to the MEU, to the training, to common mental illnesses, and to each other.

At 0800 hours, the training moved to its first substantive unit, entitled "Mental Health Overview" on the MHIT's agenda. Each of the six groups was responsible for researching and then presenting a question about mental health to the rest of the class while Nick, the session's facilitator, circled the room providing feedback and making small talk. Nick, a veteran Licensed Clinical Social Worker (LCSW) with the County of Los Angeles Department of Mental Health (hereinafter LA DMH), was also part of the MEU's LA DMH section. Nick had tasked my group with researching the basic ways that psychotropic medications affect the brain and, though there were five of us in the group— three Police Officer IIIs (PIII), two Police Officer Is (PI), and me—LAPD's paramilitary structure dictated that the actual task of writing our answer on the flip chart and presenting to the rest of the class fell to the two PIs, who, as low-ranking probationary officers, were at the hierarchy's bottom. One PI cracked a joke as he read over the question. "I don't know what this shit is," he lamented after reading it out loud. Our group's laughter attracted Nick's attention, who paused by our table and noticed that our flip chart was still blank. "Come on, are you guys the special ed table?" he joked. The rib refocused us on the task at hand and the PIs began to research on their phones while the P3s chatted about why "5150s" don't take their medications.

The phrase 5150 is LAPD shorthand for a person with mental illness, which is itself shorthand for the Lanterman-Petris-Short Act (LPS). The LPS is now better known by its California Welfare and Institutions Code (WIC) section number: 5150. WIC § 5150 establishes California's legal guidelines for handling involuntary civil commitments to mental health institutions and authorizes the police to apply for an involuntary psychiatric hold when they

encounter an individual who "is a danger to others, or to himself or herself, or gravely disabled" as a result of a "mental health disorder." Just as the code section serves as LAPD slang, the law also serves to sketch, at least in a broad sense, the formal boundaries around the category of mental illness for LAPD officers.

Nick soon gathered the room together to begin the small group presentations. Our group presented third and the PIs began to describe how psychotropic medications work by trying to re-balance the chemical imbalances in the brain that are responsible for mental illnesses. Nick jumped in, "I want to thank you for being really honest by admitting that you didn't know what the shit this is."

"I thought it was some kind of mental illness diagnosis or something like that," the PI said with a sheepish grin. Nick used the moment to pivot from the science of mental illness to a historical discussion of how society has managed the mentally ill.

> It's only been in the last fifty years or so that we've gotten smart about this [mental illness]. It's not like heart disease or cancer or broken bones—things that we have worked with forever. Mental illness has really been a mystery. If we go back into history, mental illness has really scared the crap out of people and society has responded with some bizarre and awful ways. What are the ways that society has dealt with mental illness overtime?

"Incarceration," someone shouted.

"Not just incarceration," Nick responded. "They put them in a mental hospital. They did all sorts of weird things to them. What else happened?"

"Kill them," someone else shouted out.

"How did that happen?"

People called out different answers. "Genocide!" "Weird beliefs!"

Nick picked up on this thread, "Like burning at the stake? Called 'em a witch." He then pivoted to the opposite side of the spectrum. "But there's also been some societies that thought people with mental illnesses were kind of special. The point is that every society has a way of trying to understand mental illness" (Pifer fieldnotes).

Nick soon steered the conversation back to psychotropic medications since we had already fallen behind schedule in covering the rest of the material included in the "Mental Health Overview" unit that kicked off the first day of the MHIT. Yet, the sidebar was at the center of this training; society has indeed struggled to make sense of—and to manage—the mentally ill. The first officer's gut reaction to Nick's question, that society is dealing with the mentally ill through incarceration, implicated the very reason we were attending the MHIT.

For an extended period of American history, the mentally ill were often, as Nick's response noted, sent to asylums; today, they are often arrested and sent to jail. The jails in urban cities like Los Angeles function as some of the country's largest inpatient psychiatric facilities and law enforcement officers routinely encounter individuals with mental illnesses during their patrols. Yet, the criminal justice system has struggled in the wake of what scholars have dubbed "transinstitutionalization" (Gilligan 2001), the process describing society's shift from the hospitalization to the criminalization of the mentally ill. This is, of course, unsurprising for scholars of punishment and social control: the criminal justice system is, by definition, designed for crime and criminals, not for treatment and the mentally ill. Prisons, are for example, driven by security logics that come into inherent tension with caring for and accommodating the mentally ill (Fellner 2006a, 2006b; Haney and Specter 2001; Kupers 1999) and police are, of course, not trained mental health workers versed in the nuances of identifying and interacting with the mentally ill (Rumbaut and Bittner 1979). The mentally ill are, as a result of this

fundamental disconnect, especially at-risk for harm—or, in the language of law, for civil rights violations—when they become involved with the criminal justice system or its agents.

In response, jurisdictions like Los Angeles have decided—or been legally required under federal civil rights laws—to implement reforms designed to improve the conditions of confinement for the mentally ill, create safer parameters for police encounters, or even divert the mentally ill from the criminal justice system into treatment. In this sense, the MHIT, and the MEU itself, are part of a constellation of policies and practices seeking to reform how the criminal justice system polices, punishes, and incarcerates the mentally ill.

This dissertation examines why and how reforms to policing and incarcerating the mentally ill have unfolded in the wake of transinstitutionalization using Los Angeles as a case study. The intersection between criminal justice and mental illness in Los Angeles allows the nuances and fallout of transinstitutionalization—as well as its role in driving criminal justice development—that might otherwise be obscured in a less dramatic site to emerge in rich detail. On one hand, the sheer volume of individuals with mental illnesses that fall within the local criminal justice system's shadow makes it an important object of study. The Los Angeles County Sheriff, Jim McDonnell, refers to the county's jail system that his department manages as a "de facto mental health treatment system" that houses more mentally ill individuals than the entire California State Hospital system (McDonnell 2015). In fact, the county's Twin Towers Correctional Facility is considered one of the country's largest mental institution (Montagne 2008), along with Chicago's Cook County Jail (Ford 2015) and New York City's Rikers Island Jail (Winerip and Schwirtz 2014). Given the staggering number of mentally ill inmates behind bars, it is no surprise that law enforcement officers, the gatekeepers to the criminal justice system, in these urban cities also have frequent contacts with the mentally ill. The New York

Police Department estimates that it responds annually to nearly 150,000 emergency calls for service involving a person in a mental health crisis (Byrne, 2017) while Chicago's Office of Emergency Management and Communications identified 25,691 Police Crisis Intervention Team events in 2016 (O'Connell 2017). And, in 2015, the LAPD's MEU logged 16,494 reported calls for service involving a mental health crisis (Los Angeles Police Department 2016).[1] The criminal justice system in Los Angeles is, as in other large urban centers, on the frontlines of managing the institutionalized mentally ill.

More importantly, however, Los Angeles is—or rather, it has been placed by the U.S. Department of Justice (DOJ)—on the frontlines of developing the policies and practices that may constitute the next turn of transinstitutionalization. Both the county's jails and the city's police force have been the subject of federal civil rights investigations that have culminated in consent decrees mandating institutional reforms to, among other things, the system's treatment of the mentally ill. California is, in the context of criminal justice trends like the rehabilitative moment of the 1950s and the tough on crime movements of the 1980s and 1990s, a "bellwether state" (Clear 1994, p. 54; Irwin 1980; Leon 2011; Page 2011; McCoy 1993; Zimring, Hawkins, and Kamin 2001) and Los Angeles itself has introduced new criminal justice strategies, like SWAT, that have since spread nationally (Gates 1993). Given its reputation as an incubator for new criminal justice practices and policies, other jurisdictions are likely to take note of—and perhaps even replicate—Los Angeles' experimental responses to transinstitutionalization. Indeed, the LAPD's MEU has trained nearly sixty other law enforcement agencies domestically and ten agencies internationally in its approach to policing the mentally ill (O'Neill 2015). As a result, while I analyze how criminal justice reforms have been developed and deployed in Los Angeles, the implications stretch beyond its geographical boundaries.

In May 1999, LAPD officers shot and killed Margret Mitchell, a 55-year-old homeless and mentally ill black woman, after they stopped her to determine if her shopping cart was stolen. Officer Edward Larrigan shot Mitchell after she allegedly lunged at him with a 12-inch screwdriver. The city's civilian Police Commission ruled that the shooting violated LAPD's use of deadly force policies and the LAPD's own inspector general found that Mitchell did not pose a deadly threat, but then Police Chief Bernard Parks deemed the incident within policy. Ultimately, no criminal charges were filed against Larrigan, but the Los Angeles City Council approved a $975,000 settlement agreement with Mitchell's family in 2000. Mitchell's death would continue to reverberate throughout the city after the settlement, serving as the catalyst for an intense public debate about the LAPD's handling of incidents—and their aftermath—involving people with mental illness. This reform tide culminated in the 2001 consent decree between the city and the DOJ; Section VI mandated that the department develop a program for better responding to persons with mental illness.

Meanwhile, as the city grappled with its policing of the mentally ill, the county navigated the jail system's management of inmates with mental illnesses against a background of increasingly serious DOJ intervention. In 1996, the DOJ began investigating conditions in the Los Angeles County Jail System, including its abuse of mentally ill inmates as well as inadequate mental health and suicide prevention procedures. The following year, it issued a report finding a series of constitutional deficiencies. Over the years, the DOJ would intensify its oversight of the jail system and the mental health of its inmates, but despite a 2002 Memorandum of Agreement (MOA) between the County and the DOJ intended to remediate civil rights violations, systematic deficiencies in key aspects of the jails' mental health program remained. A June 2014 DOJ report emphasized the suicide rate in the jails—especially at the

aging downtown Men's Central Jail—and blasted officials for their failure to make progress on implementing the proper suicide prevention practices required by the MOA. On August 5, 2015, the LASD agreed to federal oversight of its jail system both to improve its treatment of mentally ill inmates and to end a culture of deputy violence against inmates.

Today, reforms designed to improve how the Los Angeles criminal justice system manages the institutionalized mentally ill have emerged from these parallel but intertwined civil rights controversies. I anchor my dissertation around the two specialized criminal justice strategies imagined as policy solutions to the system's mismanagement of the mentally ill: the LAPD's Mental Evaluation Unit and the county's decision to replace its aging Men's Central Jail with the Consolidated Correctional Treatment Facility (CCTF), a state-of-the-art jail facility that will focus primarily on mental health treatment. Together, these reforms promise to better manage the mentally ill—I examine how these reforms and their promises have unfolded on the ground.

I employ a variety of disciplinary approaches and data sources to understand how transinstitutionalization has unfolded on the ground and to reveal how the criminal justice system has developed in its wake. My analysis is largely grounded in the field of punishment and social control and in the tradition of socio-legal scholarship; I am particularly concerned with the on-the-ground meaning of these strategies for the criminal justice system and for society. I use qualitative methods and multiple sources of original data to reveal both the processes of developing these reforms and their on-the-ground implementation. To understand how the MEU and the CCTF were designed as policy solutions to better police and incarcerate the mentally ill, I drew on media archives, legal documents related to civil rights litigation, publically-available county and city government records, and internal LAPD documents provided to me by the MEU.

I also conducted approximately 120 hours of fieldwork with the LAPD in order to analyze how the MEU's specialized policing strategies have unfolded on the ground. My access to the LAPD was facilitated through its Office of Constitutional Policing and Policy, itself a product of the 2001 consent decree. This office reports directly to the Chief of Police, and, because LAPD is structured as a para-military organization that follows a strict chain of command, I had considerable assistance in navigating LAPD's hierarchy to access ride alongs in the various Bureaus that delineate the uppermost jurisdictional boundaries of how LAPD divides the city into distinct policing areas. Over the course of five months, I participated in 10 ride alongs (N=80 hours) facilitated by 10 sergeants and 1 lieutenant in three of the four LAPD Bureaus: the Valley, Central, and South Bureaus (see Appendix 1).[2]

Under LAPD guidelines, ride alongs must be facilitated by a supervisor—usually a sergeant—so while I was not able to always observe the initial moments of an encounter between an officer and a subject, the supervisors that facilitated my ride alongs were gracious enough to monitor incoming calls for service and respond proactively to calls relevant to my study. In addition, the LAPD mandates that a supervisor be present for all calls involving someone who may be mentally ill to ensure that departmental guidelines are followed. Together, the benevolent discretion of my subjects and the LAPD's Department Manual maximized my observational access to calls that involved persons who were perhaps mentally ill. I also participated in the training classes facilitated by the MEU's Training Unit (N=40 hours) that are mandatory for all LAPD patrol officers and focus on providing officers with information—both educational and tactical—about policing the mentally ill.

My data includes both observations of how calls and training classes unfolded as well as the open-ended conversational dialogues that I had with LAPD officers during training downtime

or while driving in the squad car, at calls for service, in the station, in jail, or in the ER (N=84). I recorded my data in the step-wise fashion (Snow and Anderson 1987) by making mental and jotted notes in a reporter's notebook while in the field and then making a more detailed audio-recording immediately after exiting the field, which was later transcribed.[3] I then expanded these jottings into a detailed and extensive field narrative following each day's observations.

My university's internal review board agreement allowed me to observe how calls unfolded and to speak with LAPD officers, but not to interact with the members of the community I encountered while on a ride along. I was, however, allowed to document my observations of how LAPD officers engaged with individuals believed to be mentally ill. I identified myself as a researcher, the nature of my study, and obtained verbal consent from participants throughout the course of data collection. My ethnographic fieldnotes do not include any identifying information about the participants and use pseudonyms for people and places to protect their privacy.

Data analysis was conducted in the grounded theory tradition (Glaser and Strauss 1967) by subjecting my fieldnotes to multiple rounds of open coding and thematic analysis during a memoing process. During this iterative process, I coded first for the recurrent and significant themes that emerged from the data. Then, after several rounds of open coding and a two-stage memoing process, I built a more structured set of coding categories designed to reveal how specialized policing strategies are deployed and how mental illness is constructed on the ground by LAPD officers. I do not make strong claims about generalizability beyond the city of Los Angeles, however, the LAPD's approach to policing the mentally ill is considered a model by other law enforcement agencies and advocates alike (S. O'Neill 2015), making it an important object of study.

Throughout the dissertation, I describe my approach to and the specific data used for each field of inquiry. Chapter 1 uses archival and legal analysis to trace how the MEU and the CCTF unfolded as specialized policy solutions designed to improve the criminal justice system's management of the mentally ill against the background of federal civil rights intervention. This analysis reveals how local stakeholders kept the task of managing the mentally ill squarely within the criminal justice system by responding to external legal intervention with reforms that, like the MEU and the CCTF, hybridize care and control logics. Chapters 2 and 3 use data collected through field observations of and open-ended conversations with LAPD officers to examine how these frontline workers navigate the task of policing the mentally ill. Chapter 2 reveals the processes through which patrol officers filter individuals in and out of the category of mental illness and how MEU resources unfold on the ground. Chapter 3 describes how patrol officers understand their role on the frontlines of transinstitutionalization and navigate the line between an arrest and a hold. I use both these analyses to explore how specialized criminal justice strategies like the MEU unfold in practice and the on-the-ground meaning of policing the mentally ill in transinstitutionalization's wake.

At its core, this dissertation asks two interrelated questions about how the criminal justice system incarcerates and polices the mentally ill. First, how has transinstitutionalization shaped criminal justice development in Los Angeles? Second, how are these emergent strategies implemented and what are the consequences for the criminal justice field and for the system's management of the mentally ill? By analyzing these questions, this dissertation enhances our understanding of both the meaning and function of criminal justice reforms that seek to alleviate social problems beyond crime by targeting marginalized populations like the mentally ill. In

particular, I make two central contributions to this larger discourse on punishment and social control.

First, I argue in Chapter 1 that the MEU and the CCTF represent a profound shift in criminal justice development that has emerged in direct reaction to transinstitutionalization. Traditional analyses of transinstitutionalization depict the criminal justice system's absorption of the institutionalized mentally ill as a managerial inheritance from the collapsed asylum system. In this narrative, the criminal justice system is left to grapple with managing a vulnerable population for which its de facto methods of policing and incarceration are particularly ill suited for. And, as a rich and interdisciplinary literature has documented, it is entirely unsurprising that the system has failed at the task. In Los Angeles, Margret Mitchell's death and a rash of suicides by inmates incarcerated in the jails are both emblematic and cataclysmic. In their wake, reforms, like the MEU and CCTF, have emerged to "better" police and incarcerate the mentally ill by hybridizing care and control. I argue that these "specialized justice" strategies transform the criminal justice system's management of the institutionalized mentally ill from an accidental task to an explicit responsibility. This formal embrace is signified by the building of specific criminal justice infrastructure like the MEU and the CCFT around the management of mental illness. And, because specialized justice reforms also function to remediate constitutional concerns, they serve to legitimize criminal justice—even if it is specialized— as a solution to social problems that fall far beyond crime control in an era when the social safety net is already threadbare.

Second, I argue that these specialized reforms suffer from the same flaw that law and society scholars have identified as endemic to the nature of formal policy reform (Gould and Barclay 2013): they are vulnerable to imperfect implementation that undercuts their ability to produce meaningful reform. The project of specialized justice is particularly exposed since these

strategies leverage the category of "the mentally ill" as their operative basis for policy, which is itself a category that means very little until a frontline worker gives it meaning. My research suggests that this process is continually unfolding each time a frontline worker gives meaning to the category by making on-the-ground decisions about who does and does not fall within the boundary—and about how specialized justice is deployed. At the same time, these frontline workers must also navigate the boundary between care and control, a process that itself gives meaning to the on-the-ground function of specialized justice as an intervention to social problems.

I identify both these processes as central mechanisms that undermine the promise of these specialized justice strategies to "better" police and incarcerate the mentally ill. As I show in the context of policing the mentally ill, the patrol officers tasked with deploying the MEU's specialized policing strategies construct the category of mental illness through external factors like place and time rather than through the criteria set forth by WIC §5150. More broadly, the on-the-ground experience of policing the mentally ill threads a thin line between care and control that patrol officers struggle to navigate in the everyday context of patrolling the city and engaging with the MEU. I find that, despite the presence of care logics in specialized justice, control logics dominate in both the process of deciding who is mentally ill and how specialized justice is deployed. If specialized justice does indeed represent, as I argue here, the next turn of transinstitutionalization, then the project falls short of its formal promise.

Ultimately, a larger question about whether the criminal justice system should indeed manage the mentally ill percolates throughout the project. I analyze the MEU and the CCFT in order to reveal the processes that drive—and frustrate—criminal justice development, but I do not evaluate their efficacy as policy interventions in quantifiable terms. In other words, this

dissertation does not conduct a program evaluation so I make no empirical claims about whether specialized justice does in fact "better" police and incarcerate the mentally ill—whatever better might mean in this context. They may very well represent a tangible improvement to the criminal justice system's status quo approaches to managing this vulnerable population. Regardless, my analysis still implicates the real-world stakes of leaving the criminal justice system to manage the mentally ill.

In 2015, just as I was beginning to conceptualize this project, Southern California's Public Radio station did a four-part series on police and the mentally ill in Los Angeles. In a part subtitled "*LAPD's Mental Health Unit Praised as Model for Nation*," the story provided an intimate look at the MEU—published just one week after LAPD officers shot and killed Charley "Brother Africa" Leundeu Keunang, a 43-year-old homeless Cameroonian immigrant with a documented history of mental illness, in downtown Los Angeles' Skid Row (S. O'Neill 2015). The story said this of policing the mentally ill:

> The task is a challenging one. Minor encounters can quickly escalate out of control even when officers have some mental health training, as was the case with last week's killing of a man by LAPD officers on Skid Row. (The Mental Evaluation Unit was not involved in the Skid Row incident.).

The story's interpretation of policing the mentally ill raises both a normative and an empirical question that illustrate the stakes of specialized justice.

Yes, policing the mentally ill is a challenging task, but so too is the task of managing the mentally ill. Society has, as the swing of transinstitutionalization's pendulum between jails and asylums demonstrates, struggled with it for centuries. The rise of specialized justice functions to entrench this task within the criminal justice system, but should it? And, yes, encounters between the police and the mentally ill can escalate quickly. In this, Margaret Mitchell's ghost is

impossible to ignore in making sense of the shooting of Brother Africa—both black, homeless, and mentally ill—her presence more pronounced for the reforms to policing the mentally ill that unfolded in the wake of her death. LAPD may have developed a model approach to policing the mentally ill, but why was the MEU not deployed to deescalate the encounter between LAPD officers and Brother Africa on Skid Row? My data cannot answer either of these questions, but my analysis of how specialized justice unfolds in the chapters that follow can illuminate a pragmatic question that bridges the two: what is gained and what is lost by deploying this as a criminal justice solution to the social problem of managing the marginalized?

1. Specialized Justice: Criminal Justice Development in Transinstitutionalization's Wake

A significant body of literature calls attention to the criminal justice system's contemporary role in managing the mentally ill. This literature typically conceptualizes the criminal justice system's responsibility for the institutionalized mentally ill as a de facto one inherited after the slow fade away of the asylums during the second half of the 20th century and the failure of any medical-model replacements, such as community-based mental health facilities, to meaningfully materialize. Collectively, this scholarship traces how the criminal justice system arrived on the frontlines of this social problem in the wake of the deinstitutionalization of the mentally ill from state hospitals and identifies the ways in which the system has mismanaged its inherited responsibility.

Under the "transinstitutionalization" thesis (Gilligan 2001), jails and prisons are conceptualized as the new asylums, housing more mentally ill individuals than mental hospitals do (Torrey et al. 2014) and police serve as "streetcorner psychiatrists" (Teplin and Pruett 1992). Yet, as numerous researchers have analyzed, the criminal justice system, concerned with punishment, is poorly equipped to perform care functions, like diagnosing, treating, and accommodating people with mental illnesses. The incarcerated mentally ill are, for example, particularly at-risk for experiencing conditions of confinement that may exacerbate their pre-existing vulnerabilities and for receiving substandard mental health treatment (Haney 2006; Kupers 1999; Reiter and Blair 2015; Rhodes 2004). In the community, the mentally ill are especially vulnerable to being injured during encounters with police officers (Cordner 2006) who, even despite a general knowledge of mental illness (Engel and Silver 2001), may misconstrue symptoms as aggressive, disrespectful, or hostile behavior (Morabito and Socia

2015). These parallel lines of research have done much to trace and expose the failings of the criminal justice system to manage the mentally ill in the wake of transinstitutionalization.

However, rather than examine the causes of transinstitutionalization or the criminal justice system's failure in its face, I analyze how it has reshaped the system's contours to understand contemporary developments in the field of punishment and social control. Managing the institutionalized mentally ill has become a central— if de facto—function of the criminal justice system over the second half of the twentieth century. Police encounters with the mentally ill constitute only between 7% and 10% of all law enforcement contacts (Deane et al. 1999; Janik 1992) but consume a disproportionate amount of patrol time (DeCuir and Lamb 1996; Pogrebin 1986), create a high risk for the potential use of force (Ruiz and Miller 2004), and fill correctional systems with non-serious but high-maintenance inmates as officers struggle to dispose of calls that tax their control schemas (J. C. Bonovitz and J. S. Bonovitz 1981; Borum et al. 2016; Clark, Ricketts, and McHugo 1999; Drake et al. 1993; Frankle et al. 2001; McFarland et al. 1989; J. Monahan and Steadman 1983).

Further, more than half of the nation's inmates have a mental health problem (James and Glaze 2006), and, according to a recent editorial in the Journal of the American Medical Association, they "live in an environment anathema to the goals of psychiatric recovery; it is often unsafe, violent, and designed to both control and punish" (Sisti, A. G. Segal, and Emanuel 2015, p. 243). Increasingly, these realities have become a lightning rod for civil rights challenges alleging that the status quo approach to policing and incarcerating the mentally ill is untenable (Hill and Logan 2001; Simon 2014).

This chapter examines how the criminal justice system has evolved in the face of transinstitutionalization and its discontents. I trace the contours of transinstitutionalization's

ripples throughout the criminal justice system by analyzing the development of two foundational reforms to how Los Angeles polices and incarcerates the mentally ill: a specialized Los Angeles Police Department unit focused on policing the mentally ill and a planned state-of-the-art Los Angeles County jail facility focused on mental health treatment. These reforms bookend an era of federal civil rights intervention and, as I argue, reveal a shift in how the criminal justice system manages the mentally ill. These "specialized justice" strategies transform the system's responsibility from de facto to explicit and hybridize care and control to re-entrench rather than reform the role of criminal justice on the frontlines of managing the mentally ill.

Here, I map the next turn of transinstitutionalization and explore its implications for analyses of punishment and social control. First, I describe the historical arc through which the criminal justice system inherited its responsibility for managing the institutionalized mentally ill as well as contemporary research on the system's failures in the face of transinstitutionalization. I then trace how the responded to these failures—and to federal legal intervention—focusing on two reforms to policing and incarcerating the mentally ill in Los Angeles. In the final part, I reveal the meaning of these reforms for understanding both criminal justice development and the unfolding role of criminal justice in managing the mentally ill.

The Arc of Transinstitutionalization

Over the second half of the twentieth century, the primary social control organizations responsible for managing the mentally ill shifted. The institutionalization of those labeled as insane in a state mental hospital, or insane asylum, had been, since the mid-1800s, "the standard procedure of society" and so strong was the nation's "cult of asylum" (Rothman 1971, p. 130) that in 1955, some 558,000 people were institutionalized in asylums (Harcourt 2011b)—a per capita figure that is comparable to the number of people incarcerated in jails and prisons during

the era of mass incarceration (Harcourt 2011a, p. 221-31). However, by the 1950s, this trend had peaked and between 1960 and 1980, the state mental hospital population began to fall dramatically (Earley 2007). By the late 1990s, many of these institutions had begun to close and by the turn of the century, the population had fallen to below 100,000 (Gottschalk 2010; Harcourt 2011b). This dramatic reduction in the number of those institutionalized in asylums over the last half of the 20th century is succinctly termed deinstitutionalization.

More complex, however, is what exactly explains deinstitutionalization. At its most narrow, deinstitutionalization is defined as a shift in the formal policy of the federal government that culminated in 1963 when President John F. Kennedy signed the Community Health Care Act into law (Rose 1979). This law sought to reduce the inpatient psychiatric population by some 50% by replacing asylums with comprehensive community care. However, sociological accounts describe a more complex process at work in deinstitutionalization, citing factors as diverse as medical innovations like psychotropic drugs (Bachrach 1976; Gronfein 1985; Pollack and Taube 1975), an ideological shift in how to treat those with differences (Ben-Moshe 2011), anti-institutional critiques (E. Goffman 1961), anti-psychiatry social movements (Chamberlin 1978; Chesler 1972; Morrison 2005; Szasz 1963), and the expansion of federal health and welfare programs (Aviram, Syme, and Cohen 1976; Lerman 1982; Scull 1977; S. P. Segal and Aviram 1978). What is clear, however, is that, regardless of the precise factor or set of factors that most accurately explains why the process of deinstitutionalization unfolded, by the end of the 19th century, the asylum was no longer dominate in managing the institutionalized mentally ill.

Yet, the promised alternatives—the community-based mental health facilities intended to reintegrate and care for the deinstitutionalized—to the state mental hospitals never fully materialized. Instead, a perverse reality of "transinstitutionalization" (Gilligan 2001) took hold

between the 1960s and 1990s in which the jails and prisons replaced the asylums as the primary repositories for the nation's institutionalized mentally ill. This organizational shift is perhaps better conceptualized as the second turn of transinstitutionalization since the asylums themselves had emerged in the early 19th century as an alternative to institutionalizing the severely mentally ill in local jails and almshouses (Rothman 1971). Today, the pendulum has swung yet again and the jails in the country's largest cities like Chicago, Los Angeles, and New York function as some of the country's largest de facto inpatient psychiatric facilities (Earley 2007; Torrey et al. 1990). Estimates by the U.S. Bureau of Justice place the rate of mental illness among the incarcerated at 50% or higher (James and Glaze 2006) and there are about ten times more persons identified as mentally ill in prisons and jails than in mental hospitals (Torrey et al. 2014).

The collision between the vacuum in organizational management left by deinstitutionalization (Dear and Wolch 1987; Torrey 1997) and the rise of the culture of control (Garland 2001) during the late 20th century suggest that the increasingly punitive policies of mass incarceration may explain the scores of incarcerated mentally ill individuals. However, persons with mental illnesses are but one of the various sub-populations that have contributed to the explosion of the U.S. prison population (Harcourt 2011). Research finds that deinstitutionalization accounted for only 4% to 7% of incarceration growth between 1980 and 2000 and none of the earlier increases (Raphael and Stoll 2013). Still, though they are distinct processes, mass incarceration and transinstitutionalization have unfolded along similar lines.

Just as mass incarceration has disproportionately affected the most disadvantaged segments of society (Beckett, Nyrop, and Pfingst 2006; Blumstein and Beck 1999, 2005; Mauer 1999; Wakefield and Uggen 2010; Tonry 1996; Western 2006; Wheelock and Uggen 2008; Zimring and Hawkins 2005) the phenomenon of institutionalization also unfolded over raced,

classed, and gendered lines (Dorr 2006; Gambino 2008; Trent 1995). Asylums were disproportionally filled with already marginalized members of society who had been diagnosed as "insane" or "feebleminded"—labels that were socially constructed based on assumptions about race, class, and gender dynamics (Szasz 1961). The "institutionalized mentally ill" is, like the category of criminal (Chambliss 1964), not neutral, but rather a constructed category of analysis. These categories have collided through transinstitutionalization such that those marginalized individuals who would have been vulnerable to institutionalization are now vulnerable to criminalization.

In transinstitutionalization's wake, an interdisciplinary literature crafted by criminologists, legal scholars, psychologists, and sociologists has emerged to critique the criminal justice system's treatment of the mentally ill. In an ironic nod to the pendulum swing of transinstitutionalization, the core of these contemporary challenges track closely with the arguments made by 19th century reformers like Dorthea Dix, Mosses Sheppard, and Thomas Scattergood in their fight against the warehousing of the severely mentally ill in the jails and poorhouses of post-colonial America (Rothman 1971). Today's prisons and jails are still all too often cruel and but not unusual places for the incarcerated mentally ill. Most obviously, they frequently lack adequate mental health care systems, which can cause inmates with mental illnesses to deteriorate (Fellner 2006a; 2006b; Haney and Specter 2001; Kupers 1999). In California, approximately one prisoner committed suicide per week in 2006; more than 70% of those were, with proper treatment, preventable (*Plata v. Brown* 2011). Carceral spaces also operate in more subtle ways to the detriment of the mentally ill. For example, the incarcerated mentally ill often struggle to follow the myriad rules that govern prison life, which means they are especially vulnerable to being punished through internal administrative mechanisms (Adams

1986; Fellner 2006b; Lovell and Jemelka 1996) and face heightened exposure to punitive solitary confinement (Haney and Lynch 1997; Reiter and Blair 2015; Rhodes 2004).

Police also routinely encounter individuals with mental illness (Bittner 1967), and while they may be able to identify someone as mentally ill in general (Engel and Silver 2001), they are not trained mental health workers and cannot identify the full range of conditions and symptoms associated with the category (Rumbaut and Bittner 1979). As a result, police may misconstrue symptoms of mental illness as aggressive, disrespectful, or hostile behaviors (Novak, Engel, and Novak 2005; Teplin 1984), so it comes as no surprise that police consider interactions with the mentally ill among their most dangerous calls (Margarita 1980; Ruiz and Miller 2004; Watson, Corrigan, and Ottati 2004). In reality, though, people with mental illnesses are more likely to be injured during encounters with the police (Cordner 2006) and this myth of dangerousness may be an unnecessary stigmatization of an already vulnerable population (Morabito and Socia 2015).

Together, the literature has well documented both the historical trajectory of transinstitutionalization and the criminal justice system's failures in its face, but there is little research analyzing how the system has evolved in reaction. This gap in the literature is especially surprising given the intense focus on identifying and explaining how punishment and social control has changed at both the macro- (Garland 2001; Gottschalk 2006; Simon 2009; Wacquant 2009; Whitman 2003; Young 1999), meso- (Goodman, Page, and Phelps 2014), and micro- (Campbell and Schoenfeld 2013; Gartner and Kruttschnitt 2004; Goodman 2012; Lynch 2010; Phelps 2011) levels during the late 20th century. However, while punishment and social control scholars have analyzed contemporary developments in punishment (Feeley and Simon 1992; Harris, Evans, and Beckett 2010; Kalhan 2010) and policing (Beckett and Herbert 2009; A. Goffman 2014; Rios 2011; Stuart 2016) through the prism of mass incarceration, the particular

dynamics of transinstitutionalization in shaping criminal justice policies have been largely unexamined.

Tracing Criminal Justice Development in Los Angeles

In this section, I analyze the unfolding of two criminal justice reforms in Los Angeles as a lens to examine how the criminal justice system has developed in the wake of transinstitutionalization. Beginning in the late 1990s, the status quo of policing and incarcerating the mentally ill in Los Angeles became increasingly untenable. Against a background of escalating legal intervention, local criminal justice agents sought to remedy constitutional defects in the treatment of the mentally ill in the jails and by the police. I use a combination of archival and legal documents to trace each reform's trajectory from its genesis in a period of open criminal justice conflict and to its destination as an ostensible policy solution to chronic civil rights violations. My analytical materials include media archives, legal documents related to civil rights litigation, publically-available county and city government records, and internal LAPD documents.

My framing leverages the analytical concept of the criminal justice field (see Wacquant and Bourdieu 1992; Page 2011). The criminal justice field is envisioned as a social space in which the criminal justice policies and practices in Los Angeles are shaped by and in relation to the struggles between its various agents for criminal justice capital and by the field's orientation. I consider local governmental officials, local law enforcement officials, federal government agencies, private contractors and vendors, as well as advocacy groups as key agents in this analysis of the criminal justice field in Los Angeles and I describe how their struggle to determine the course of criminal justice policies and priorities unfolded in the context of managing the mentally ill. I also focus on revealing how the criminal justice field's orientation to

its responsibility to the mentally ill functioned as a central mechanism in how the field responded to external legal intervention demanding reform. This analytical perspective facilitates a nuanced examination of how criminal justice policies have developed and illuminates the meaning of these reforms for the field in which they unfolded.

Los Angeles' Specialized Policing Unit: The Mental Evaluation Unit

On a Friday afternoon in May 1999, two Los Angeles Police Department (LAPD) officers patrolling Los Angeles' Mid-Wilshire neighborhood on bicycles observed a woman pushing a shopping cart down La Brea Avenue. They recognized her, as then-LAPD Chief Bernard Parks would describe months later, as "possibly being a transient known to Wilshire Area officers for her explosive, violent nature" and, suspecting that her shopping cart was stolen, ordered her to stop (Parks 1999). Margaret Mitchell—a 55-year-old mentally ill and homeless black woman—refused to stop and, when the officers continued to pursue her, allegedly brandished a 12-inch screwdriver while yelling for the officers to leave her alone. The confrontation continued to escalate as Mitchell refused to comply with the officers' orders to stop and drop the screwdriver and, at the corner of La Brea and Fourth, Officer Edward Larrigan fired a fatal shot into Mitchell's chest.

Margaret Mitchell's shooting and its handling by LAPD prompted public outcry over law enforcement's treatment of both the mentally ill and people of color. The Los Angeles Board of Police Commissioners (hereinafter Police Commission), LAPD's civilian oversight committee, ruled that the shooting violated LAPD policy while Chief Parks deemed it justifiable; ultimately, Officer Larrigan was cleared by a LAPD disciplinary panel and no criminal charges were filed. Mitchell's shooting is easily subsumed by the decade's earlier infamous LAPD controversies—beginning with the filmed beating of Rodney King by LAPD officers in 1991, the 1992 South

Los Angeles uprising, and the revelation of deeply entrenched police corruption in the LAPD's Rampart Division's CRASH anti-gang unit in 1999—but it too is a pivotal event in the modern history of Los Angeles' criminal justice system that placed the policing of the city's mentally ill squarely on the reform agenda set by the 2001 consent decree negotiated between the city and the DOJ in the wake of chronic civil rights violations by the LAPD.

Much of the consent decree's mandates were designed to remediate excessive force, false arrests, unreasonable searches and seizures, and racial discrimination, but its legacy includes, as Section VI is titled, the "Development of Program for Responding to Persons with Mental Illness" (Consent Decree 2001, p. 52). This directed the LAPD to evaluate three key areas related to "dealing with persons who may be mentally ill": (1) "successful programs" used by other law enforcement agencies; (2) a review of the LAPD's own training, policies, and procedures; and (3) the review of LAPD contacts with persons who appeared to be mentally ill. Based on this analysis, LAPD was then directed to report to the Police Commission with recommended changes in "policies, and procedures, and training methods" designed to de-escalate the potential for violence in police contacts with the mentally ill. In this section, I trace how the LAPD's "Consent Decree Mental Illness Program" unfolded in order to "better" police the mentally ill.

Consolidating Care and Control in a Specialized Squad Car

The February 2000 edition of the *Los Angeles Police Beat*, the LAPD's official newsletter, started with an editor's note.

> The 1999 fatal shooting of a homeless woman Margaret Mitchell, has spurred unjustified criticisms of the Department. Within the Department, however, exists SMART (Systemwide Mental Assessment Response Team), collaborative units dedicated to assist police officers, the mentally ill and their families (Office of the Chief of Police 2000).

The newsletter's stance, though explicitly defensive and perhaps anticipatory of the looming consent decree, was not entirely unwarranted. The LAPD had indeed been actively engaged in developing new models to improve law enforcement's interactions with the mentally ill a full decade before the consent decree.

In January 1993, LAPD implemented its SMART co-response model, which teamed a LAPD officer who had received Crisis Intervention Training with a licensed mental health clinician from the Los Angeles County Department of Mental Health (hereinafter LA DMH) in a single mobile unit to assist field officers and divert the mentally ill from custody to treatment by making mental evaluations and referrals in the field. SMART guidelines directed all field officers who encountered a person who may be mentally ill to contact the LAPD's long-standing Mental Evaluation Unit (MEU) to receive advice or assistance in the field from a SMART unit as determined by the MEU. Where a limited number of SMART units—in 1997, there were only nine teams tasked with providing 24/7 coverage of all eighteen LAPD policing districts—provided on-scene assistance in the field, the MEU primarily provided real-time assessment support over the phone to officers in the field (Los Angeles Police Department 1997, n.d.; Lodestar 2002b). Together, the MEU and SMART functioned as collaborative, but separate specialized response programs for policing the mentally ill during the LAPD's pre-consent decree era.

In the spring of 2001, just before the city entered into the consent decree with the DOJ in June, LAPD also implemented a "Crisis Intervention Team" (CIT) as an independent pilot program in LAPD's Central Area, a 4 ½ square mile area in downtown Los Angeles.[4] The CIT pilot program provided a mental health training program to a cohort of LAPD patrol officers so they could serve as "generalist-specialists," able to provide a specialized response to calls

involving a suspected mental health crisis as well as perform regular patrol duties in the Central Area. LAPD's CIT Coordinator developed a 40-hour training program in conjunction with social service agencies, such as the LA DMH, the Homeless Task Force, and the Midnight Mission, designed to enable CIT officers to resolve mental health crises in the field through de-escalation, negotiation, and verbal crisis intervention.

Then, in December 2001, the LAPD hired Lodestar Management/Research, Inc. (hereinafter Lodestar) to complete its consent-decree mandated evaluation of both its own policies, procedures, and practices for encounters with individuals who may be mentally ill as well as other law enforcement models used elsewhere. Five months later in May 2002, Lodestar submitted its final report, which contained twenty-nine recommendations for improving the LAPD's approach to policing the mentally ill ranging from retooling the mental health training provided to LAPD officers to clarifying the department's data procedures for use of force incidents to centralizing the LAPD's specialized responses in a single entity. And, in between the "Organizational Infrastructure" and "Training and Curricula" recommendations, the benignly-titled "Mental Crisis Encounter" section dealt explicitly with the consent decree's mandate that the LAPD "create a mode of response that minimizes the likelihood of force being used in encounters between officers and people with mental illnesses" (Lodestar 2002a, p. 35) and, as a secondary goal, the appropriate disposition of the call. To these ends, Lodestar recommended a "two-layered" response that prioritized increasing the number of specially-trained officers available as first responders on mental health calls and utilized mental health clinicians as a secondary resource for patrol officers to facilitate the appropriate disposition of the call. This strategy reflected Lodestar's finding that the initial period of contact between the officer and subject was fundamental in facilitating a "positive (non-violent)" (p. 35) encounter and sought to

comply with the consent decree by increasing the number of specially-trained officers available to make that initial contact with the mentally ill in the field.

The Lodestar report provided LAPD with a starting point to make its own set of recommendations for its July 15, 2002 "Consent Decree Mental Illness Project" report to Police Commission, the body tasked with overseeing the LAPD and setting its policies. And, in many respect, the LAPD's recommendations corresponded with those made by Lodestar. Both, for example, recommended expanding LAPD's specialized response capabilities and mental illness training, but, where Lodestar emphasized increasing the number of specially-trained officers working in the field, LAPD's emphasized expanding its co-responding SMART program over its CIT Pilot Program. Under the department's proposed "Mental Health Crisis Response Program," the LAPD would work "towards having more SMART units on every shift and staffed in each geographic bureau" (Los Angeles Police Department 2002a, p. 3) and would expand the CIT Pilot Program to just the Van Nuys Area in the city's San Fernando Valley. The DOJ pushed back against LAPD's curation of Lodestar's recommendations, especially the department's decision to not expand its CIT Program citywide and to ostensibly reject Lodestar's "two-layered" response. The Police Commission instructed the LAPD to respond to the DOJ's concerns before it would decide how to proceed.

When LAPD submitted its supplemental report to the Police Commission in September 2002, the department countered that its recommendations actually did reflect Lodestar's "two-layered" strategy since its CIT and SMART officers "will function as first and secondary responders" while the MEU would "provide a 24-hour hotline for advice to officers." (Los Angeles Police Department 2002b, p 3). The revised report continued to prioritize SMART's citywide expansion and defended its original recommendation to expand the CIT Program to

only the Van Nuys Area. CIT's expansion to the Van Nuys Area would both increase the number of "trained first responders" in an area that LAPD's data suggested experienced a high number of calls that may involve mental illness. The expansion would also represent a preliminary but necessary step towards assessing whether CIT should be expanded citywide by providing an opportunity to evaluate the "effectiveness and potential benefits" of the CIT approach (p. 4). On October 8, 2002, the Police Commission approved the revised report, with the caveat that the issue could be reopened as necessary to address any DOJ concerns.

The Office of the Independent Monitor (hereinafter Independent Monitor) tasked with overseeing the department's progress on the consent decree's mandates shared the DOJ's concerns about the Mental Illness Project. The Independent Monitor's November 2002 quarterly report concluded that while LAPD had made "substantial progress" on developing its response to persons with mental illnesses, it could not yet determine "functional compliance" because of concerns about "the Department's failure to recommend the deployment of CIT citywide" (p. 74). By the next quarter, the Independent Monitor reported that LAPD had recommended that the CIT Pilot Program and its 40-hour training course be expanded to the Harbor and West Los Angeles Divisions—and that the "Monitor's previously stated concern regarding citywide CIT deployment has eased with the anticipated expansion" (2003, p. 46).

Yet, when the CIT Pilot Program ended in August 2003, the department recommended that, based on its evaluation of the program, it not be expanded citywide. On May 18, 2004, the Police Commission recommended that it be disbanded completely due to "budgetary and deployment issues" and replaced with a more limited training for all patrol officers (Independent Monitor 2004, p. 43). Meanwhile, SMART and MEU continued to expand. Just one week before

the Police Commission recommended disbanding CIT, it directed LAPD to expand both MEU and SMART to provide the city with coverage twenty hours a day, seven days a week.

As the MEU and SMART expanded, the department continued to develop new pilot programs also designed to provide patrol officers with specialized resources. In September 2005, for example, the department collaborated with the LA DMH to implement the Crisis Assessment and Management Program (CAMP) Pilot Program to identify and direct those individuals who had been the subject of multiple calls for service because of suspected mental illnesses, to mental health treatment instead of the criminal justice system and to reduce the amount of time spent by patrol officers handling repeat calls for service (Independent Monitor 2005, p. 39). A month later, the department implemented a SMART Pilot Program that assigned a SMART unit specifically to the Central Division three days a week between 7 a.m. and 3 p.m. to assist patrol officers who encountered an individual who may have a mental illness while in the field.[5] In addition, the department tasked the MEU with additional training responsibilities designed to create awareness about mental illness and the department's specialized responses to mental illness. For example, the MEU partnered with the Autism Society of America to generate autism-awareness and a segment on supervisor responsibilities regarding calls involving the mentally ill was added to the department's Supervisor and Watch Commander Schools.

By June 2009, when the Independent Monitor issued its final report, these specialized units—the MEU, SMART, and CAMP—constituted the core substantive components of the LAPD's Consent Decree Mental Illness Project. In its report, the Independent Monitor described that the LAPD was now "in the national forefront of this important policing issue" and recommended that the department simply "continue to do what it has been doing" (p. 93). The LAPD has followed this instruction and continued to develop its specialized units. Today, the

MEU, SMART, and CAMP are housed within one unit in the LAPD's Crisis Response Support Section on the 6th floor of the department's Police Administration Building in downtown Los Angeles (S. O'Neill 2015). Some twenty-eight LA DMH clinicians and sixty-two LAPD officers and detectives work together to provide support to patrol officers twenty hours a day, seven days a week. And, as the MEU's so-called "Compstat" data documents, they have been busy assisting officers in the field who police the city's mentally ill. In 2014, the MEU logged 14,238 calls from patrol officers who had encountered someone who may be mentally ill while in the field, SMART units responded to 4,724 calls, and the CAMP unit handled 712 cases.

Los Angeles' Specialized Jail: The Consolidated Correctional Treatment Facility

In July 2013, 23-year-old Austin Losorelli was arrested on charges of resisting an officer and public drunkenness (Chang 2015a). His 20s had been marked by mental health problems and, after a judge sentenced him to mental health and substance abuse treatment, he was released until a space at the treatment facility opened. But, as Austin's mental health continued to deteriorate, his family reached out to his arresting officer to ask for help. The Los Angeles County Sheriff's Department (LASD) officer recommended re-arresting Austin so that he would be safe in jail.

Austin reportedly described his psychiatric history to jail mental health workers, which included auditory and visual hallucinations, previous suicide attempts, a string of psychiatric holds, and a barrage of antipsychotic medications. Yet, he was placed in general population in Men's Central Jail (MCJ), located in downtown Los Angeles and across the street from the Twin Towers Correctional Facility (hereinafter Twin Towers) that includes a special wing that the press has dubbed the "nation's largest mental institution" (Montagne 2008). Austin's odd behavior—pacing and grabbing his head—and comments—that the TV was talking to him and

others were talking about him—caused Austin's cellmates at MCJ to flag down a jail deputy; eventually he was moved to a single-man cell (Chang 2015a). Later that day, Austin committed suicide by looping a sheet around an air purifier in his cell.

Austin's suicide was, along with fourteen other inmate suicides, described in a June 2014 DOJ report reviewing the county's progress towards remediating constitutional violations in the jail system's mental health care program as part of an ongoing civil rights investigation into the treatment of mentally ill inmates in the county's jails (Smith and Birotté 2014). The DOJ first announced its intention to investigate the treatment of mentally ill inmates in the county's jail system in June 1996 under the Civil Rights of the Institutionalized Persons Act and toured conditions along with a team of mental health experts. The following year, the DOJ issued a report finding constitutional deficiencies in the mental health care system along with a set of recommended remedial measures. By 2002, the DOJ and the county reached a Memorandum of Agreement (MOA) intended to resolve the jails' on-going civil rights violations by requiring constitutionally-adequate mental health care, suicide prevention protocols, and bi-annual visits to the jails by federal officials to report on the jail system's progress on the MOA.

In its June 2014 report, the DOJ reported that, while jail officials had achieved substantial compliance with some aspects of the MOA, such as the delivery of mental health services, there remained systematic deficiencies in key aspects of the jails' mental health program (Smith and Birotté 2014). The DOJ cited the fifteen completed suicides—including Austin's—that had occurred in the jails over the previous thirty months and contended that, even after the number of jail suicides more than doubled from 2012 to 2013, jail officials made little progress on implementing the proper suicide prevention practices required by the MOA. The report also noted that the poor conditions of confinement across the system's facilities but especially at MCJ

"present, rather than prevent a risk of suicide (p. 3). It also highlighted the "dimly lit, vermin-infested, noisy, unsanitary, cramped and crowded" housing units at MCJ that exacerbated inmates' mental distress and the architectural feature like "bars, open bunks, wide mesh vent covers, hidden corners, [and] small cell windows" that constituted "known suicide risks" (p. 13).

The report marked a turning point for the jail system; in a press release accompanying the report, the DOJ announced that it intended to seek "a court-enforceable agreement to address the remaining [mental health care] areas with serious deficiencies that violate prisoners' constitutional rights" (2014). On August 5, 2015, the LASD agreed to federal oversight of its jail system both to improve its treatment of mentally ill inmates and to end a culture of deputy violence against inmates (McDonnell 2015). Yet, even as county officials welcomed the consent decree's promise to bring a sea change to the jails, they pointed out a fundamental obstacle to their compliance with the agreement's mental health care provisions: MCJ.

"You can't do all the things that are required [by the consent decree] in that broken-down facility," said Sheila Kuehl, a member of Los Angeles County Board of Supervisor (hereinafter Board), in a *Los Angeles Times* article on the consent decree (Chang and Rubin 2015). Elsewhere, Assistant Sheriff Terri McDonald, whose role includes overseeing the county's jails, explained that LASD would not be able to eliminate the suicide risks posed by MCJ because the facility is "in and of itself a risk factor. It's a depressive environment" (Chang 2015b). Just six days later, the Board voted to replace MCJ with the Consolidated Correctional Treatment Facility (CCTF), a state-of-the-art facility intended to primarily focus on psychiatric treatment (Sewell and Chang 2015). In this section, I trace how the CCTF emerged as a policy solution to the crisis of mental health care in the county's jail system.

From Cameras to Closure: Remediating Conditions in Men's Central Jail

From the vantage of 2015, the Board's decision to close MCJ seems unsurprising and perhaps even long overdue. After all, MCJ had been a frequent target of American Civil Liberties Union (ACLU) litigation decades before the consent decree and the Board's decision to replace it with CCTF. Most notably, the ACLU of Southern California has, in coordination with the ACLU's National Prison Project, targeted MCJ since the mid 1970s as part of its "Jails Project," which includes regular monitoring of jail conditions pursuant to a series of court-approved agreements between the ACLU and the LASD (e.g. Kupers 2008) and calls for MCJ's closure (e.g. Bird 2009). Even beyond its role at the heart of civil rights litigation, its age made its future uncertain. Built in two phases during the 1960s and 1970s, MCJ was, as the county's oldest jail facility, increasingly showing its age. A structural analysis conducted in 2006, for example, found numerous building deficiencies that would comprise MCJ's ability to survive a major earthquake and recommended that the structure be fully replaced (Fujioka 2008).

However, despite its long history of controversy and deteriorating structural conditions, closing MCJ was not originally on the County's official—and lengthy—jail reform agenda, even as its role in the jails' civil rights crisis came into ever increasingly sharp focus. Instead, in an initial $257 million "Jail Plan" authorized by the Board of Supervisors in August 2006, MCJ was, along with Twin Towers, to receive "security enhancements" while the Sybil Brand Institute, closed in 1997 due to damage incurred during the Northridge earthquake, would be reopened and a new medium security facility would be built at the 2,620-acre Pitchess Detention Center complex located some 40 miles north of downtown Los Angeles in Castaic (Fujioka 2008). Against this background, Los Angeles County's Chief Executive Officer (CEO) William Fujioka described in a 2008 letter to the Board of Supervisors that the Jail Plan was designed to

"enhance the Sheriff's ability to manage a volatile and fluctuating inmate population" and to increase inmate safety and decrease overcrowding.

But, against a background of escalating local and federal civil rights actions, MCJ itself soon emerged as an increasingly insurmountable obstacle to remediating the jail system's constitutionally-inadequate mental health care. In June 2006, just two months before the Board of Supervisors voted to approve the Jail Plan, the U.S. District Court ordered a panel comprised of representatives from the LASD, the CEO, and the ACLU to address the unconstitutional conditions at MCJ pursuant to ongoing ACLU litigation. Under the supervision of the "Rutherford Panel"—named after the lead plaintiff in the ACLU's lawsuit against the jail system—LASD began transferring inmates from MCJ to other facilities to remediate overcrowding and worked to improve its performance in other areas of concern, such as supervision and facility maintenance, while the ACLU worked with the CEO on alternative repair and rebuilding plans for remediating the conditions at MCJ (Fujioka 2008).

The panel's work made it clear that MCJ's antiquated design and deteriorating conditions rendered the facility itself a fatal impediment to achieving compliance and that repairing MCJ would be neither feasible nor cost-effective. The CEO's March 2008 letter the Board of Supervisors offered a "Revised Jail Plan" that explicitly prioritized remediating the civil rights violations at MCJ. Under this plan, MCJ's oldest building, constructed in the 1960s, would be closed while its newer building, which opened in the 1970s, would, with increased ongoing maintenance, survive another five to ten years. This would be enough time, the plan hoped, for the County to develop new programs that would mitigate the need for all or nearly all of the building's 3,000 beds.

Linking Care, Control, and the Constitution: The Consolidated Correctional Treatment Facility Emerges

Over the next five years, the CEO's Office and LASD continued to present variations of this Revised Jail Plan to the Board, prioritizing the replacement of MCJ in each iteration, and facing considerable resistance from the Board over the project's approximately $1 billion price tag. By 2013 though, as the threat of federal intervention begin to loom on the jail system's horizon, replacing MCJ quickly emerged as inevitable and the Board began to take steps accordingly—including debating what exactly should replace MCJ.

On March 19, 2013, the Board voted to retain Vanir Construction Management, Inc. (hereinafter Vanir) as an independent consultant to produce a comprehensive report regarding the Jail Plan that would include alternative options. Then, on May 21, 2013, Supervisor Zev Yaroslavsky, who had raised serious objections to the $1.4 billion price tag attached to an October 2011 "Revised Jail Facility Plan" that would have replaced MCJ with a three eight-story towers with 5040 beds, introduced a motion that would change the course of the debate. The motion asked the Board to consider replacing MCJ not with a general population facility, but with "medical/mental health/substance abuse Integrated Inmate Treatment Center designed to serve inmates with mental illness, co-occurring substance abuse and specified medical conditions" (Los Angeles County Board of Supervisors 2013c, p. 2). It passed unanimously and the Board directed Vanir to include this option in its analysis.

When Vanir presented its report to the Board in July 2013, each of its five jail renovation options—priced between $1.3 and $1.6 billion—included tearing down MCJ and building a new "Consolidated Correctional Treatment Facility" (CCTF) for the "treatment of inmates with serious medical and mental health issues (Vanir 2013, p. 12-13). The Board meeting's transcript

documents that members of the community had serious objections "using the prison system as a solution to mental health" (p. 100-01) and that audience members who had their backs turned to the Supervisors chanted "No More Jails! Alternative Solutions!" (Los Angeles County Board of Supervisors 2013d, p. 105). Regardless, the Board voted unanimously to accept Vanir's report.

Over the next year, CCTF emerged as an instrumental piece of the County's jail strategy—now called the "Jail Master Plan"—that was designed in strategic anticipation of looming DOJ intervention, which had escalated in response to the jails' rash of inmate suicides in 2013. At a May 2014 board meeting, Supervisor Antonovich described the plan as:

> a replacement of the current men's jail facility with a detention facility that effectively resolves a concern by the Department of Justice and by members of this board of supervisors and the community. . . . If we don't act, the choice will not be ours, but up to a [court-appointed] receiver who will force us to act at a higher cost (quoted in Los Angeles County Board of Supervisors 2014, p. 88-9).

And, act the Board did, voting 3-1-1 to move forward on a $2 billion plan that would demolish MCJ, replace it with a new two-tower, 4,860-bed jail facility focused on inmates with mental health issues and substance abuse treatment programs and to create a new women's jail. That same day, it also voted to undertake an assessment of programs, like those that would divert the mentally ill from jail to treatment and, as a result, reduce the number of mentally ill inmates—and the need for specialized jail beds. These analyses would soon reconfigure the "Jail Master Plan" yet again.

The next summer, Supervisor Sheila Kuehl, who joined the Board in November 2014 after the Jail Master Plan's adoption introduced a motion ordering the suspension of all work on the Jail Master Plan and requesting an independent analysis of the actual number of treatment beds that would be required at the proposed CCTF in light of the county's jail population, diversion programs, and the impact of recent state legislation that, like Proposition 47, stood to

alter the county's jail population.[6] At the Board's June 9, 2015 meeting, Kuehl described the proposed CCTF, conceptualized as a dedicated treatment facility for people "who cannot be dealt with anywhere else" in the jail system or in the community, as a "tectonic shift . . . in the idea of corrections" (quoted in Los Angeles County Board of Supervisors 2015a, p. 68-9) that deserved more thorough consideration of its size and of mental health diversion options. Both Supervisors Don Knabe and Michael Antonovichto, who voted for the May 2013 "Jail Master Plan," feared that the work stoppage would leave the county vulnerable to a federal intervention "that would take control of building that jail away from the county" (in Angeles County Board of Supervisors 2015a, p. 59), echoing the very same fears that percolated in the background of the Board's May 2013 decision. Ultimately, a divided Board voted 3-2 to halt planning work on the Jail Master Plan for forty-five days and requested concrete estimates "on the actual number of beds needed in the facility [CCTF] because they cannot be treated somewhere else or receive better treatment somewhere else" (quoted in Los Angeles County Board of Supervisors 2015a p. 68-9).

In early August, the requested independent analysis, performed by Health Management Associates (HMA) and Pulitzer/Boagard & Associates, LLC (hereinafter Pulitzer/Boagard), recommended that the proposed CCTF should contain 4600-5060 beds—roughly the same number of beds created by the "Master Jail Plan" adopted in May 2013. HMA and Pulitzer/Boagard's report (2015) based this recommendation on a twenty-year forecast analysis of the county's "Patient-Inmate" population, which predicted that, without increased diversion efforts, the mental health population would almost double by 2035. Mentally ill inmates would then constitute, as the Board heard during their presentation at the August 4 meeting, nearly a third of the overall jail population (Los Angeles County Board of Supervisors 2015b). During the public comment portion of the Board meeting, community members and advocacy groups like

the ACLU lodged serious critiques of the methodology (p. 198) underlying this forecast analysis and continued to lobby for diverting the funds allocated to jail construction to treatment programs. Despite these objections, the Board's halt on the "Master Jail Plan" would soon end.

The very next day in fact, the LASD and the DOJ announced the consent decree providing for federal oversight of the jails. In a LASD press release, Sherriff Jim McDonnell described the agreement as a commitment "to developing and implementing emerging best practices regarding humane treatment of mentally ill inmates" and called for continued efforts to improve jail facilities like MCJ that impede compliance and to develop diversion strategies (McDonnell 2015). This sentiment would be echoed the next week at the Board's August 11 meeting when it voted to allocate about $10 million annually to diversion programs and, though the jail was not on the agenda, to resume work on the "Master Jail Plan." During the surprise jail vote, the Board considered three competing plans for CCTF—a 4,600-bed facility, a 3,885- bed facility, and a 3,243-bed facility—before voting 3-1-1 to move forward on a $2 billion plan to both build a 3,885- bed CCTF and a new women's jail at the Mira Loma Detention Center (Los Angeles County Board of Supervisors 2015c). Despite challenges to the plan from advocates who opposed any new jail construction, from the LASD who believed that a 3,885- bed facility would prove a grossly insufficient replacement for MCJ, and from the District Attorney's Office who alleged that the Board's vote had violated state open-meeting laws, on September 1, the Board voted once more and reaffirmed their plan to build a smaller jail facility focused on psychiatric treatment (Los Angeles County Board of Supervisors 2015d). That same day, bringing the discontent with MCJ full circle, the Board also voted to approve a $1.6 million payment to settle the lawsuit brought by Austin Losorelli's family.

Discussion & Implications

After the collapse of the asylums, the criminal justice system assumed de facto responsibility for managing the institutionalized mentally ill. Its ability to do so humanely—and more recently, constitutionally—has been the subject of an interdisciplinary set of critiques that echo those made by 19th century reformers against the post-colonial practices of warehousing the severely mentally ill in local jails and poorhouses. Recently, there have even been calls to "bring back the asylums" (Sisti et al. 2015) to provide an antidote to the grim reality of a criminal justice system's mismanagement of the mentally ill that suggest the pendulum of transinstitutionalization is poised to swing back once more. Yet, while the 19th century saw a dramatic shift from the jails to the asylums, followed by the 20th century's turn from the asylums back to the criminal justice system, this chapter has described developments in the criminal justice field that I argue constitute a turn of transinstitutionalization that is more subtle but no less significant than its predecessors.

This chapter has shifted the analysis of transinstitutionalization from the criminal justice failures in its face to its evolution in its wake. I find that in Los Angeles, the criminal justice field has responded to the crisis of external legal intervention demanding reform with a novel set of criminal justice strategies that I term "specialized justice" that seek to "better" police and incarcerate the mentally ill by developing new policies, practices, and even infrastructure that are specially tailored to the task of managing the ill. On the ground in Los Angeles, for example, this transformation will see the destruction of and replacement of Men's Central Jail—the structure that some of the field's agents bemoaned as an insurmountable obstacle to remediating the jails system's mental health care civil rights crisis—with the CCTF, imagined as a state-of-the-art jail facility designed primarily with the "Patient-Inmate" in mind. Less dramatic, but still

transformative, the officers who work in the LAPD's specialized policing unit, SMART, are not required to wear the department's standard blue uniform (O'Neill, 2015). SMART officers, for example, wear their street clothes while on duty since the presence of police uniforms can serve to escalate rather than the de-escalate a mental health crisis. These tangible changes to the physical landscape of the criminal justice system are driven by a shift in the field's relationship to its responsibility to the mentally ill. At their core, I argue that these specialized justice strategies signal a transformation of the criminal justice system's responsibility for the mentally ill from an ostensibly de facto one inherited from the asylums to an explicit one that drives criminal justice development at both the tangible and conceptual level.

These reforms are, on their face, designed to address civil rights concerns raised by external actors like the DOJ against the violence of the criminal justice status quo. Specialized justice strategies therefore serve an instrumental purpose for key agents in the criminal justice field as a pathway to legal compliance. They are designed to prevent Austin Losorelli from committing suicide in his cell because he is provided with constitutionally-adequate mental health care in a jail designed explicitly as a psychiatric facility and to de-escalates Margaret Mitchell's encounter with LAPD because patrol officers have 24/7 access to specialized units like the MEU and SMART that can offer advice and field assistance. The nature of these reforms suggests another dimension of specialized justice: these strategies seek compliance through the hybridization of care and control. The field's process of hybridization is explicit in Los Angeles: planning a jail that will literally "consolidate" corrections and mental health treatment into a single jail facility and the partnering of police officers and clinicians in a single LAPD car to get "SMART" on policing the mentally ill.

Specialized justice strategies may provide the field with an instrumental policy solution to pressing civil rights challenges, but they also signal broader consequences. In the case of managing the mentally ill, my analysis reveals how criminal justice agents leveraged care logics to reconfigure existing punishment and social control configurations. These specialized justice strategies may remediate civil rights violations, but they also signal a transformation of the field's relationship to managing the mentally ill that re-entrenches rather than reimagines the criminal justice system's responsibility for this task. This expansion of the criminal justice system's substantive scope to explicitly and properly include responsibilities beyond crime control resonates with analyses documenting how the carceral state has widened both its shadow and net to expand its power (Beckett and Murakawa 2012). In this sense, specialized justice strategies also serve an instrumental function. Their role as a policy solution to a constitutional defect in the status quo of policing and incarcerating the mentally ill serves to legitimize the criminal justice system's' role on the frontlines of this social problem in an era where the welfare state is already precarious.

2. The "Right Kind of Crazy": Policing the Boundaries of Mental Illness

It was midmorning in the city of Los Angeles when a man worried about his sister called 911 to request officer assistance. Two Los Angeles Police Department (LAPD) patrol officers arrived to the residence shared by the two siblings to find the woman vacuuming the living room. She explained that yes, she had been up for several days—and that these episodes did happen to her from time to time—but insisted that she did not need any help from officers. In fact, she was upset that her brother had even called the police at all and became more frustrated when the officers requested that she turn off the vacuum so they could talk with her; she wanted to finish cleaning before she left the house and she was already running late. Later, the same officers responded to reports of a woman in a park who had reportedly been communicating with the "Supreme Leader" about a series of covert missions she was undertaking to save the planet. Finally, they responded to a high-rise rooftop where a man was swaying on the ledge, a bottle of vodka in one hand and a cell phone playing Tom Petty's "Free Falling" in the other. He was, he told the officers, ready to take one last jump.

These three scenarios constitute the final examination for participants in the LAPD's mandatory fourty-hour "Mental Health Intervention Training" (MHIT) series facilitated by the department's Mental Evaluation Unit (MEU). Their purpose is two-fold: first, they allow participants to apply the techniques that have learned during the training and, second, they test whether participants can properly identify when to contact the MEU for assistance during a call for service. Under LAPD guidelines, all officers responding to a call involving someone who may be mentally ill must call the MEU's Triage Desk to receive guidance in real-time from a MEU member and to, when necessary, receive field assistance from a Systemwide Mental

Assessment Response Team (SMART) units that pair a Los Angeles County Department of Mental Health clinician and a specially-trained LAPD officer.

The LAPD's MEU has developed in reaction to the nature of policing in a criminal justice system that is on the frontlines of managing the institutionalized mentally ill. Police encounters with the mentally ill are a routine (Deane et al. 1999; Janik 1992) but a risky (Ruiz and Miller 2004) and time-consuming (DeCuir and Lamb 1996; Pogrebin 1986) part of patrol work. Specialized policing strategies like the MEU's Triage Desk and SMART units are a direct policy intervention that seek to remediate the challenges of policing the mentally ill. The MEU's various components purport to work together to assist LAPD officers responding to calls in the field that involve someone who may be mentally ill to create safer parameters for these police encounters and to divert the mentally ill from arrest to treatment (Los Angeles Police Department n.d.).Yet, for its specialized policing strategies to be deployed, a patrol officer must first identify someone as mentally ill and make that initial phone call to the Triage Desk. While the policing literature finds that police are, at least in general, able to identify someone as mentally ill (Engel and Silver 2001), it does not examine the processes through which the category is constructed and how individuals are filtered in—or out—of the category during police encounters. Identifying these mechanisms are especially important because the meaning of fluid categories like "the mentally ill"—and, consequently, of the reforms that leverage them— is contingent on context and the nuances of implementation (Pifer 2016a, 2016b Reiter and Blair 2015)

In the context of policing the mentally ill in Los Angeles, California law provides officers with a definition of who is "mentally ill" for the purposes of determining if a particular call is one that falls within the MEU's purview. Under the Lanterman-Petris-Short Act, better known by its California Welfare and Institutions Code (WIC) section number, 5150, police are

authorized to apply for an involuntary psychiatric hold when an individual "is a danger to others, or to himself or herself, or gravely disabled" as a result of a "mental health disorder." In the scenarios above, MHIT participants are expected to elicit enough information from the subject and to draw from the context of the call itself to determine if the person meets the criteria for requesting a WIC §5150 hold.

So, if the responding officers were to ask the woman why she is so intent on cleaning the house, she would tell them that she is running late for the poker game that she has skipped work in order to attend. This sort of impulsivity, together with her history of stretches of sleeplessness, might suggest that she is experiencing a manic episode that leaves her unable to take care of herself—sufficient perhaps to be considered "gravely disabled." At the park, the officers should ask the women questions about her mission and duties as a secret agent. If they did, she would tell them that she flies all over the planet on those missions, which is really all she can say given the top-secret nature of her work, but this detail should suggest to the officers that her ability to "fly" might pose a danger to her wellbeing or to others. And, finally, the man swaying drunkenly on the building before taking "one last jump" is a plain danger to himself, but to talk him down from the ledge, the officers should ask enough to understand and connect to the man's experiences as a paratrooper who has been unable to access services at the Veterans Affairs Hospital for his post-traumatic stress disorder since he returned home from his last deployment. Thus, though WIC §5150 functions to sketch the outermost boundaries of who is considered mentally ill, in practice, the law vests police officers with considerable discretion to decide who fits the category and when to contact MEU.

This chapter analyzes the on-the-ground processes that shape how police officers give meaning to the category of mentally ill and, consequently, how they decide to deploy specialized

policing strategies. I use approximately 120 hours of ethnographic data collected through both ride-alongs with LAPD patrol officers and through Mental Health Intervention Training (MHIT) classes facilitated by MEU members to offer insights into the material reality of mental illness as constructed by its "streetcorner psychiatrists" (Teplin and Pruett 1992). My analysis pays special attention to trouble cases (Llewellyn and Hoebel 1941), or those calls where it is not readily apparent whether the subject is a danger to others, or to himself or herself, or gravely disabled as these calls most clearly reveal how officers exercise their discretion to filter an individual in—or out—of the category of mentally ill. I argue that these calls—those that I term a 5149 1⁄2 call—allow the role that discretion and external factors play in constructing the category of mental illness to most clearly emerge.

Here, I consider how officers police the boundaries of the category of mental illness and explore the implications of this process for the criminal justice system's contemporary role in managing the mentally ill. First, I contextualize the landscape against which the MEU has emerged as a policy solution in Los Angeles to "better" police the city's mentally ill. Then, I discuss the theoretical frameworks that inform my analysis of how categorization, a necessary precursor to deploying specialized policing strategies, unfolds on the ground in policing. I use data collected through fieldwork with the LAPD to demonstrate how the power of place and the pressure of time function to move individuals in and out of the category of mentally ill. The final section explores the consequences of this categorization process for policing the mentally ill in Los Angeles—and for how we think about criminal justice policy decisions that reform how we police, punish, and incarcerate the mentally ill.

Policing the Mentally Ill in Los Angeles

Police have traditionally managed the mentally ill as a component of their obligation to protect and serve (Bittner 1967), but, against a background of shifting mental health and criminal justice policies that have unfolded during the last half of the 20th century, police have increasingly functioned as "streetcorner psychiatrists" (Teplin and Pruett 1992) who serve on the frontlines of managing the mentally ill. This shift has occurred within the larger process of "transinstitutionalization" that describes the transfer of responsibility for the institutionalized mentally ill from the state hospital system to the criminal justice system (Gilligan 2001). Police routinely respond to calls for service involving individuals with mental illness and, as a result, serve not only as the gatekeepers to the criminal justice system, but also to the mental health system.

However, police are traditionally ill-equipped to serve as "streetcorner psychiatrists" and transinstitutionalization has presented the criminal justice system with, as policing scholars have documented and the case of Los Angeles demonstrates, serious policy problems. Police contacts with the mentally ill, regardless of how officers dispose of the call, consume a disproportionate amount of patrol time and criminal justice resources (DeCuir and Lamb 1996; Pogrebin 1986) and create situations that inherently risk police use of force (Ruiz and Miller 2004). On one hand, transporting an individual experiencing a mental health crisis for emergency psychiatric care is lengthy as officers must wait for the hospital to formally admit the person and sometimes futile if the facility has no available beds or refuses admission if, for example, the person is intoxicated (Teplin 2000). The *Los Angeles Times* reported that LAPD officers tasked with transporting someone on a 5150 hold spent, on average, two hours in the waiting rooms of one of the County's three increasingly over-burdened public psychiatric emergency departments (Sewell

2015). In July 2016, when I attended a MHIT series, officers I spoke with placed the average wait time at four hours and some described being off the streets and tied up with a 5150 hold for an entire "watch," or shift (Pifer fieldnotes).

On the other hand, when these contacts lead to arrest, they contribute to the on-going crisis in corrections that has transformed jails like Los Angeles' Twin Tower's Correctional Facility—infamously dubbed the "nation's largest mental institution" (Montagne 2008)—into the new asylums where often non-serious but high-maintenance individuals whose mental health needs cannot be met in a carceral setting are warehoused (Torrey 1997). At their worst, these encounters can escalate when police officers misconstrue symptoms of mental illness for aggressive, disrespectful, or hostile behavior (Teplin 1984; Novak and Engel 2005). As a result, people with mental illnesses are especially at risk of being injured or killed by police (Teplin, McClelland, Abram, and Eeiner 2005; Cordner 2006). Against this background, a considerable policy debate about how to "better" police the mentally ill has unfolded.

This is especially true in Los Angeles, where the fatal shooting of Margaret Mitchell, a 55-year-old mentally ill and homeless black woman, in May 1999 by an LAPD patrol officer served as the catalyst to include improving the department's "dealing[s] with the persons who may be mentally ill" in the sweeping civil rights reform agenda outlined by the 2001 federal consent decree (Consent Decree 2001, p. 52). Under the consent decree's supervision, the LAPD's Mental Evaluation Unit (MEU) has evolved into a national model for policing the mentally ill. The MEU's various components—the Triage Desk, the Systemwide Mental Assessment Response Team (SMART), the Case Management Program (CAMP), and the Training Unit—work together to assist LAPD officers responding to situations involving the mentally ill to save patrol officers time, divert the mentally ill from jail to treatment facilities,

and deescalate potentially volatile—or fatal—encounters between officers and the mentally ill (S. O'Neill 2015).

The MEU's SMART units and Triage Desk are particularly important in the everyday context of policing the mentally ill in Los Angeles. The LAPD's policies mandate that its officers contact the MEU's Triage Desk for real-time assistance whenever they encounter a person who officers suspect may be mentally ill (Los Angeles Police Department 2015). The Triage Desk is staffed twenty hours, seven days a week by MEU members, which include both specially-trained LAPD officers and clinicians from the Los Angeles County Department of Mental Health (hereinafter LA DMH). The Triage Desk helps the field officer determine if the individual should be transported to an emergency psychiatric facility under WIC § 5150 where a psychiatrist will evaluate whether an involuntary psychiatric hold is appropriate. The Triage Desk also manages the MEU's SMART units, which partner a specially-trained LAPD officer and a LA DMH psychologist, nurse, or other clinician in a single mobile response team to respond to incidents involving people who are mentally ill or assist responding officers in the field. Two SMART units are deployed in each of the LAPD's four Police Bureau per watch, which provides the city with full-time SMART coverage.

Between July 1, 2014 and June 30, 2015, the LAPD reported 15,454 interactions between officers and a person with a mental illness (Lopez 2016). This number, however, includes only those interactions that were logged in the MEU's database after an officer in the field phoned its Triage Desk. The departmental mandate that officers must notify the MEU during any encounter with someone who may be mentally ill suggests that this number should include the "majority" of these encounters (Lopez, 2016, p. 30), but, in practice, identifying someone as mentally ill—and phoning the Triage Desk—are subject to forces that render this statistic under inclusive. In

the next section, I discuss the theoretical considerations that inform how the category of "the mentally ill" is constructed and deployed by the criminal justice system.

Theoretical Considerations

Policies that leverage the category of "the mentally ill" have proliferated as the criminal justice system faces increasing pressure to reform how it manages this vulnerable population. Some reconfigure how the mentally ill can be punished; in 1986, for example, the U.S. Supreme Court ruled in *Ford v. Wainwright* that "insane" death row inmates cannot be executed. Others limit the conditions in which prisoners with mental illnesses can be confined. In 1995, a federal district court ruled in *Madrid v. Gomez* that confining those inmates who are already "mentally ill" in the Secure Housing Unit at California's Pelican Bay State Prison violated the Eighth Amendment and other jurisdictions have considered or implemented policies designed to protect the "mentally ill" from solitary (Reiter and Blair 2015). Others, like the LAPD's MEU, mandate the use of specialized policing strategies when officers encounter the mentally ill.

All too often, however, criminal justice reforms purporting to protect the mentally ill fail to provide a meaningful definition of the category (Pifer 2016b). In the context of policing in Los Angeles, the meaning of mental illness is ostensibly defined by WIC § 5150, but the language of its three prongs—(1) danger to self; (2) danger to others; and (3) gravely disabled—vests officers with considerable discretion to decide who meets the law's criteria for an involuntary psychiatric hold. Police, as street-level bureaucrats, function as improvisational agents who draw upon their beliefs and experiences with people in real time to decide how to "dispose" of any particular situation (Goldstein 1980; M. R. Gottfredson and D. M. Gottfredson 1980; Manning 1977, 1984; Smith 1986; Smith and Visher 1981; Teplin and Pruett 1992; Wilson 1968). Discretion is a powerful force in shaping on-the-ground meaning in a diverse range of public policy spheres

(Lipsky 1980; Watkins-Hayes 2009), but categories like mental illness are also constructed through social processes that reflect and serve specific historical and cultural forces, such as race, class, and gender dynamics (Hacking 1999; Horwitz 2002, LeFrançois, Menzies and Reaume, 2013, Szasz 1961; Metzl 2009). As a result, the practical meaning of reforms that are predicated on the "mentally ill" are especially dependent on how criminal justice practitioners exercise their discretion in bounding the category of mentally ill—and deciding who falls within or outside the category.

In the penal context, recent research on solitary confinement has, for example, described this boundary as pivoting on how correctional officers delineate and negotiate the lines between "mad" and "bad" prisoners and between care and punishment (Rhodes 2004; Lovell 2008; Reiter and Bair 2015). Police officers navigate similar lines when deciding how to dispose of a call involving someone whose behavior blurs the lines between criminal, psychiatric, or simply odd (J. Monahan and B. Monahan 1986; Stone 1976). Today, research finds that police can, at least in general, identify someone as mentally ill (Engel and Silver 2001), but these studies do not examine the processes through which officers make this determination.

Classic policing studies on how officers determine whether to dispose of a particular call through hospitalization, arrest, or informal mechanisms find that this decision-making process is rife with the discretion inherent to policing. In part, officers draw from the specific context of any given call. For example, Bittner's (1967) seminal study of how police manage the mentally ill found that officers decided to initiate a hospitalization only if they determined that a call had the potential to escalate into a so-called "serious problem." Officers also draw from their perceptions of the structural constraints that govern policing, such as the extent of the bureaucracy (Rock, Jacobson, and Janopaul 1968) or the amount of time (Matthews 1970)

involved in pursuing hospitalization, when deciding how to dispose of a call. Yet, while these studies unpack how calls unfold, they, like contemporary policing research, do not examine how police categorize individuals as mentally ill or not. I fill this gap by using original qualitative data to examine how officers construct the category of "mentally ill" and decide to deploy specialized policing resources to manage the mentally ill.

Constructing the Category of "Mentally Ill"

The findings highlight the role two external factors—place and time—play in constructing the category of mental illness on the ground in policing Los Angeles by revealing how officers filter individuals in—and out—of the category of "mentally ill" during patrols when deciding how to deploy specialized policing resources.

The Power of Place

Place worked as a central mechanism in the process of categorizing an individual as mentally ill. Police used their pre-existing knowledge about a particular place to pivot the subjects officers suspected *might* be mentally ill between 'mad' and 'bad' or 'odd' to determine if he or she properly fit within the criteria delineated by WIC § 5150. The power of place could, as these examples demonstrate, function in the background of calls to shift people in or out of the category of mentally ill.

For example, while on a ride along in South Los Angeles, Sergeant Reyes and I arrived at a school just moments after the patrol unit. We reviewed the incident detail displayed on the computer screen in Sergeants Reyes' patrol car before joining the patrol officers on scene. A staff member at the Brea Academy had called 911 asking for officer assistance with a teenaged-male student, who was threatening staff with a stapler. A final note on the incident detail reminded officers in all capital letters to "CONTACT THE MENTAL EVALUATION UNIT

IMMEADIATLEY UPON SCENE STABILIZATION" (Pifer fieldnotes). This standard reminder automatically attaches to all calls for service that involve a person who *may* be mentally ill, but is not determinative of how an encounter will unfold. Instead, whether a subject will be categorized as mentally ill or if the MEU will be contacted are both products of patrol officer discretion.[7]

Sergeant Reyes recognized the school as we walked towards its front door and commented that his division receives frequent calls for service from its staff because the "school is for special kids, you know, the ones with problems that regular schools can't deal with" (Pifer fieldnotes). Brea Academy is one of the dozens of special education schools in Los Angeles that educate students with disabilities that, under federal law, cannot be accommodated in a mainstream public school setting.[8] In some cases, these schools will specialize in serving a specific type of disability, such as students with learning disabilities, intellectual disabilities, visual impairments or the nebulous category of emotional disturbance, while other serve a diverse population of students with disparate qualifying conditions. It was unclear which type the Brea Academy was, but Sergeant Reyes' statement about the place set the tone for the LAPD encounter with Brendan, the fifteen-year old at the center of this call for service.

We found Brendan in the school's interior courtyard facing the wall, his hands cuffed behind his back, being searched by Officer Williams as his partner Officer Perez interviewed a school staff member. Officer Williams finished the pat down and began to question Brendan.

"Do you have a diagnosis?"

"I don't know" mumbled Brendan. He refused to make eye contact, but his darting, bloodshot eyes and puffy face made it obvious that he had been crying

Officer William continued, his tone sharper, "Do you see a doctor?"

Brendan seemed to sense the shift and looked up. “Yes.”

“Do you take medication?”

“Yeah, for anxiety.”

Officer Williams began to probe on §5150’s first prong, danger to self: “Have you ever tried to hurt yourself?”

“I was just playing basketball on the roof.”

“Were you trying to jump off?”

Brendan countered, “No! I was mad so I was throwing the ball at the railing.”

“What made you upset?”

“My head was hurting.”

The interview then shifted to §5150’s second prong, danger to others: “Did someone here make you upset?”

“No! I grabbed a stapler and was playing with it but I didn’t want to hurt anyone.” (Pifer fieldnotes)

Officer Perez finished interviewing the staff member and joined us to ask Sergeant Reyes if the MEU should be contacted. “Absolutely. Let’s get a SMART unit out here or have them meet us at the station,” Sergeant Reyes answered. Officer Williams and Sergeant Reyes walked Brendan to a small conference room while Officer Perez called the Triage Desk from the courtyard to describe the scene and information learned during interviews. Officer Perez started to relay a condensed description of the scene to the MEU’s Triage Desk. “Well, right now he’s calm. When we showed up, he was just walking around. But the school says he’s emotionally disturbed and he got aggressive with a teacher, waving a stapler at her” (Pifer fieldnotes).

Meanwhile, Officer Williams and Sergeant Reyes continued to interview Brendan, who was sitting but still handcuffed in a chair, and learned that he had an open juvenile delinquency case and that he did in fact know his diagnosis—attention-deficit/hyperactivity disorder. Officer Perez popped in, the phone still by his ear, to ask Brendan if he hears voices (he answered no), and then returned to announce that the MEU would be sending a SMART team to assess whether Brendan should be taken to a hospital, where a doctor would determine if he met the criteria for an involuntary psychiatric hold.

Brendan started to cry at the prospect of a hold. He had plans with his Dad that weekend and was worried that instead, he would be going to spend the weekend in the hospital—or be sent back to juvenile hall to serve the rest of his sentence. As we waited for SMART to arrive Officer Williams used a sweatshirt to wipe at Brendan's tears and reminded him that, even though he was in handcuffs, he was not in trouble. The handcuffs were only on for "his safety and ours," Officer Williams promised (Pifer fieldnotes). Forty-five minutes later, a plain-clothes SMART team arrived to begin their assessment. Sergeant Reyes and I soon walked back to his car and I asked him what he thought would happen to Brendan.

> I don't know, probably take him to County for a hold? This school, you know I've been here at least twice before. Last time, I walked in and they [the staff] had a big girl pinned in the office and she was banging her head on the desk. Places like this, you gotta just call the MEU and have them deal with it (Pifer fieldnotes).

Patrol officers like Sergeant Reyes quickly become familiar with the places in their division that, like the Brea Academy where this call unfolded, serve a specialized, or "problem," population. That familiarity manifested—sometimes quite explicitly as in Sergeant Reyes' remarks about the school—in the process of categorizing individuals like Brendan as a "problem" for the MEU or for patrol. Here, Sergeant Reyes' decision to contact the MEU was

based more on the place at which the call unfolded than on whether the specifics of Brendan's behavior in his classroom and on the basketball court rendered him a danger to self or others. Even though his decision to request that a SMART unit respond to assess Brendan was very likely the "right" decision given the LAPD's mandate that the MEU be contacted whenever a subject is suspected of having a mental illness, the sublimation of context by the power of place prevents a nuanced categorization process.

This next excerpt, which draws from a Friday night ride along in downtown Los Angeles with Sergeant Vega, also highlights what happens when the categorization of a place percolates in the background of a call and bleeds into the process of categorizing the person, though to a very different outcome. Around 10:30pm, we responded to a request for a supervisor made by two patrol officers who had picked up a call for service reporting that a woman was running naked in the streets of downtown Los Angeles. As the MHIT instructors teach when they introduce the laws that govern LAPD encounters with the mentally ill, running in traffic as a result of a mental illness is a textbook example of behavior that would authorize officers to apply for an involuntary psychiatric hold under WIC § 5150. That person is both a danger to self since he or she might be struck by a passing car as well as a danger to others since those in nearby cars could be injured in an accident caused by striking, or trying to avoid striking, the person. The call, based solely on its incident log description, seemed ripe for potential MEU intervention.

When we arrived on scene, a woman was already sitting in the back of a squad car, mostly wrapped in a blanket and swinging her legs back and forth over the curb. The two patrol officers who had initially responded to the call for service briefed Sergeant Vega. The woman had indeed been running naked down the street when they arrived on scene but they had been able to detain her in the back of their squad car without incident. They were waiting for a

supervisor to question her since it was unclear what explained her behavior. As bits and pieces of Mary's story emerged, the cause of her nakedness and late night run through the streets shifted between a mental illness or drug use. Place would soon emerge as the central fulcrum upon which the disposition of this call—and the categorization of Mary—would pivot.

A patrol officer asked Mary if she had been using drugs and she responded that yes, she had been smoking methamphetamine earlier. The police seemed to think that this explained her behavior and I asked why. Sergeant Vega explained that meth overheats the central nervous system. "She got high and then got hot so she tore her clothes off" (Pifer fieldnotes). Sergeant Vega deemed the call a "medical emergency" situation, which, under LAPD guidelines, meant that Mary would need to be transported to the nearest Los Angeles County Hospital (hereinafter County) in a rescue ambulance (RA) and that the police would accompany her until she was admitted. A patrol officer turned to request a RA, but when Sergeant Vega asked Mary when she had used the drugs, she responded that she had smoked the meth some six hours ago.

This detail undermined the Sergeant's certainty that this was just a medical emergency. He explained that six hours was just too long ago for the high to have caused her to be still be hot—and to explain her nakedness. "Maybe she's crazy, too?" he wondered (Pifer fieldnotes). Mary interjected to explain that she took her clothes off "for just a second" at the nearby mission where she has been staying and that someone had stolen them. Mary offered no explanation for why she had then started running through the streets, but that she had been staying at the mission earlier in the night seemed to stop the Sergeant from following up on his suspicions that she may have also had a mental illness.

In fact, Sergeant Vega and I had also just come from that mission where he had, during the downtime between responding to calls, given me a brief tour of its crowded courtyard. The

mission's courtyard remains open all night to provide a place to sleep for homeless individuals who are resistant to the idea of a formal shelter placement—and, as Sergeant Vega explained, the rules, structure, and sobriety requirements that shelters enforce. This construction of the courtyard and its surrounding areas as a home to a bustling narcotics trade and filled with addicts tilted Mary back into the category of addict.

Soon, a Los Angeles Fire Department (LAFD) RA arrived and its two paramedics jumped out to assess Mary. They helped her to the stretcher that would take her to County and, as the streetlamp fully illuminated her face hidden only partly by stringy blonde hair cut into a blunt bob, Sergeant Vega said that not only did he recognize her, but that she was a repeat naked runner. The paramedics loaded Mary into the RA and as we walked back to the Sergeant's car, he directed one of the patrol officers to ride with Mary to County and the other to follow in their squad car. The MEU was not contacted and as Sergeant Vega told me, she would likely be back on the streets by that morning. Mary would certainly not see a mental health professional during her trip to County, despite the possibility that a mental illness was functioning alongside or even instead of the meth as the cause of the night's naked run. Here, the power of place had rendered drug use and mental illness as competing rather than co-existing categories.

Still, Sergeant Vega was satisfied with how the call had unfolded because categorizing Mary as in need of emergency medical attention meant that she could be transported to County in the RA rather than in a patrol car. Though the patrol officers would stay with her until she was admitted to the emergency room, she would be admitted through the ambulance bay rather than through the front doors that those who arrive in a squad car must be processed through. This nuance would significantly expedite the process—and minimize the amount of time that the patrol officers would spend off the street and away from their field duties.

The Pressure of Time

These efficiency concerns often percolated in the background of constructing mental illness since any call involving someone who may have a mental illness triggers LAPD's specialized policing procedures. The process begins with a mandatory call to the MEU's Triage Desk. At the bare minimum, this call involves a check-list of questions that unfolds through an extended game of telephone played between MEU members working the unit's Triage Desk and the patrol officers at the scene's frontlines. In addition to gathering information about the situation in the field, MEU staff check both the MEU's own database to determine if the subject has a history of contact with the police and a LA DMH database to identify any case managers, psychiatrists, or treatment centers involved in the subject's mental health care. Ultimately, the phone call to the Triage Desk determines if the subject is, as one LAPD patrol officer described it to me, "the right kind of crazy" (Pifer fieldnotes).

If the subject is indeed the "right kind of crazy"—someone who meets the criteria for a WIC § 5150 hold—the patrol officers must then either wait for a SMART unit to evaluate the subject or transport the subject themselves to an emergency psychiatric facility where a doctor will evaluate the subject and the officers' WIC § 5150 application to determine if an involuntary psychiatric hold is indeed necessary. Patrol officers navigate their categorization of any given situation involving someone who may be mentally ill in the shadow of this lengthy process and can strategically decide when to avoid or deploy the MEU's specialized policing resources—and all its time-consuming procedures—to maximize patrol efficiency.

In this excerpt from a Friday ride along in downtown Los Angeles, time is eventually revealed as an instrumental force in how the call unfolded. A caseworker at a shelter had called 911 to report that Terry, one of her clients, was threatening to commit suicide. Terry, she told the

911 operator, had made concerning statements to his counselor during a session and had become increasingly agitated afterwards, yelling and slamming doors in the dormitory. Sergeant Hunt and I responded to a patrol unit's request for a supervisor and met the patrol officers on the sidewalk before the four of us went inside to meet Terry's caseworker and counselor. Terry had been upset all morning after losing his wallet, yelling in the hallways that "there's no hope anymore and there's no point in going on anymore" and, cryptically, that he was "just going to go out today and see what happens" (Pifer fieldnotes). We also learned from his counselor that Terry had stopped taking his prescription mood stabilizers two weeks ago.

The question then for patrol on this particular call was not if Terry had a mental illness—his counselor explained that Terry had been diagnosed with bipolar years ago—but whether Terry was experiencing a mental health crisis acute enough to justify the officers initiating a WIC § 5150 hold. So, while a call to the Triage Desk was unavoidable given that the counselor had confirmed that Terry was indeed mentally ill, officers seeking to avoid the time-consuming procedures associated with a potential 5150 hold need only strategically navigate their description of the situation to avoid triggering one of the law's three prongs. In Terry's case, the extent of MEU involvement would hinge on how patrol framed their description of the situation. If they constructed Terry as a danger to himself, this would trigger the wait for a SMART unit to respond in person to assess Terry or require the patrol officers to transport Terry themselves to the nearest emergency psychiatric facility and wait for him to be admitted. If Terry was not deemed a danger to himself, the officers could simply leave since he had not committed a criminal offense that would expose Terry to arrest.

As a result, the determinative phone call to the Triage Desk can function as a game of cat and mouse in which patrol officers are able to strategically frame their description of the

situation to get the result they want. Here, the patrol officer tasked with calling the Triage Desk relayed a condensed description of the scene. He began with the case worker's initial phone call to 911, describing that staff were concerned about one of the shelter's residents who had been slamming doors and yelling. Next, he described the scene when the officers arrived—that Terry was agitated and upset that the police had been called, repeating that he was a Vietnam veteran who had no criminal record—and that they had learned from conducting on-scene interviews that Terry had lost his wallet and was upset that he would have to start the process of applying for benefits again since he no longer had a valid ID. Then, the officer played his final card. "No, he didn't say he was going to kill himself," he told the Triage Desk (Pifer fieldnotes).

This was true. No one on scene had reported that Terry had mentioned suicide and Terry himself was adamant that he was just upset, not suicidal, but the patrol officer's explicit operationalization of WIC § 5150's "danger to self" prong as requiring an affirmative declaration of intent to self-harm misrepresented the complete context of the call. Sergeant Hunt, who had been listening to the officer's side of the phone call to the Triage Desk intervened, calling over Terry's caseworker to repeat her story so the officer could relay a more nuanced description of Terry's comments and behavior to the Triage Desk. After this, the Triage Desk determined that Terry should be taken into custody to wait for a SMART unit to respond.

The patrol officers escorted Terry to a side hallway, one still on the phone with the Triage Desk while his partner placed Terry in handcuffs. Terry shouted at the officers, asking "why is this happening, why am I am in cuffs? I'm a vet—an American hero! I'll never trust you again Michael [his counselor], I have no criminal record!" Michael apologized, explaining that "I had no choice," and then more quietly and seemingly more to himself than to Terry, "this is wrong" (Pifer fieldnotes). We moved outside and Terry was placed in a squad car while the officers

finished the check-list of questions posed by the Triage Desk. Some forty-five minutes after we arrived at the shelter, the patrol officers were instructed to transport Terry to the division where they were to wait for a SMART unit. As Sergeant Hunt and I left the scene to continue patrolling downtown, he asked me what I thought of the process. "I don't know," I responded. "What do you think?"

> Yeah, they [patrol] didn't want to deal with this. Did you hear the way he was answering the MEU's questions? Yeah, Terry didn't say he wanted to kill himself, but that wasn't the whole story. That's why I jumped in to grab the caseworker so that she could repeat what she told us and it could be repeated to the MEU (Pifer fieldnotes).

Later that afternoon, Sergeant Hunt and I saw Terry walking down the street. We called out to him and he stopped to tell us what had happened since we had last seen him in handcuffs at the shelter. He had been released from the police station after a SMART unit determined that he did not fit the criteria for an involuntary psychiatric hold. Sergeant Hunt asked Terry if he understood why his caseworker had called the police and Terry said, "I get it. This all started with me making a joke that got twisted up" (Pifer fieldnotes). Terry was in good spirits by then, joking that his only complaint now was the length of the walk back to the shelter.

Officers know that calls for service involving the mentally ill will likely be time consuming, especially if the subject needs to be admitted to an emergency psychiatric facility under WIC § 5150. Time simmered in the background of every call involving the mentally ill and here, Sergeant Hunt's intervention as a supervisor prevented it from prevailing in the responding officers' categorization of Terry. Of course, as it turned out, they were right that Terry was not a danger to himself, but they arrived at this conclusion based not on the context of the call, but because of their desire to avoid spending their watch waiting for SMART or a doctor to take custody of Terry.

Other times, however, the pressures of time proved determinative in categorizing subjects, as in this excerpt from a ride along in South Los Angeles. Around 10:30pm and some six hours into the shift, we received a request for a supervisor on a call for service involving someone who might be, as the incident log description noted, mentally ill. Sergeant Wood radioed in to confirm that he would respond and when we arrived, we found two patrol officers on the sidewalk in front of a large house on a dark street. A woman in handcuffs sat on the curb while a man watched from the house's front porch. The patrol officers briefed Sergeant Wood. The man had called 911 concerned because the woman was dancing on his front lawn and refused to leave. This odd behavior explained the incident log's note to contact the MEU, but, as the call unfolded, Sergeant Wood worked hard to move the woman away from this category—and from LAPD's responsibility—to protect his officers from spending their watch off the streets and in a hospital waiting room.

After the briefing, Sergeant Wood instructed the officers to request a RA so that paramedics could evaluate Elizabeth and perhaps identify a medical explanation for her behavior. The paramedics arrived some ten minutes later and first approached me, asking a series of questions about how I was doing. I engaged with them until we all realized that they thought that I was the subject of the call. I was flustered but they were unfazed by the mix-up; I pointed them towards Elizabeth and they escorted her to their RA to check her vitals. However, to Sergeant Wood's dismay, they soon returned with Elizabeth in tow. There was nothing to suggest that she needed immediate medical attention, which meant that, under policy, they were not required to transport her to County. Sergeant Wood, however, was determined to insulate his officers from the task of transporting Elizabeth to the hospital and waiting there until she was admitted by the emergency room. He was already down a unit after two of his officers had been

tasked with transporting a mentally ill man to the hospital for an emergency psychiatric evaluation at the beginning of his watch, and some five hours later, they had still not returned. Loosing another unit to transport Elizabeth to the hospital, Sergeant Wood made clear to his officers, was simply not an option. Elizabeth began to protest from the squad car that she had done nothing wrong and Sergeant Wood turned to question her.

"How are you feeling tonight?"

"I'm feeling good, man," she said.

"Oh, so you're feeling good? What did you take?" Sergeant Wood motioned for the paramedics to come back.

"Listen, I'm just dancing, having a good time," Elizabeth countered. She laughed, "I'm Bob Marley." She looked more wayward flower child than Rastafarian with her matted blonde hair and army green backpack covered in patches, but Sergeant Wood took her assertion seriously.

"Oh, you think you're Bob Marley?" Sergeant Wood's tone was sharp.

"Yeah, I think I'm Bob Marley," Elizabeth challenged, her words dripping sarcasm.

Sergeant Wood turned his back to Elizabeth, and ignoring her tone, called the paramedics back over. "Did you guys check her out for drugs? She's altered. She thinks she's Bob Marley. She's your problem" (Pifer fieldnotes). Sergeant Wood told his officers that Elizabeth's comment about Bob Marley was going in the report and instructed them to make sure the paramedics transported Elizabeth. He reminded them as he returns to his car that they cannot get tied up at the hospital any longer than necessary to get her admitted to the emergency room. He did not wait for the paramedics to follow up on his claim that Elizabeth was high before driving away, signaling the end of LAPD's responsibility with his departure.

Later that watch, around 1am, Sergeant Wood supervised another call involving someone who may be mentally ill—a young boy whose mother had called 911 to ask for officer assistance after the boy threatened his sister with a knife. I do not know how the call was disposed but as Sergeant Wood arrived to supervise his third call involving someone who may be mentally ill, his officers from the watch's first call were still not back from the hospital. Again, the pressure of time loomed heavy in this call.

Discussion & Implications

In the city of Los Angeles, where the on-the-ground realities and tragedies of transinstitutionalization are particularly acute, the LAPD has developed its MEU to "better" police the mentally ill and to prevent encounters that end in violence. In the LAPD's model, patrol officers are directed to call the MEU's Triage Desk during any encounter that involves someone who may be mentally ill to receive real-time guidance from MEU members and perhaps even field assistance from a SMART team to save patrol officers time, divert people with mental illnesses from jail to treatment, and prevent encounters from escalating.

However, the MEU's practical ability to accomplish these policy promises hinges on how patrol officers identify someone as mentally ill and decide to invoke these specialized policing strategies by making that initial phone call to the Triage Desk. California's WIC § 5150 outlines who should be considered mentally ill in the context of policing by empowering officers to apply for an involuntary emergency psychiatric hold when someone is a danger to self, to others, or gravely disabled, yet it also vests officers with considerable discretion in how they operationalize its three prongs. This ambiguity of law is compounded by the fluid nature of the category of mental illness itself and, as a result, I argue that the material reality of mental illness—and the

practical effect of specialized policing strategies like the MEU—is dependent on how officers exercise their discretion to filter individuals in and out of the category of mental illness.

The encounters I have analyzed above are similar to the first two training scenarios that comprise the MHIT's final examination in that it is not readily apparent whether or not the subject is a danger to others or to himself or herself, or gravely disabled. Instead, these "trouble case" (Llewellyn and Hoebel 1941) calls, which I term 5149 ½ calls, allow the role of discretion and external factors like place and time in constructing the category of mental illness to emerge. In short, I find that "the right kind of crazy" is constructed less by law and more through the factors that percolate in the background of discretionary policing decisions, including how to manage the mentally ill (Bittner 1967). My analysis of these 5149 ½ calls is not concerned about assessing whether officers "got it right" when it comes to deciding if someone was mentally ill. Instead, I focus on revealing how officers make that decision because this process reveals both the meaning of mental illness on the ground as well as how—and even if—specialized policing strategies will unfold.

My analysis of this process comports with classic policing studies identifying the social and structural processes through which police decide how to dispose of calls involving the mentally ill (Bittner 1967; Matthews 1970; Rock et al. 1968) but locates the power of discretion earlier in the process by revealing how officers categorize individuals as mentally ill or not. I identify place and time as the mechanisms through which patrol officers construct the boundaries of mental illness and trace how this process bleeds into how officers decide whether to invoke the MEU. These two processes are inextricably linked—how officers determine whether an individual is the "right kind of crazy" also determines whether they should contact the MEU—yet they could, as my data sometimes showed, also function independently. In part, these

mechanisms served a constitutive function when officers used time and place to filter an individual in and out of the category of mental illness, as when the power of Skid Row rendered Mary and her naked run the product of drug abuse rather than mental illness. Yet, these factors also served a strategic role for officers in constructing mental illness as part of the decision to invoke—or avoid—the MEU, as when the patrol officers sought to avoid extended MEU involvement in Terry's case because that was the most efficient choice.

However, though my analysis frames time and place as separate and external mechanisms, I do not mean to oversimplify the process through which mental illness is constructed. There is likely much to learn by destabilizing my analysis to consider, for example, the relational aspect of these mechanisms. For example, while I analyze Elizabeth's story as an example of the institutional pressure of time, the example may also reveal an equally powerful relational mechanism at work. Consider how the paramedics' initial assumption that I was the subject of the late-night call in South Los Angeles might bridge the context of the call with its subject by pivoting the analysis to my relationship to the place where the call unfolded. In this speculative analysis, it is the discordant relationship between a white female and a dark street corner in a community of color (see Frohmann 1997) rather than just the power of place that prompted the paramedics to ask me "what seems to be the trouble tonight?" (Pifer fieldnotes). The data does not permit this level of analysis, but it suggests that the relational quality of time and place in constructing mental illness—and in distinguishing it from non-actionable oddity and arrestable criminality—merits further study with data that collects both the internal and external context of calls.[9]

As separate mechanisms though, time and place render the invocation of MEU resources for 5149 ½ calls contingent on discretion rather than mandatory as the LAPD's policies promise.

This gap between policy and practice emerges in sharp contrast given the modern history of policing the mentally ill in Los Angeles and the LAPD's fatal encounter with Margret Mitchell in 1999. Mitchell's shooting and the subsequent demands of the 2001 consent decree that the LAPD do better revealed a deep conflict between civil rights law and the LAPD's institutional performance that forced a reexamination of assumptions about how to police the mentally ill. Against this background, the LAPD devoted itself to making its MEU a national model for policing the mentally ill—a goal it has, according to the Independent Monitor, achieved (Office of the Independent Monitor of the Los Angeles Police Department 2009).

Yet, in March 2015 as I was developing this project, LAPD officers shot and killed Charley "Brother Africa" Leundeu Keunang, a 43-year-old homeless Cameroonian immigrant with a documented history of mental illness, in downtown Los Angeles' Skid Row. The shooting was recorded by a civilian's cellphone and catapulted the LAPD's policing of the mentally ill back into the public debate. In early 2016, LAPD Chief Charlie Beck said that the "incident prompted his department to reexamine how officers are trained to interact with people who have mental illness" and that the LAPD was working to expand its number of SMART units to "better respond to calls of crisis like the one involving Keunang" (quoted in Mather, Queally, and Holland 2016). Of course, as my analysis demonstrates, there are a host of forces operating in the space of street-level judgements about both who is mentally ill and who is mentally ill enough to necessitate MEU intervention that can leave these specialized strategies un-deployed. This begs the question of how and whether the MEU—this formal policy change to policing the mentally ill—solves the problem as it is revealed by Mitchell shooting's and its aftermath. In the case of Brother Africa, the MEU was not contacted (S. O'Neill 2015).

This engages a larger emergent thread in the transinstitutionalization literature: reform in its aftermath (Reiter and Blair 2015). As the criminal justice system grapples with the fallout from its mismanagement of the institutionalized mentally ill, jurisdictions are increasingly developing new policies that seek to better police, punish, and incarcerate the mentally ill (Pifer 2016b). The LAPD's MEU and the department's mandate that its officers invoke its resources during any encounter with someone who may be mentally ill is but one example of criminal justice reforms that respond to transinstitutionalization with specialized policies and procedures. And, while I do not contend that my analysis of 5149 ½ calls is generalizable, my analysis does here implicate a university socio-legal reality with which reforms predicated on the category of mental illness must contend: the practicalities of implementation turn on the nuances of category construction.

3. Policing the Mentally Ill in Los Angeles on the Frontlines of Transinstitutionalization

The patrol officers in Southwest Los Angeles are familiar with Angels Landing, a residential facility in their division that serves as a temporary, "halfway" home for people who have transitioned from living in a secure institution but have not yet entered into an independent living situation. 911 calls for service from Angels Landing staff members requesting officer assistance in managing the residents were so frequent that the place became a normal and expected part of any given patrol shift. Patrol officers became even more familiar with David, a longtime resident of Angels Landing who was often at the center of these calls for service. "We'd go there at least once a month to place him on a hold. If he's on his meds, he's fine, but if he's not, he's very violent. We'd go there so often, we actually got to know him by his first name," Sergeant Sosa, who is assigned to a Los Angeles Police Department (LAPD) patrol division in Southwest Los Angeles, began (Pifer fieldnotes).

On one of these calls, officers responded to Angels Landing and found David crouched behind a couch, yelling and yielding a knife. "The officers who got there first, one of them knew David and called him by his first name. He was able to talk David down and get him in cuffs, but it could have easily gone sideways, you know?" Sergeant Sosa took a breath and then described the last time officers encountered David.

> He just went crazy with a knife and started charging the officers. He actually cut one of the officers and we had to shoot him. He survived, but we had to shoot him. This is a guy who is mentally ill and needed help, but every time we took him for a hold, he ended up back [at Angels Landing]. And that's the problem I have with our mental health system—a lot of it [mental illness] is drug-induced, but the people who actually need help aren't getting it' (Pifer fieldnotes).

Sergeant Sosa's account of David's shooting is a dramatic example of policing the mentally ill in Los Angeles during an era that has placed the criminal justice system on the frontlines of managing the institutionalized mentally ill.

Individual encounters with people with mental illness like David may seem routine to patrol officers like Sergeant Sosa—between July 1, 2014 and June 30, 2015, the LAPD reported 15,454 interactions between officers and a person with a mental illness (Lopez 2016)—but collectively, they reveal an important shift in policing in urban cities like Los Angeles that has transformed officers from being not just the gatekeepers to the criminal justice system, but also to the mental health system (Bittner 1967, Lurigio and Watson 2010). The evolution of the police into "streetcorner psychiatrists" (Teplin and Pruett 1992) has unfolded alongside the larger phenomenon of "transinstitutionalization" (Gilligan 2001), the process describing the transfer of responsibility for the nation's institutionalized mentally ill from the state hospital system to the criminal justice system during the late 20th century.

Yet, as David's story suggests, police struggle to manage this seemingly routine role on transinstitutionalization's frontlines. For example, officers report that they feel ill-equipped to help individuals experiencing a mental health crisis and frustrated with the failings of the mental health system (Hanewicz, Fransway, and M. O'Neill 1982; Perkins, Cordner, and Scarborough 1999; Pogrebin 1986), which can lead to the overuse of arrest to dispose of calls involving the mentally ill (Bonovitz and Bonovitz, 1981; Borum, Swanson, Swartz, and Hiday, 1997; Clark, Ricketts, and McHugo, 1999; Drake, Bartels, Teague, Noordsy, and Clark, 1993; Frankle et al., 2001; McFarland, Faulkner, Bloom, Hallaux, and Bray, 1989; Monahan and Steadman,1983; Teplin, 1984) or, as David's case exemplifies, the use of force.

The effects of the overuse of arrest and of the use of force during police encounters with

the mentally ill have reverberated throughout the criminal justice system (Hails and Borum 2003). In Los Angeles, for example, the county jail system's status as a "de facto mental health treatment system" (McDonnel 2015) and high-profile police shootings like Margret Mitchell's fatal encounter with LAPD officers in May 1999 have instigated a series of policy reforms. These reforms have dual goals: to improve the system's management of the mentally ill and comply with federal civil rights litigation demanding change. In Los Angeles, for example, the LAPD has, under the supervision of the independent federal monitor appointed to monitor the department's compliance with the 2001 consent decree with the Department of Justice, developed a set of novel strategies to "better" police the mentally ill that are housed within its Mental Evaluation Unit (MEU). The unit is staffed by both specially-trained LAPD officers and clinicians from the Los Angeles County Department of Mental Health (hereinafter LA DMH) who work together to assist LAPD officers responding in the field to situations involving the mentally ill. The unit is designed to save patrol officers time, divert the mentally ill from jail to treatment facilities, and deescalate potentially volatile—or fatal—encounters between officers and the mentally ill (S. O'Neill 2015).

The MEU's co-partnership approach is considered a model for law enforcement agencies seeking to improve their response to individuals with mental illness (Office of the Independent Monitor of the Los Angeles Police Department 2009) and its philosophy is proliferating as both domestic and international agencies seek training from the MEU (S. O'Neill 2015). However, despite the MEU's appeal as a policy solution to the challenges inherent to policing the mentally ill, its members work out of the LAPD's Police Administration Building in downtown Los Angeles and function primarily as secondary rather than first responders to mental health crises. Under this configuration, LAPD's patrol officers remain on the frontlines of policing the city's

mentally ill. As a result, examining how patrol officers navigate this task offers on-the-ground insights into how transinstitutionalization and its ostensible policy solutions are unfolding in Los Angeles.

This chapter describes how patrol officers understand their role in managing the mentally ill to examine the criminal justice system's place on the frontlines of social problems that, like mental illness, reach far beyond crime control. I analyze a variety of sources to describe and ultimately reveal the everyday experiences—and challenges—of policing the mentally in Los Angeles in transinstitutionalization's wake. First, I trace the historical context against which the police have arrived on the frontlines of managing the mentally ill and describe the policy consequences for the criminal justice system. I then describe how specialized policing strategies have developed to "better" police the mentally ill by hybridizing care and control logics, ending with how the LAPD's MEU is imagined as a policy solution. Next, I use original data collected through observations of and open-ended conversations with LAPD officers to examine how patrol officers understand both the task of policing the mentally ill and their department's specialized policing strategies. These findings reveal that officers struggle to navigate their dual role as agents of care and control and that policing the mentally ill is, despite the promise of specialized policing strategies designed to deliver care, ultimately an exercise in control. Finally, I explore the implications of this imbalance between care and control for policing the mentally ill in Los Angeles—and for the system's place on the frontlines of this social problem.

Policing in Transinstitutionalization's Wake

A set of policies have unfolded during the last half of the twentieth century that have seriously transformed the criminal justice system. In the punishment and social control literatures, this transformation typically conjures the phenomena of mass incarceration and an

analysis of the unparalleled growth of the penal system. Perhaps less familiar, however, is the process of transinstitutionalization (Gilligan 2001), which accounts for the significant increase in the number of persons with mentally illness that are involved in the criminal justice system through a historical analysis of the set of policies and practices implicated in the deinstitutionalization movement's unfolding.

State mental hospitals housed, for much of the 19th century, almost the entirety of the nation's institutionalized mentally ill population (Grob 1987) but, in the years after World War II, public and policymaking discourses shifted to resist the asylums and the historical practice of institutionalizing those individuals labeled as mentally ill. As the federal level, these culminated in the Community Mental Health Act, which President Kennedy signed into law in 1963 to officially signal the death of the asylum in favor of a community mental health center model of caring for the mentally ill (Scull 1977; Gronfein 1985; Grob 1987, 1991). Under the deinstitutionalization movement, state mental hospital populations fell dramatically. In 1955, the population was, at 559,000, nearly as large on a per capita basis as the contemporary prison population; by 2000, it was 100,000 (Gottschalk 2010; Harcourt 2011a; 2011b).

The new community-based mental health facilities promised by federal law, however, failed to materialize and, in deinstitutionalization's vacuum, the criminal justice system has absorbed scores of individuals with mental illnesses who, just a few decades ago, likely would have been institutionalized in a state hospital (Teplin 1984; Gilligan 2001). And, as the gatekeepers to the criminal justice system, the police have had increasingly common encounters with individuals with mental illnesses (Cordner 2006; Engel and Silver 2001; Teplin 1984)—in New York City, for example, officers respond to calls for service involving someone with a mental illness every six minutes (Borum, Deane, Steadman, and Morrissey, 1998)—and often

serve as first responders to a mental health crisis since there is usually no one else to call (Abramson 1972, Swanson, Borum, Swartz and Hiday, 1999, McLean and Marshall, 2010, Teplin, 2000). In this sense, police serve an integral role in facilitating access to mental health care by transporting individuals to emergency departments (van den Brink et al. 2012).

However, there are profound costs and consequences of designating the police as "streetcorner psychiatrists" (Teplin and Pruett 1992). Even routine encounters with the mentally ill consume a disproportionate amount of police resources since these calls consume significant amounts of officer time and energy (DeCuir and Lamb 1996; Pogrebin 1986). At their worst, these encounters are especially vulnerable to violent escalation (Pfeiffer 2007). Police may be able to identify someone as mentally ill in general (Engel and Silver 2001), but they are not trained mental health workers and cannot identify the full range of conditions and symptoms associated with the category and may misconstrue symptoms of mental illness as aggressive, disrespectful, or hostile behavior (Morabito and Socia 2015). This, in combination with officer perceptions that calls for service involving the mentally ill are among the most dangerous (Margarita 1980; Ruiz and Miller 2004, Watson, Corrigan, and Otatti 2004), fosters the potential for volatility as officers attempt to navigate these encounters using traditional law and order strategies like arrest and use of force.

Unsurprisingly, many departments have experienced a high-profile use of force case involving a person with mental illness (Lurigio and Watson 2010). In Los Angeles, for example, LAPD officers shot and killed Margaret Mitchell, a 55-year-old mentally ill and homeless black woman, in May 1999 during an encounter in Los Angeles' Mid-Wilshire neighborhood. The patrol officers recognized Mitchell as then-LAPD Chief Bernard Parks would describe months later, as "possibly being a transient known to Wilshire Area officers for her explosive, violent

nature" and, suspecting that the shopping cart she was pushing was stolen, ordered her to stop (Parks 1999). Mitchell refused to stop and, when the officers continued to pursue her, soon brandished a 12-inch screwdriver while yelling for the officers to leave her alone. The confrontation continued to escalate as Mitchell refused to comply with the officers' orders to stop and drop the screwdriver, climaxing when Officer Edward Larrigan fired a fatal shot into Mitchell's chest.

Mitchell's shooting and LAPD's handling of its aftermath prompted public outcry over law enforcement's treatment of both the mentally ill and people of color. Officer Larrigan was cleared by a LAPD disciplinary panel and no criminal charges were filed, but Mitchell's death served as the catalyst to include the department's policing of the mentally ill among the series of reforms mandated by the 2001 consent decree negotiated between the city of Los Angeles and the Department of Justice. The consent decree ordered the LAPD to develop new policies, procedures, and training methods designed to de-escalate the potential for violence in police contact with the mentally ill (Consent Decree 2001, p. 52).

Specialized Policing Strategies

Against this background, law enforcement agencies, including the LAPD, have increasingly emphasized the development of new policing strategies designed to be more responsive to the task of policing the mentally ill, reduce the likelihood that these encounters will result in the use of force, and mitigate the potential for departmental liability (Hill and Logan 2001, Pfeiffer 2007). These strategies have generated a robust policing literature concerned with the nature and efficacy of the various approaches that departments have utilized. The first generation of these specialized approaches to policing the mentally ill focused on training officers to better identify, manage, and dispose of call involving with mental illnesses (Hails and

Borum 2003). By 1996, some 88% of law enforcement agencies nationally had some form of training (Deane et al. 1999) and, while research found that trainings generally did improve officer knowledge of mental health issues (Godschalx 1984) and increased their ability to identify and communicate about mental illnesses (Janus et al. 1980), training, by itself, was ultimately considered insufficient to "fundamentally change the nature of police encounters with the mentally ill" (Borum 2000, p. 333).

A second generation of approaches then developed to combine training efforts with some sort of specialized program designed specifically to respond to individuals who are experiencing a mental health crisis (Hails and Borum 2003). There are, in general, three models for these specialized responses: (1) police-based specialized police responses in which sworn officers who have specialized training serve as the frontline responders to mental health crises; (2) police-based specialized mental health responses in which mental health professionals are employed to provide consultations to officers in the field; or (3) mental-health based specialized mental health responses in which mental health agencies partner with police to provide mobile mental health crisis teams that operate independent of the police (Deane et al. 1999; Hails and Borum 2003). In 2000, researchers compared each of these models in a three-city case study and found that the Memphis Police Department's Crisis Intervention Team (CIT)—a police-based specialized police response—was particularly effective since it had a low arrest rate for calls involving someone with mental illness, a high rate of utilization by patrol officers, a rapid response time, and resulted in frequent referrals to treatment (Steadman et al. 2000).

The so-called "Memphis Model" has since been widely adopted by departments (Lord et al. 2011). In general, CIT programs identify those officers who, based on interest, attitude, and interpersonal skills, show promise as specialized responders and provide them with intense

training to create a cadre of frontline responders who can be deployed to calls involving individuals with mental illness (Watson et al. 2009). Research suggests that CIT programs have a "strong potential to reduce unnecessary use arrests and uses of force" (Hails and Borum 2003) CIT officers, for example, report feeling substantially more equipped to handle encounters with those who have mental illnesses (Ritter et al. 2010) and having a better perception of and attitude towards those who are mentally ill (Ellis 2014), while the program itself can be effective at reducing the rate at which individuals with mental illnesses are placed under discretionary arrest (Franz and Borum 2010).

In Los Angeles, however, the LAPD has, under the supervision of the consent decree, developed its own co-partnership approach to policing the mentally ill that pairs police with mental health professionals. LAPD's Systemwide Mental Assessment Response Teams (SMART) pair a specially-trained LAPD officer from the department's MEU with LA DMH clinicians in a mobile response unit that can respond to assist field officers and divert the mentally ill from custody to treatment by making mental evaluations and referrals in the field. Where CIT programs emphasize deploying trained officers as the primary responders to mental health crises, the SMART model functions primarily as a secondary response and leaves patrol officers on the frontlines of policing the mentally ill. LAPD policies mandate that any field officer who encounters a person who may be mentally ill call the MEU's Triage Desk, which provides guidance on whether the individual should be transported to an emergency psychiatric facility and manages how SMART units are dispatched in the field. Together, the Triage Desk and the field officer determine how the call should be disposed and if a SMART unit should and is available to respond to assist the responding officers in the field.

Today, the LAPD's program is considered a national model for specialized policing responses to the mentally ill. For example, the Independent Monitor's final report on the department's compliance with the consent decree described that the LAPD was now "in the national forefront of this important policing issue" and recommended that the department simply "continue to do what it has been doing" (2009, p. 93). Over the years, SMART has continued to expand to provide the city with increased coverage and local officials have praised its ability to divert individuals with mental illness from arrest to treatment and to save patrol officers time (Office of the Mayor of the City of Los Angeles 2015). The MEU estimated that, in 2014, its SMART teams saved more than 6000 hours of patrol time (S. O'Neill 2015) and over a one year period between July 2014 and June 2015, only 1.4% of SMART contacts resulted in arrest (Lopez 2016). Yet, despite SMART's promise, of the 15,454 phone calls placed to the MEU's Triage Desk during a one-year period, patrol officers handled nearly two-thirds of the department's reported interactions with persons with mental illness (Lopez 2016). As a result, while the MEU may be conceptualized as the LAPD's "solution" to better policing the city's mentally ill, its patrol officers remain on the frontlines of transinstitutionalization. I use their perspectives to analyze how policing the mentally ill in Los Angeles unfolds on the ground.

Perspectives from the Frontlines

The findings draw from my fieldwork with the LAPD to describe how patrol officers navigate their role on the frontlines of transinstitutionalization. I analyze how patrol officers make sense of policing the mentally ill and engage with the LAPD's specialized policing strategies.

The Experience of Policing the Mentally Ill: A "Crazy," Everyday Task

The police officers and sergeants I engaged with during my fieldwork experienced the task of policing the mentally ill as an everyday part of patrolling the city. Inevitably, every officer who facilitated a ride along for me assured that I had, as Sergeant Hunt put it during a ride along in downtown Los Angeles, "come to the right place" (Pifer fieldnotes). Sergeant Hunt's statement referred explicitly to the Skid Row community, a fifty-four-block area in downtown that is home to the country's largest unsheltered population (Martinez and Meeks 2015), and reflects the dominance of the trope of "the homeless mentally ill" (Ben-Moshe 2017) in LAPD culture. Officers I engaged with uniformly explained that, because Skid Row had the highest density of people with mental illnesses, I need only go there if I wanted to understand the task of policing the mentally ill.

Yet, officers from every division conceptualized managing the area's mentally ill as a fundamental component of their patrol work. For example, Sergeant Sosa described that incidents involving the mentally ill were among the most common calls for service in his division in South Los Angeles while Sergeant Williams, a patrol supervisor in a neighboring division, estimated that "at least 50% of my job is mental health management." Later, after we were flagged down on the street by a mother hoping that the officers would be able to talk her teenage daughter into following the rules at home, Sergeant Williams joked that the other half of her job was "just dealing with other people's drama" (Pifer fieldnotes). However, even as officers experienced the task as routine, they expressed frustration with both the task itself and with the larger system within which they operate to manage the mentally ill.

For example, Officer Rogers, who I met during the MHIT series I attended, recalled a call for service that he and his partner responded to on a recent Saturday night while on patrol in their

division in East Los Angeles involving a woman who had reportedly swallowed a handful of prescription pills.

> When we got there, she's on the phone with someone, and when she handed the phone to me, it's the crisis hotline. We tell her that we got a call that she wanted to hurt herself, but she denies it, says everything is fine and that she didn't call, didn't even take anything. At that point, I called the MEU and the RA [rescue ambulance] because even though she's not displaying any symptoms, she may have taken the pills. But she didn't say anything because she knows the game. And the MEU didn't have anyone to send down to use to talk to her, so we ended up sitting on her for like four hours and took her to [the public emergency psychiatric facility]. She was really mad that we took her to the hospital and she said, 'When I get out of here, I'm going to finish the job' (Pifer fieldnotes).

When I asked Officer Rogers if four hours was a long time to spend off the street, he answered, "Yeah. For somebody with mental illness. It's not like we don't want to help, but, man, four hours" (Pifer fieldnotes).

The task of policing the mentally ill was not just a frequent part of the job, but could also be an all-consuming one that officers came to resent since it took them off the streets and away from the tasks they believed constituted policing the city. Patrol supervisors, such as the sergeants who facilitated each of my ride alongs, felt this frustration even more acutely. As Sergeant Vega explained during a ride along in downtown Los Angeles, patrol officers are a limited resource.

> You hear LAPD and you think, oh yeah, there's like 10,000 cops patrolling the city, but that's not true. Most of those cops are working inside, in like headquarters or working at a desk, and not out in the field. Like tonight, you know, I've only got like four units out. That's eight cops and me for the area I'm responsible for (Pifer fieldnotes).

Losing a unit to the waiting rooms of emergency psychiatric facilities frustrated supervisors like Sergeant Vega. This is part of the SMART units' function—to save patrol officers time by meeting them in the field to take over the calls involving the mentally ill—but SMART units are

themselves a limited resource and, as was the case in Officer Roger's story, not always available to respond in the field.

Officers expressed frustration beyond just the time absorbed by individual encounters with the mentally ill to raise an implicit critique of the system that has placed police on the frontlines of this task. This was percolating in the background of Sergeant Sosa's account of David and Angels Landing and, later in the shift, emerged as explicit as we drove past another halfway house in his division. "We get a lot of 5150 calls from this place," he said, gesturing out his open window towards what looks like a non-descript apartment building (Pifer fieldnotes). Sergeant Sosa was using LAPD's shorthand for mental illness, which is itself shorthand for the Lanterman-Petris-Short Act— better known by its California Welfare and Institutions Code (WIC) section number: 5150. WIC § 5150 authorizes the police to apply for an involuntary psychiatric hold when an individual "is a danger to others, or to himself or herself, or gravely disabled" as a result of a "mental health disorder" and creates the formal category of "mental illness" in the context of policing in California.

> Yeah, the staff there is useless and they call us [LAPD] anytime they can't handle the residents. But they don't even seem like they have any training and they won't go hands on, so that's all the time. And there's another facility nearby that lets the residents just wander around like zombies. You could tell this place was in it for the money from the state or whatever. I think it's crazy that they call cops to deal with their residents. Shouldn't these places be able to do their job? (Pifer fieldnotes).

While Sergeant Sosa's critique was focused on secure residential facilities like Angels Landing, other officers described responding to calls for service at schools for students with special needs or to private homes when staff or families members were unwilling or unable to cope with a mental health crisis.

For example, on a ride along in downtown Los Angeles, I observed a call for service involving a young man with mental illness. The incident log description noted that the subject had attention deficit disorder and anti-social personality disorder; the caller was the man's mother and she was hoping that the officers would find her son and detain him so that she could wire him money for a bus ticket home. The address the caller had provided was for a store, which was closed for the night, and though the officers walked up and down the block, they were unable to locate the young man. I asked the officers what they would have done had they been able to find the young man and one of the patrol officers who had been first on scene explained that there was likely nothing that the police could have done. "People call us all the time when they don't know who else to call, but there's not much we can do unless it's a 5150" (Pifer fieldnotes). The officer shrugged this off, but his comment captured more than frustration with the task of policing the mentally ill—his tone expressed helplessness.

Though officers usually experienced these calls as routine, some calls allowed the tension inherent to serving on the frontlines on managing the mentally ill to emerge. For example, during the inevitable downtime that stretched between calls during ride alongs, I asked Sergeant Sosa to share his most memorable call involving someone with mental illness.

> There was this twelve-year-old girl and something would flip in her and she wanted to kill her mom with a knife because her mom was the devil. And we get there and, sure enough, she was right up in the house with a butcher knife and I'm like, 'oh my goodness, I'm not going to shoot a little girl.' Luckily, we talked her out to the porch and she kept yelling, 'my mom's the fucking devil, she's a fucking whore'—and I have a fourteen-year-old daughter and I wouldn't expect her to say that stuff—saying all kinds of dirty stuff. An officer came behind her and grabbed the knife and we took her into custody. But it could have gone totally bad. I don't want to shoot a little girl. She got placed on a hold. Anyways, those are the ones I remember: the little kids (Pifer fieldnotes).

For Sergeant Sosa, the tension officers experienced navigating their dual role as agents of both control and care in policing the mentally ill manifested in dramatic terms as he confronted the possibility of shooting a child in midst of a mental health crisis. Of course, this tension could also emerge through more subtle and routine processes when, for example, officers grappled with whether to arrest or to apply for a 5150 hold.

Inside Cops, Outside Cops, and the Meaning of Policing the Mentally Ill

Phone calls to the MEU's Triage Desk functioned to reveal the slippage between the formal definition of mental illness that law provides to the police and the on-the-ground experiences of policing the mentally ill. For example, during a ride along in South Los Angeles, Sergeant Reyes shared a story that revealed the schism between the meaning of mental illness for patrol officers and for the MEU.

> The resident called 911 because a male black was standing on the front lawn acting strange. The call got upgraded when the man moved from the lawn to the porch and began to sharpen a knife. The officers get there and take the man into custody [put him in handcuffs]. The man is dirty, a little disheveled, wearing no shoes and unresponsive when the officers asked him his name, just rambling, just incoherent. He did have a small little pocket knife on him. You could tell he was mentally ill just by looking at him and just by talking to him and the things he was doing, acting, looking. So, we called our MEU people and they were like 'he doesn't fit our criteria.' And I was like, you've got to be kidding me. If he doesn't then I don't know who does. He needs help, you know? (Pifer fieldnotes).

I asked Sergeant Reyes why the man didn't fit the MEU's criteria, which is outlined in broad stokes by WIC § 5150's three prongs: danger to self, danger to others, or gravely disabled. "Because he wasn't a danger to himself. But I still think he was gravely disabled, that he couldn't take care of himself. . . . He obviously needed help . . .," he explained (Pifer fieldnotes). In his recollection, Sergeant Reyes' directed his frustration at the MEU's Triage Desk, staffed by an officer who did not seem to understand the situation in the field as Sergeant Reyes

experienced it, but the call was also complicated by the ambiguity of policies governing the line between an arrest and an emergency involuntary psychiatric hold.

On one hand, WIC § 5150's three prongs are vague and require officers to do interpretive work to decide who is be eligible for a hold. For their part, the MEU members I encountered openly acknowledged WIC § 5150—and the task of policing the mentally ill—as a valid source of frustration for patrol officers. For example, at the four-day MHIT series run by MEU members, one of the MEU's officers opened his lecture on WIC § 5150 with a hypothetical situation designed to guide the patrol officers in attendance through how to decide if a subject should fall within the law's scope.

"Okay, so you got one shit-head gangster from one neighborhood walking into another neighborhood. Is he a danger to himself?"

Someone shouted, "Oh, yeah. I'd book him."

"Hell yeah," the MEU officer agreed. "Is he a danger to others?"

The audience laughed. "Oh yeah. Oh yeah."

"Hell yeah, right? Is he going to be gravely disabled?"

"Oh, he will be."

"Okay, he will be, right after he gets his ass kicked. But, given all we know about this situation, is it due to mental illness? What's missing with the 5150?" (Pifer, fieldnotes). The example was tongue-and-cheek, focused on the law's operative requirement that the criteria be due to a mental illness rather than just garden-variety deviance, but it set the tone for a discussion of how to navigate the ambiguity inherent to WIC § 5150—and the meaning of policing the mentally ill.

Earlier that day, Nick, a LA DMH licensed clinical social worker with the MEU, in a session designed to introduce officers to mental illness gave the group a hypothetical situation. Nick's point was that not all mental disorders, like dementia or down syndrome, could be managed with medications but the example quickly generated a heated debate about the thin line between care and control in policing the mentally ill. Nick asked,

> Has anyone been in a call like this, when the family is at their wit's end because Grandma, who has dementia, thinks they're out to kill her and she's running around yelling and screaming and coming at them with a knife. You ever been on this type of call? Is this a 5150 type of call? Sounds like it.

Officer Rogers, a Police Officer III assigned to a division in East Los Angeles, interrupted to share the details of a call he had responded to just that weekend. Officer Rogers' story complicated Nick's narrative and highlighted the porous boundary between an arrest and a hold that officer must navigate in the field.

> In cases where I run into someone with mental illness that does commit a crime that's not necessarily against a person, we've been told by MEU to book 'em on the open charge. My feeling was that they needed to be put on hold because they're not acting out criminally because they're in that 'criminal mind' set, they're acting out because of the mental illness and arresting them on an open charge isn't going to address the mental illness (Pifer fieldnotes).

In the back of the room, Officer Hernandez, an officer with the MEU, stood up to answer, but Nick jumped back in:

> The people that work at MEU don't always have the right answers. Sometimes you guys are smarter than anyone at MEU.
> Don't underestimate your knowledge or experience. Anyone that's telling you to take Grandma who's eighty-eight years old and has dementia and she comes after everyone with a knife and they call 911—and I'm using this scenario specifically—why would you ever book [her] on any type of charge unless, of course, she did get to stab someone. This is a person that needs to get to the hospital to be mentally evaluated. There's something out of whack medically because her brain is not working regularly. So, I think MEU made a mistake. I have the

> same freakin' arguments with my people up in MEU because they say dementia isn't a mental illness and I say is this the bullshit you give to people out in the field? The family has a crisis. They don't know what to do. Patrol doesn't know what to do. This is crazy to book this 88-year-old grandma. So, you were given wrong information.

"This is very common," Officer Rogers complained.

Officer Hernandez, still standing in the back and listening intently to the exchange, asked Officer Rogers a follow-up question, "Was this a felony or a misdemeanor? Felonies are shall book and misdemeanors are at your watch commander's discretion."

Officer Rogers paused, "I think it was a misdemeanor. Brandishing with a knife."

"Then it's at your watch commander's discretion."

The officer sitting next to Rogers, also a Police Officer III, interjected to add another detail that would elevate Grandma's offense from a misdemeanor to a clear felony:

> Okay, let's say it's brandishing but the words 'I'm going to kill you! I'm going to kill you!' come out of your mouth. That's a terrorist threat now. They have the means, the opportunity, but it's still mental illness, you know? I want to make the arrest. I want 'em to get help. But, it's a criminal threat. Book 'em (Pifer fieldnotes).

In this version of events, the officers would have no choice but to arrest Grandma for the felony criminal threat—even if they believed, as Nick had just put it, that it would be "crazy" to book her and that she should be evaluated for a WIC § 5150 hold.

Officer Cruz, also a MEU officer, interjected in hopes of ending the sidebar and asked Officer Rogers to bring up his example during the MHIT session on legal issues. Nick continued though, asking the group, "How did I put my foot in my mouth?"

"Because you gave us the perfect scenario of what we deal with in the field," Officer Roger answered.

> I put my foot in my mouth by not saying in the beginning that I don't know what the legal realities are, so if you're going to the MEU and

> they're looking at the legal things, which is your guys' business, and might trump some decisions.

Nick paused and then indicated the very system in which the MEU functions.

> Taking that person for a mental evaluation is probably the best thing to do rather than taking them to jail . . .[because] once they get there do they're not going to get any help there. Jails have become huge mental health hospitals. It's crazy—the system's a little bit broken (Pifer fieldnotes).

Nick then moved back to the agenda, wrapping up his presentation with a discussion of why people decide to stop taking their medication, but the sidebar was telling. Nick, though a full-time member of the MEU, approached the task of policing the mentally ill from his perspective as a clinician that wanted to see Grandma get help, not arrested. Yet, the line between an arrest and a hold turned not on Nick's professional judgment as a clinician, but on the penal code.

During a break, Officer Cruz reiterated that he wanted Officer Rogers to bring up the issue up during the Legal Issues Unit. "It's going to get heated," warned Officer Rogers.

"It's okay," Officer Cruz explained, "because just like everything, there's policy and then there's practice. That's how we normally do thigs and the way we should be doing things and the reason behind."

Officer Rogers cast me a sidelong look. "You may not have heard it before, but there's this thing called 'the right way, the wrong way, and the LAPD way'."

Officer Cruz gave us a slow nod. "Sometimes they come together and a lot of the time they don't."

"Is policing the mentally ill a good example of that saying?" I asked.

Officer Rogers gave me another a long look. "I just think sometimes the way our department has to deal with things is not necessarily the way we should be doing things." (Pifer fieldnotes). On the surface, Officer Rogers' cryptic comment embodied the frustration he had

described earlier in navigating the boundary between an arrest and a hold when he encountered a mentally ill his version of Nick's grandma armed with a knife and altered by dementia. However, it also foreshadowed a more fundamental critique of the MEU and the very project of policing the mentally ill that would emerge more clearly during the promised "heated" discussion of Legal Issues.

After lunch, Officer Cruz, the MEU officer tasked with leading the MHIT's Legal Issues section looped in a MEU detective with more than a decade of experience in the unit to adjudicate whether the MEU's Triage Desk had given Officer Rogers the "right" advice to book on the criminal threat. "Ultimately, the decision is not MEU's," the Detective began.

> Are we there in your back pocket? No. Can we see everything you see? No. We're inside and you're outside. . . . If you're calling for advice on the phone and we're not sending a team out there, ultimately, it's your investigation and you own it. Ultimately, the discretion of the management of that body is the responsibility of that area's watch commander. I would say take the time to read the Special Order No. 6 because it's really straightforward about the process when it comes to booking versus an application (Pifer fieldnotes).

LAPD Police Chief Charlie Beck issued Special Order No. 6 on March 16, 2016 to revise parts of the Department Manual section applicable to persons with mental illness. The MEU Detective was presumably referencing § 260.20, which delineates LAPD's protocol for "Taking Persons with Mental Illness into Custody," and makes clear when a subject is a suspect in or has a warrant for either a felony or high-grade misdemeanor crime, the "criminal matters shall take precedence." If the subject meets the WIC § 5105's criteria, but is under arrest for a low-grade misdemeanor, misdemeanor warrant, or infraction, then the decision to book or not is at the Area watch commander's discretion. Yet, the criminal threat at the heart of Officer Roger's example is a so-called "wobbler" under California Penal Code, which means that a prosecutor can file it as either a misdemeanor or felony.

Officer Rogers pointed this out to the Detective, who took the wrinkle in stride and explained, “It’s about risk management—how can you best manage that call. There is no one size fits all. And if you have a disagreement with the officer on the phone at MEU, talk to the watch commander. Talk it out and we’ll figure out the best way to manage the situation” (Pifer fieldnotes).

The group tossed out several other examples of calls that patrol had encountered in the field where the line between an arrest and a hold was ambiguous. In each, the dialogue between the MEU members and the patrol officer ended with the same response: officers in the field should always work to find the best way to manage the call, but there is no standard answer because, as the MEU Detective put it, both systems—the criminal justice and mental health systems, are “fragmented. We [the police] are just a small part of a bigger system, a bigger problem . . .” (Pifer, fieldnotes) Eager to get back to his agenda, the MEU officer facilitating the MHIT’s Legal Issues unit ended the freestyle session with one last aside. “As cops, we get crapped on, right? We gotta (sic) handle all these calls we’re not trained to handle, or best equipped to handle, but you gotta (sic) do it anyways. That’s why we’re here [at the MHIT]” (Pifer fieldnotes).

The extended exchange highlights the slippage between the formal law and policies the MEU uses to advise officers as to whether an encounter should be disposed of through an arrest or a hold and the everyday contradictions that patrol officers experience in policing the mentally ill. On the ground, patrol officers encounter grandmas who need help, not criminal justice, and grapple with moments of discretion that can affect whether a person with a mental illness ends up in jail or at an emergency psychiatric facility on a hold. This disconnect manifests quite literally in the physical space between the MEU’s “inside cops” advising over the telephone from

LAPD's headquarters in downtown and patrol's "outside cops" on the ground all over the city. More symbolically, though, this space reveals the meaning of policing the mentally ill as an exercise ultimately in management through which both inside and outside cops navigate a blurred boundary between care and control on the frontlines of transinstitutionalization.

Discussion & Implications

The criminal justice system has, in the vacuum left in deinstitutionalization's wake, inherited responsibility for the nation's institutionalized mentally ill. Under the transinstitutionalization thesis, prisons and jails have become the new asylums and police function as the gatekeepers to both the criminal justice and mental health systems. Yet, police struggle to serve as "streetcorner psychiatrists" (Teplin and Pruett 1992) and, over time and often in reaction to civil rights scandals, law enforcement agencies have developed specialized strategies to ostensibly better police the mentally ill. In Los Angeles, the LAPD has developed a co-response model partnering cops and clinicians in a single unit. The MEU is considered on "the national forefront of this important policing issue" (Office of the Independent Monitor of the Los Angeles Police Department 2009) and other agencies eager to replicate LAPD's approach work with the MEU's Training Unit (S. O'Neill 2015).

Yet, despite the praise the MEU has received for diverting the mentally ill from arrest to treatment and saving patrol officers time in the field, the unit primarily provides a secondary response to mental health crises. Departmental policy mandates that officers contact the MEU's Triage Desk in LAPD's downtown headquarters building whenever they encounter someone who may be mentally ill. The Triage Desk will provide field officers with guidance and perhaps dispatch a SMART unit if it is appropriate—and if one is available—to relieve patrol officers from disposing of the call. As a result, patrol officers—the outside cops to the MEU's inside

cops—serve as the primary responders to mental health crises and, in this chapter, I have used their perspectives to reveal the everyday experience of and contradictions in policing the mentally ill on the frontlines of transinstitutionalization.

Patrol officers may be resigned to their role, but they are reluctant gatekeepers to the mental health system and their frustrations implicate a tension about the meaning of policing in the wake of transinstitutionalization that threads throughout my analysis. At times, this emerged in the data as explicit as, for example, when officers reflected on their relationship to institutions like Angels Landing that house individuals with mental illness but fail to hire staff equipped to manage a mental health crisis or when MEU members acknowledged that police must perform their role within a larger, broken system. More subtly though, this tension also percolated in the background as officers navigated the decision to dispose a call through a WIC §5150 hold or though arrest. Patrol officers quite literally navigate the boundary between care and control when they decide whether to open the gate to the criminal justice or mental health systems to dispose any given call, yet this decision is ultimately driven by criminal justice logics.

There are perhaps pragmatic refinements to LAPD's model for policing the mentally ill and to the training it provides it officers on mental illness that would affect a more even balance between care and control. Perhaps, for example, the MEU's "inside cops" could spend more time outside in the field where their expertise would be better able to adjudicate calls that skirt the boundary between care and control, between a hold and an arrest. However, police are ultimately agents of the criminal justice system and, when a subject is eligible for a WIC §5150 hold and for a felony arrest, even the MEU must defer to the penal code. Officers may intuitively understand that these two conditions may exist simultaneously and even signal frustration with the dominance of the penal code in disposing of calls but, ultimately, the very arrangement of

embedding care within the criminal justice system renders these states competing rather than coexisting. If the LAPD is indeed on the cutting edge of "better" policing the mentally ill by pairing cops and clinicians, then even this model approach reveals the pitfalls of leaving the police on the frontlines of this social problem.

More broadly, this analysis problematizes the larger systems in which officers police the mentally ill. Officers respond to residential facilities, schools, and private homes to manage the mentally ill because staff and family members are unable or unwilling to do so themselves and they have no one else to call but the police. In cases where the police are able to use their toolkit of formal interventions, officers decide to dispose of these calls through one of two competing mechanism—arrests or holds—yet neither option affects a meaningful solution to the social problem of managing the mentally ill. Even when police dispose of these calls through a hold, ostensibly achieving the MEU's stated policy goal of diverting the mentally ill from arrest to treatment, individuals may cycle through emergency psychiatric facilities in a loop that mirrors the very cycle of arrest and incarceration the MEU is designed to thwart. Other times, these calls involve someone who is experiencing an active and acute mental health crisis and officers arrive to a scene that is, almost by definition, already escalated and ripe for the use of force as a means to secure the scene as officers are trained to do. Sergeant Sosa's account of Angels Landing and David's shooting is, in this context, a tragic but almost inevitable outcome to a series of missed opportunities to provide David with meaningful help.

David's story encapsulates the stakes of leaving the criminal justice system to manage the mentally ill and the costs of focusing reform efforts on tinkering with the edges of specialized policing strategies designed to "better" police the mentally ill. Refining the model is, of course, a pragmatic solution that recognizes the reality that the police are indeed on the frontlines of this

social problem, but, to truly better care for the mentally ill, the policy conversation must expand its scope beyond the confines of criminal justice. Police contextualize their place on the frontlines as part of a larger, dysfunctional network of institutions that are failing the mentally ill—so too should the reform agenda.

4. Conclusion

On a hot August day in the Los Angeles San Fernando Valley, I joined a small group of Los Angeles Police Department (LAPD) officers for a foot patrol. A phalanx of cars rolled out at 1000 hours and soon parked on the shoulder of Sepulveda Boulevard, a main artery that threads alongside the 405 Freeway that runs North-South through Southern California. We hopped over the guardrail separating the shoulder's edge from the wooded expanse snaking between Sepulveda Boulevard and the 405 and began knocking on doors—or rather, on tent flaps, tarps, propped-up scrap materials, and even one elaborate tree house door.

That Wednesday, the Homeless Outreach Partnership Endeavor (HOPE) Team was making the rounds to visit those living in homeless encampments in the Sepulveda Basin area. At the 0900 roll call, HOPE's sergeant had reminded the team that they were in the prime window to engage with Sepulveda Basin residents with the goal of connecting people with services and relocating them in advance of a planned inter-agency clear-out of the area. "There are some 7000 homeless over a 26-square mile area. We are responsible for actively engaging them before enforcement," the sergeant said (Pifer fieldnotes). The HOPE team anticipated that sometime in the next thirty to sixty days, a clean-up crew would descend on the area, which is federal land leased by the city of Los Angeles, to clear debris—and people—from the flood plain, effectively ending the window for engagement. During the cleanup, HOPE officers would provide security for the crews and enforcement against those individuals who remained in the encampments, but that Wednesday, the team was focused on service and outreach.

For some three hours, I walked along with ten LAPD officers, two sergeants, and two members of the Los Angeles Homeless Services Authority's emergency response team through encampments winding along a small creek running between Sepulveda Boulevard and the 405

and then in a dusty portion of the flood plain that surrounds the Sepulveda Dam and the Los Angeles River. The team contacted a handful of people who were at home in the encampments, reminding them that the cleanup was coming, explaining available services, and warning that arrest for trespass was imminent. During the day's last contact, I watched as two HOPE officers talked with a pregnant woman they recognized. That morning was in fact her third HOPE contact and, when officers asked why she was still living in the Basin, she reminded them that she had gotten kicked out of the shelter she had been staying at because of her pregnancy. The officers had already heard her story, though, and told her that they would arrest her on the fourth contact. "You're going to force my hand," one officer said as the threat of arrest for trespass loomed in the dusty air (Pifer fieldnotes). She shrugged and turned to go back inside the tent.

HOPE debuted in the LAPD's Valley Bureau as a pilot program in May 2016, just a few months before I joined them in August, and one month before LAPD Police Chief Charlie Beck issued a new special order directing officers to show "empathy and compassion" to homeless people and to offer information about housing, medical, or psychological services—and to respect people's right to refuse help (Mather 2016). The order also reminds officers that people who are homeless may also have mental health or medical conditions that affect their ability to communicate. By fall 2016, HOPE had expanded citywide and, today, a HOPE team operates in each of the LAPD's four Bureaus with the goal of identifying homeless encampments in the area and getting people into permanent housing (Walton 2016). LAPD has dedicated ten officers and a sergeant to each HOPE team, each of which are connected to the city's Sanitation Department, the mayor's office, the city's attorney office, and the Los Angeles Homeless Services Authority.

My contacts at LAPD recommended that I observe the HOPE team as part of my research on policing the mentally ill in order to maximize the utility of my time in the field. LAPD'

culture has embraced the trope of "the homeless mentally ill" (Ben-Moshe 2017) and my contacts encouraged me to conduct observation in areas with a high density of unsheltered individuals if I wanted to understand the reality of mental illness from LAPD's perspective. As a result, my fieldwork includes time spent with specialized units that are, like HOPE and the Resources Enhancement Services Enforcement Team (RESET) that operates in Skid Row, focused explicitly on policing the homeless. [10] I conceptualize HOPE and RESET as variations on the specialized justice model I have identified in this dissertation in that they also hybridize care and control to "better" police yet another social problem: homelessness. Homelessness is not the social problem I focus on in this project, but I include this vignette from my time among the tent cities of the Sepulveda Basin because I think specialized justice offers a new lens through which to understand the meaning of novel criminal justice strategies like HOPE.

This hybridization manifested as similarly explicit during my fieldwork with HOPE. Where the MEU imported mental health clinicians from the county Department of Mental Health to better police the mentally ill, the HOPE team deployed two emergency social workers from the county's Homeless Services Authority to better police the unsheltered. Yet, even as the HOPE team patrolled the tent communities of the Sepulveda Basin with the explicit mission to deliver service and outreach, the subduction of care by control continued to unfold. Arrest awaited the pregnant woman should the HOPE officers find her still living in the Basin during their next engagement patrol just as arrest awaited everyone still in the Basin by the clean-up deadline. As a specialized justice strategy, HOPE may offer care, but it will ultimately leverage control to solve the problem of homelessness.

This dissertation has focused on the Mental Evaluation Unit (MEU) and the Consolidated Correctional Treatment Facility (CCTF) to provide an in-depth account of how specialized

justice reforms are developed and deployed as an ostensible solution to the criminal justice system's mismanagement of the mentally ill. At the outset, understanding this emergent form of criminal justice reform requires that we rethink transinstitutionalization's meaning for the system. Over the last four decades, an interdisciplinary literature has both traced how the prisons and police arrived on the frontlines of managing the nation's institutionalized mentally ill (Gilligan 2001; Teplin and Pruett 1992) and documented the fundamental flaws in their treatment of this vulnerable population (Haney 2006; Kupers 1999; Reiter and Blair 2015; Rhodes 2004; Simon 2014; Teplin 1984). These accounts of the criminal justice system's failures in transinstitutionalization's wake tend to focus on the necessity of reform, but they do not interrogate the consequences for criminal justice development.

My analysis here has made the pivot from explaining why jails and prisons fail as the new asylums and police make for poor streetcorner psychiatrists to instead consider how criminal justice policy and practice has evolved in reaction to those realities. I have begun this examination by first tracing two criminal justice reforms that unfolded against the background of federal legal intervention alleging that the system's status quo approach to policing and incarcerating the mentally ill constituted a civil rights violation. This analysis described how the MEU and the CCTF emerged as policy solutions designed to "better" police and incarcerate the mentally ill—and to address constitutional deficiencies as mandated by the Department of Justice—and argued that these represent a unique form of criminal justice strategy that I have termed "specialized justice."

The rise of specialized justice has consequences for the arc of transinstitutionalization and for the criminal justice system. Over the last 200 years, the task of managing the mentally ill has swung pendulum-like from the post-colonial jails and almshouses to the asylums of post-

Civil War America and back again to the modern criminal justice system; recently, there have been calls to "bring back the asylum" (Sisti et al. 2015). Yet, I have argued that specialized justice signals the entrenchment of the task within the criminal justice system in both symbolic and literal terms. On one hand, the specialized function of the MEU and CCTF reflects a shift in the meaning of the criminal justice system's relationship to managing the mentally ill from a de facto one inherited from the collapse of the asylums to an explicit one. And, on the other hand, the physical construction of new criminal justice infrastructure quite literally embeds the management of the mentally ill within the system. Together, specialized justice replaces de facto approaches to managing the mentally ill and locates tailored strategies firmly within the purview of the criminal justice system. These processes are explicit—for example, tearing down Men's Central Jail to build the CCTF and locating the MEU in the LAPD's headquarters—but also unfold through the more subtle mechanisms that I have traced in this dissertation's later chapters.

I have also argued that these reforms have sought to transform the substance of the criminal justice system's relationship to managing the mentally ill by hybridizing care and control to produce a specialized piece of criminal justice infrastructure. The MEU pairs police with clinicians to respond to mental health crises while the CCTF is designed for the "Patient-Inmate" and these hybridized models promise to better police and incarcerate the mentally ill—and to address the mandates set forth by federal consent decrees. In this sense, the logic of hybridizing care and control serves to legally legitimize and further entrench the criminal justice system's claim on managing the mentally ill.

Against this backdrop, I have also examined how one of these specialized justice reforms—the LAPD's MEU—functions in practice and, as it turns out, the meaning of specialized justice for reforming the system's management of the mentally ill turns on the

nuances of implementation. My analysis here builds on a long tradition of scholarship focused on the proverbial gap between law and practice (Gould and Barclay 2013) and is focused on how patrol officers, as the frontline workers tasked with calling the MEU's Triage Desk whenever they encounter a person with mental illness in the field, construct the category of "the mentally ill" and navigate the task of policing the mentally ill. Both processes reveal that specialized justice, though hybridized, is ultimately driven by criminal justice logics.

At the outset, patrol officers refer less to Welfare and Institutions (WIC) Code § 5150's prongs and more to external factors like the power of place and the pressure of time to filter individuals in and out of the category of mental illness and, by extension, when to contact the MEU. And, when officers do deploy the MEU's specialized strategies, they must navigate the boundary between arrest and applying for a 5150 hold in a system that privileges the penal code over the welfare and institutions code. These realities demonstrate that both when and how specialized justice is deployed to manage the mentally ill depends less on care and more on control. Indeed, the very configuration of MEU's co-deployed SMART teams makes this imbalance explicit: police are in the driver's seat while clinicians ride shotgun into the field. Ultimately, specialized justice may purport to deliver care to the mentally ill, but its delivery is embedded both physically and symbolically within the criminal justice system and driven by its logics. Even hybridized, specialized justice remains, at its core, a criminal justice endeavor.

This implicates an inherent critique underlying the project of specialized justice: are these reforms just refining a fundamentally flawed arrangement? The MEU and the CCTF may represent an improvement over Los Angeles' pre-consent decree practices of policing and incarcerating the mentally ill, and perhaps even the criminal justice system's most evolved approach to managing the mentally ill, yet these reforms re-entrench rather than reimagine the

criminal justice system's role in remediating this social problem. My empirical analysis of how specialized justice unfolds on the ground is limited to the MEU because the CCTF has not yet been built, but it is easy to imagine how the inherent tension between care and control that I have identified in policing the mentally ill through specialized justice might arise in the context of incarceration. How will inmates be filtered in and out of the CCTF to and from other jail facilities? How will frontline workers navigate the line between patient and inmate, between care and control, that is inherent to the CCTF? How will care unfold in this specialized jail?

These questions are critical because specialized justice reforms fail to interrogate the implicit assumption that the criminal justice system should remain on the frontlines of managing the mentally ill. My analysis of how frontline workers deploy and navigate specialized justice in the context of policing the mentally ill in Los Angeles highlights how the nuances of implementation emphasize control at the expense of care and, while refinements are possible, the project also implicates a larger turn of criminal justice. Punishment and social control literature has traced the thinning of the welfare state and the expansion of the carceral state (Garland 2001) through the lens of mass incarceration. This literature has, for example, traced the reach of the carceral state to new sites traditionally beyond its reach. Beckett and Murakawa (2012), for example, map the progress of the "shadow carceral state" by tracing blended civil, criminal, and administrative pathways to sites including, but not limited to, immigrant detention and the incarceration of debtors through civil contempt. I think these examples reflect not only the expansion of the criminal justice system through increasingly punitive policies and practices that travel through increasingly varied pathways, but also an increasingly firm criminal justice grip on social problems far beyond crime that warrants confrontation. This confrontation matters

because if the carceral state continues to expand in size and in reach, it risks eclipsing and foreclosing alternative pathways to responding to social problems.

This dissertation has focused on managing the mentally ill in Los Angeles, but the case study offers a useful lens to identify and make sense of other initiatives designed to manage social problems through criminal justice. Forrest Stuart (2016), for example writes about LAPD's Safer Cities Initiative as an example of "therapeutic policing" that is designed to manage the urban poor in Skid Row and my own fieldwork with the LAPD's HOPE team and RESET unit suggests the spread of specialized justice as a mechanism to manage the homeless. Like the MEU, these initiatives purport to better police a marginalized group through specialized justice strategies but, also like the MEU, they legitimize the propriety of tasking the police with "solving" the social problem of poverty or homelessness. Specialized justice may promise to manage these tasks better, but real reform requires questioning the very place of the police and prisons in these policy spheres in the first place and engaging with alternative approaches.

Notes

[1] As I discuss throughout this dissertation, there is good reason to believe that LAPD's count does not capture the universe of officer interactions with the mentally ill.

[2] LAPD further subdivides each Bureaus into several Policing Areas. However, I do not reveal the specific Policing Areas in which I participated in ride alongs in order to preserve the anonymity of my subjects. Instead, I identify my fieldsites by their general location in the city of Los Angeles.

[3] I asked permission to take notes at the outset of each ride along and each field encounter with an officer. Permission was always granted.

[4] The LAPD's Central Bureau includes Skid Row—an area home to the country's largest unsheltered population. For an account of this area, see Stuart, *Down, Out, and Under Arrest.*

[5] SMART units are not based in a single LAPD Policing Division; instead they have citywide jurisdiction.

[6] On the key changes in the state laws affecting correctional populations, see Austin "Regulating California's Prison Population.

[7] For example, on a ride along in South Los Angeles, we responded to an afternoon request for a supervisor on a call for service placed by a mother worried that her adult son was becoming violent because he was refusing to take his anti-psychotic medications. The incident log displayed not only the standard reminder to contact the MEU, but also the son's specific diagnosis. Patrol did not contact the MEU, despite having explicit information that this call did indeed involve someone with a mental illness, because the officers determined that this incident did not require any police action.

[8] Under the Individuals with Disabilities Education Act, public schools are required to provide students with one of thirteen qualifying conditions a "free and appropriate education."

[9] I did not systemically collect demographic data and personal characteristics, such as race and demeanor, from the subjects of the police interactions I observed in accordance with my university internal review board agreement.

[10] RESET replaced the LAPD's Safer Cities Initiative in Fall 2015. Despite claims to the contrary (e.g. Flanagan 2015), my fieldwork with RESET suggests the name change was largely a symbolic decision in the wake of the shooting of Brother Africa. For an ethnographic account of the Safer Cities Initiative, see Stuart, *Down, Out, and Under Arrest*.

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Appendix 1: Map of Los Angeles Police Department Bureaus and Areas