PREFACE

In 2015, I spent a year in France researching the mental health system there for my PhD dissertation at the University of California, Berkeley. I arrived during a dramatic rise in involuntary psychiatric hospitalizations (also known as civil commitments) that commentators saw as a symptom of a fracturing society and withering social safety net. The increasing frequency with which citizens' civil rights were being restricted in the name of their mental health provoked parliamentary inquiries and was treated as Exhibit A for a public psychiatric system in deep crisis.[1]

I returned to the United States wondering if the story was the same back home. Anecdotally, I heard that rates of involuntary hospitalization were increasing, but I could not find even the most basic data on the frequency of forced treatment in the United States or in New York, where I was living. In fact, I was discouraged from even looking. I spoke to a prominent academic psychiatrist who told me, no doubt concerned about my future prospects as a researcher, that "in the 1970s, civil commitments were a hot topic, and that spawned a large number of studies. . . . [But] we're on to new questions now." He was right. For decades, planning and oversight for the American mental health care system have treated involuntary hospitalization as an afterthought.

Despite having been warned away from the subject, I began conducting observations in courtrooms tucked away in psychiatric hospitals in New York City. There, people who had been hospitalized against their will requested to be released by a judge. I quickly realized that, unremarked though it may be, hospitalization remains the backbone of our response to the most serious mental illnesses. I saw people who had been hospitalized and discharged more than one hundred times. Others had been institutionalized for decades. Our mental health system spends more on psychiatric hospitals than it does for clinics or clinicians and about as much as it spends on medications.[2] A majority of people in America's psychiatric hospitals are there involuntarily.[3] As I saw in the courtrooms, many desperately want to get as far away from them as possible.

I returned to California in 2017. After two years' absence, the amalgam of disruptive behavior, drug use, and untreated suffering among unhoused individuals, which had been visible since I first moved to the Bay Area in 2011, seemed to have reached a new level of acuteness. As in France, involuntary treatment was on the agenda; unlike in France, the focus was on increasing its use. Legislators from San Francisco were pushing to ramp up the use of "conservatorships," a legal tool that allows a third party to force someone to take medication and to place them in a locked facility, sometimes for years at a time.

This was happening despite the lack of any real investigation from the legislature or state government into what was happening to the people who were already conserved. A quick internet search revealed that there was almost no recent academic research on conservatorship either. I embarked on a small side project on California's conservatorship system. Still, I feared the topic was too niche to appeal to readers beyond social service professionals or the parents of children tangled up in the system.

Enter Britney Spears. The explosive 2021 revelations of the wide range of abuses the pop star had experienced during a thirteen-year conservatorship in California meant that suddenly I was studying a hot topic. I circulated a draft of some of my findings to advocates working in the policy arena. Their positive response convinced me that there was real hunger for a comprehensive look at the system that many people, up to Governor Gavin Newsom, were talking about expanding and that others, like the Free Britney movement, were trying to tear down. When I told Eric Schwartz, the editor at Columbia University Press, to whom I owed an academic tome comparing the mental health systems in the United States and France, that I wanted to write a more accessible book focused on conservatorship in California specifically, he told me to go for it. So that's how we got here.

In some ways, I have conducted four years of research and hundreds of interviews only to confirm my initial intuitions. Conservatorship is being used to forcibly treat and institutionalize thousands of people per year in California. Yet I find an astonishing lack of government oversight and leadership, which means that the conservatorship system continues to fail the most visibly vulnerable people in the state. This book documents the myriad ways that government has abdicated authority, declining to ensure the accountable and coherent exercise of its own power. This makes coercive treatment haphazard, inconsistent, and rarely successful in transforming an individual's careening trajectory between hospitals, jails, shelters, and the street. More broadly, the book investigates what happens when "hypermarginalized" people become the targets of intervention from a mass of disjointed, privatized, and conflicting institutions of care and control.[4]

Even a long book cannot do everything. For one thing, this book is not an attempt to answer the perennial question of whether involuntary treatment "works." Proponents insist forced care is an indispensable "lifesaving" intervention.[5] Opponents counter that there is "little evidence" that coercion "confer[s] any clinical benefit."[6] The truth seems murkier. Many studies show that people subject to involuntary hospitalization demonstrate improvements in symptoms.[7] A significant minority of them will ultimately tell researchers that their hospitalization was justified.[8] Yet others finds that forced treatment leads to symptoms of post-traumatic stress[9] and increased risk of suicide.[10] There is a wealth of contradictory studies about whether involuntary treatment decreases people's subsequent willingness to engage with the mental health system in the longer term.[11] Yet these studies are plagued with methodological problems, and nearly all of them deal with hospitalizations that last days or weeks. There is almost no recent evidence showing the efficacy of longer-term institutionalization or conservatorship, which is what policy makers are proposing to expand.[12] This book does not seek to resolve this long-running debate. Rather, it shows how abdicated authority makes involuntary care crueler than it needs to be and voluntary services less effective alternatives than they could be.

This book is also not focused on the vitally important question of whether forced treatment is imposed equitably on different social groups. It almost certainly is not. A host of studies document that Black people are more likely to be misdiagnosed with schizophrenia,[13] more likely to be subjected to coercive hospitalization,[14] and more likely to be placed in low-quality facilities,[15] where they are more likely to be forcibly given medication and physically restrained.[16] Britney Spears's stifling conservatorship at the hands of her father reminded us that claims around who is "crazy" have all too frequently reinforced patriarchal domination.[17] And in interviews with LGBTQ people subject to forced hospitalization, I heard multiple times of the failure of the mental health system to ensure the basic dignity that comes from calling a patient by their chosen gender pronouns.

While this book nods to these disparities, it does not center on them. It highlights, instead, inequities that emerge from an underregulated and fragmented system. It reveals how some individuals are abandoned to the streets and others relegated to locked facilities not because of their clinical needs but because of which side of a county's border they live on, whether they see a cop or a clinician when in crisis, and whether they wind up in a private or a public hospital.

Before starting, a final note on terminology. The choice of words to describe the people subject to conservatorships is fraught. On the one hand, some advocates for expanding conservatorships (often parents) have called for relabeling conditions like schizophrenia as "neurobiological disorders." They are taking their cue from some reformers in the National Institute of Mental Health and have won over politicians such as Governor Newsom, who talks about "serious brain illnesses."[18] The assumption is that these labels reduce stigma (no one can be held responsible for their faulty genes or broken mental circuitry). They also imply that medical need should trump civil liberties ("you don't have to have the permission of a judge to treat someone for a brain disease like Alzheimer's," I have often been told).

In this book, I eschew terms like *brain disease* or *neurobiological disorder*. For one thing, they are potentially harmful. Describing people with schizophrenia as having damaged brains actually seems to increase stigma and fear.[19] They are also misleading. I am sympathetic to advocates' attempts to argue that conditions like schizophrenia are as "real" as diabetes or dementia. But the fact that psychiatric treatment can be imposed on people explicitly refusing it also makes conditions like schizophrenia unique in a way that terms like *brain illness* deliberately seek to elide.

On the other end of the spectrum are terms like *consumer*, *survivor*, or *ex-patient*, which are used by people on the receiving end of involuntary care. *Survivor* or *ex-patient* captures some people's lived experience of forced treatment but are rarely used among recipients of mental health services more generally.[20] *Consumer* harkens too much to the privatization of care that this book critiques. I do occasionally join activists and scholars who have reclaimed the otherwise pejorative term *mad* (much as LGBTQ activists have done for *queer*). I also talk about *clients* in clinics, *patients* in hospitals, and *residents* in board-and-care homes because those administrative labels are accurate shorthand for where someone is in the conservatorship system.

In the end, I have largely chosen the most banal route. In this book, I speak of "people living with serious mental illness" to describe individuals who are diagnosed with conditions such as schizophrenia, bipolar disorder, or major depression.[21] Studies have shown that such "person-first" language increases empathy toward those so labeled.[22] That said, this, too, is an imperfect moniker. While 4.5 percent of American adults had a "serious mental illness" in the past year,[23] this book is only about a tiny sliver of them. Even among the 0.4 percent of adults who live with schizophrenia,[24] many reside in the community without ever being considered for conservatorship. This book's focus is on those who have fallen through the cracks of the public mental health system. It offers less attention to those who have been well served and have thrived with its help.

Another drawback of talking about "people living with serious mental illness" is that the label *mentally ill* is precisely what some people subject to forced treatment are contesting. I'm tipping my hand here. As innumerable anthropologists have shown, "massive and lasting disturbances of reason, intellectual, and emotions" are "to be found in all known societies."[25] Whether and how we carve up those experiences into medical diagnoses varies enormously by social and cultural context.[26] Patients are right that these diagnoses are often applied in unfair and unhelpful ways. But the point is that "serious mental illness" captures experiences that are, in an important sense, "real." For some individuals, the suffering these conditions cause can be alleviated by biomedical treatments like pharmaceuticals, though too often our mental health system—and forced treatment in particular—exacerbates it.

Of course, the best option is to talk about people living with mental illnesses as, simply, people. Throughout this book, any person I interviewed who is introduced with a first and last name has given consent for their real name to be used. Other names are pseudonyms. I have let participants choose their preferred level of anonymity, which is why some people are introduced with a precise location and job title while others are referred to in vague terms. It is my hope that all these invaluable contributors to this study, whether or not they agree with my conclusions, find that I have accurately shed light on their experiences and given voice to their perspectives.

CONSERVATORSHIP