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Chronic, Disruptive, or Resistant? Target Ecologies and the Medicalization of Homelessness in California

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ABSTRACT

How do place and social context shape how policymakers construct the targets of state interventions? This paper analyzes recent proposals in California to subject people experiencing homelessness to involuntary psychiatric treatment. Using newspaper articles, legislative hearings, government reports, and interviews, we show how policymakers frame "the homeless mentally ill" in distinctive ways: *Chronic and contained* people who require extended institutionalization, *disruptive and visible* individuals who need a period of forced sobriety, and a *service-resisting and underserved* population whom mental health agencies have overlooked, but who could comply with treatment with a coercive incentive. We argue these constructions reflect how policymakers represent specific *target ecologies*: concentrated but confined homelessness on LA's Skid Row, frequent and expensive use of emergency services in San Francisco's Tenderloin, and expanding homelessness in jurisdictions traditionally reticent to provide care, as in San Diego County. This paper shows the value of disaggregating broad population categories to show how they are differentially problematized, as policymakers seek to gain support and justify intervention in specific places. We also illustrate a broader policy trend of reframing involuntary treatment as a progressive and compassionate response to substance use, homelessness, and urban disorder.

KEYWORDS: mental illness; homelessness; social construction; involuntary treatment; target ecologies.

Public policies in response to homelessness reflect fundamental disagreements about who "the homeless" actually are.[1] Research emphasizing the economic precarity that precedes homelessness suggests the need for expanding the social safety net and affordable housing (Colburn and Aldern 2022; Kushel and Moore 2023). Many cities, on the other hand, have adopted punitive, policing responses, framing people experiencing homelessness (PEH) primarily in terms of disruptive or criminal behavior (Beckett and Herbert 2010; Herring 2019). Alternatively, some policymakers and researchers have defined this population pathologically, linking homelessness to the closure of state psychiatric hospitals (Dear and Wolch 2014; Markowitz 2006) and emphasizing involuntary mental health treatment as a solution.

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[1] Advocates have argued for person-first language that does not reduce people to their diagnosis or housing status. We thus use "people experiencing homelessness" and "people with mental illnesses" in our own discussions. We speak of "the homeless mentally ill" in our results section not as an endorsement, but because these are the terms used by policymakers and reflect how they define this group precisely in terms of their medical and housing characteristics.

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While previous researchers have documented this drive to "medicalize" (Conrad 1992) homelessness, there has been little analysis of how specific approaches to involuntary intervention get inscribed in policy. California is a strategic site for filling this gap. The state is home to half of the nation's unsheltered people (Office of Community Planning and Development 2022) and has, in the last five years, seen a proliferation of policy proposals to address it through expansions of forced psychiatric treatment. Despite a common focus on "the homeless mentally ill," the specific interventions have varied significantly across legislation introduced by policymakers from different parts of the state. We use this to show how distinctive places and contexts shape the medicalization process.

We approach policy debates over involuntary treatment for PEH as an example of what Schneider and Ingram (1993:335) call the "social construction of a target population." Our analysis builds on the observation that public policy is "centrally about classification and differentiation" (Stone 1988:xx): states do not simply target existing groups, but instead construct populations via distinctions between "deserving" and "undeserving" poor or those they deem "criminals" versus merely "deviant" (see, e.g., Barnard 2019; Lara-Millán 2021; Steensland 2006). Both the formal definition of target populations in legislation and less explicit discourses about the content of these categories shape what approaches policymakers view as acceptable and thus who receives the material benefits and burdens of government programs.

In this paper, we compare three of the most prominent pieces of legislation in a wave of bills from 2017 to 2022 that sought to expand various forms of involuntary psychiatric treatment in California. Across all three bills, policymakers spoke of "the homeless mentally ill" who were "dying on the streets," thus constructing them as "deserving" of coercive intervention (see Schneider and Ingram 1993). Nonetheless, in explaining and justifying these policies, policymakers' framings of the bills' target populations varied significantly. We identify three conceptualizations: the *chronic and contained, disruptive and visible,* and *service-resisting and underserved*. These were the basis for three specific interventions: extended institutionalization, forced sobriety, and coercive incentivization of treatment compliance.

These conceptualizations include a spatial dimension, because, as we argue, they embedded their target populations within *target ecologies*: broader social contexts that psychiatric interventions were intended to impact. Scholars have used the notion of "homeless ecologies" to capture the objective characteristics of homelessness in certain areas: the number of PEH, measurable population-level indicators (e.g., mortality rates or overdoses), survival strategies, and service availability (Anderson et al. 2021; Gong 2019; Gowan 2010). Following a realist social constructionism that "arc[s] back towards the materiality lurking behind social constructionist imaginary" (Dello Buono 2015:333), we consider such objective characteristics insofar as they help explain how policymakers *interpret* and *represent* the impact PEH have on specific places, whether via generating citizen complaints or consuming (or refusing) emergency resources. As we show, policymakers emphasized distinctive subsets of this population because they were trying to gain public support for and overcome opposition to proposals targeting three distinctive ecologies: segregated homelessness in Los Angeles' Skid Row, public-disturbing homelessness in San Francisco's Tenderloin, and dispersed homelessness in places such as San Diego County.

This paper builds on studies of framings of mental illness that focus on mass media (Barnard 2022; McGinty et al. 2016; Webster, Rice, and Sud 2020) by adding an analysis of policy discourses. While we do not suggest that policymakers accurately characterized these homeless ecologies, we argue that their portrayals are an important but understudied component of the social construction process. Finally, we provide an in-depth analysis of the proliferation of legislation around forced psychiatric treatment, a response to homelessness that differs from both criminalizing and addressing the underlying social conditions driving homelessness.

This paper begins with a theoretical framework that links the social construction of target populations, medicalization, and homeless ecologies. We then discuss our methodology and provide an overview of policy development around homelessness and involuntary treatment in California. Next we discuss the three policy proposals in turn, followed by a discussion that reflects on the "reaggregation" of these target populations in recent legislation. We conclude by using California to discuss a rise in coercive, medicalized policy responses to homelessness and marginality broadly.

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MEDICALIZING HOMELESSNESS AND THE CONSTRUCTION OF TARGET ECOLOGIES

Sociologists, often drawing on the influential work of Goffman (1986), have long been interested in the "framing" of social problems: the ways in which the media or social movements selectively call attention to specific dimensions of social phenomena, attribute blame, and promote preferred solutions (Saguy and Gruys 2010; Snow et al. 1986). They have paid less attention to the use of frames by agents of the state within the policymaking process (cf. Steensland 2006; Weiss and Zoorob 2021). How do policymakers characterize the people who are the objects of legislation, why do they select some groups over others, and how do these characterizations shape the passage and implementation of policy?

Political scientists Schneider and Ingram (1993:334) approach these questions as aspects of the "social construction of target populations": a process of "cultural characterization... of the persons or groups whose behavior and well-being are affected by public policy." This social construction process is significant, first, because it shapes policy design and passage. Constructions are "normative and evaluative" in their use of "symbolic language, metaphors, and stories" (Schneider and Ingram 1993:334); they thus set the bounds of how many benefits policymakers grant or which burdens they impose (Steensland 2006). The public, in turn, assesses proposals based on narratives of the worthiness of intended beneficiaries (see Polletta 2006).

Second, the social construction of target populations influences subsequent policy implementation. The seemingly pre-existing populations targeted by policy, be they "the mentally ill," "the working poor," or "pregnant women," are internally heterogenous. The actual application of formal government criteria invariably depends on the discretion of bureaucrats on the ground (Barnard 2019; Greenberg 2021; Watkins-Hayes 2009). Social constructions by policymakers send signals about how ambiguous regulations should be operationalized and thus influence "goals, targets, tools, and implementation strategies" (Schneider and Ingram 1993:345; see Norton 2014). A constructivist approach thus highlights that the "who gets what" of politics depends on the definition of "who 'who' is" (Starr 1992:294).

An analysis of this social construction process is crucial given ambiguities in the category of "homelessness" and variation in what a "medicalized" response to it actually entails. "The homeless"—as represented in popular discourse—actually "group[s] many disparate kinds of social problems together" (Eide 2022:ix): families temporarily living in shelters after eviction or domestic violence, single adults whose precarious labor-market position leads them to drift episodically on and off the streets, and chronically homeless individuals with serious mental health and substance use challenges (Lee, Tyler, and Wright 2010). Which "reality" of a target population "comes to dominate public discourse has profound implications for the future of the social problem" (Hilgartner and Bosk 1988:58). For example, differing attributions of deservingness and deviance are likely to exert a "powerful influence on public officials," given "strong pressures for public officials to provide beneficial policy to powerful, positively constructed target populations and to devise punitive, punishment-oriented policy for negatively constructed groups" (Schneider and Ingram 1993:334; see Willison 2021).

Yet, even insofar as policymakers target populations they construct as "mentally ill" or "addicted," the nature of "medicalization"—the process by which non-medical problems are defined and treated as medical ones—can vary significantly (see Conrad 1992). Some ethnographies have identified a pseudo-medicalization of homelessness, whereby people experiencing homelessness are encouraged to attribute their unhoused status to vague psychological difficulties and engage in self-work to address it (Gowan 2010; Lyon-Callo 2000). Other studies have focused on how PEH are pressured to accept supposedly-voluntary psychiatric medication or recovery programs as a condition for shelter (Ricciardelli and Huey 2016; Stuart 2016). Finally, we can see a more overtly coercive medicalization in places like 1980s New York, where the mayor hospitalized unhoused people *en masse* on particularly cold nights (Mathieu 1993). Medical interventions can overlap with efforts to address the social causes of homelessness, but also complement its criminalization. Ethnographic work has shown how medical professionals can join law enforcement or sanitation workers to exclude PEH from certain places and seclude them in less visible ones (Beckett and Herbert 2010; Herring 2014, 2019; Seim 2019). Yet, we still know little about how and why certain approaches to medicalizing homelessness get inscribed into policy.

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In our case, differences between proposals did not reflect fundamentally differing beliefs about where "the homeless" fall on a continuum between positive deservingness or negative deviance, the factor emphasized by Schneider and Ingram (1993). Instead, we argue that explaining this variation requires analyzing how policymakers constructed the distinctive *target ecologies* within which people experiencing homelessness and mental illness were embedded. Previous scholars have discussed "homeless ecologies" in terms of specific population characteristics, physical location in urban space, survival strategies, and patterns of available services and housing (Anderson et al. 2021; Gong 2019; Gowan 2010). These objective conditions—which are, themselves, products of past policy decisions around where to exclude and where to tolerate homeless populations—render specific subgroups of the homeless population particularly "legible" to policymakers (Brayne and Christin 2021; Greenberg 2021).

We are not arguing that proposals are an accurate, functional response to the actual conditions in the key ecologies we emphasize (Los Angeles' Skid Row, San Francisco's Tenderloin, and San Diego County). Instead, our primary focus is the process of how policymakers reframe complaints about PEH from citizens or address the particular pressures they place on local political economies. Policymakers use these constructions to justify their proposals to the public, counter opposition, and cue how clinicians and social service agencies should implement them.

In summary, the distinctive interventions we analyze are not just based on constructions of the target populations' moral worthiness or medical conditions, but on conceptions of how to best mitigate that group's (perceived) impact on their surroundings. These constructions ultimately impacted the possibilities for passage of these proposals. Whether and how these proposals actually achieve their goals is a topic for further research.

METHODS AND DATA

This paper draws on a broader project analyzing the development of involuntary treatment over time in California (Barnard 2023). We began by identifying sixty-nine proposals to reform involuntary treatment introduced in California in the last decade based on a keyword search on the state legislative website. With the help of interviewees, we identified three as the most prominent examples of distinctive approaches to expanding forced treatment. AB 1971, though not ultimately enacted, made it the furthest of several proposals introduced between 2017 to 2022 to reform the criteria for a long-term conservatorship to include someone's inability to attend to their medical needs. SB 1045, passed in 2018, created a new pathway onto conservatorship for people with both substance use disorders and mental illnesses. SB 1338, enacted in 2022, created a new civil court system to compel treatment.

We draw on a variety of data, including hearing transcripts, bill drafts, government reports, and press releases, emphasizing the public pronouncements of legislators, county officials, and regulators (summarized in Table 1).

We used interviews with clinicians, judges, family members, and people with mental illness themselves to provide background on each county's mental health system and homeless ecology. We linked our analysis of the construction of target ecologies to legislative outcomes with interviews with

Table 1. Data Sources

	AB 1971	**SB 1045**	**SB 1338**
Newspaper articles	**46 (majority *Los Angeles Times*)**	**87 (majority *San Francisco Chronicle*)**	**76 (majority *San Diego Union-Tribune*)**
Legislative hearings	7	11	11
Bill Drafts	4	10	10
Press Releases and Letters of Support/Opposition	5	13	21
Interviews	58	45	16

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actors familiar with the policymaking process: seven legislators and staff, twenty-two representatives of professional and advocacy organizations, and eleven officials in county and state mental health departments.

We initially divided up the three cases and open-coded them independently, generating a rough timeline of each bill's development. We then met to discuss the themes we had identified in the characterization of the target population for the three bills. When it became clear that these themes differed, we each returned to the data to identify key information (for example, how policymakers compared bills to one another, or which groups were supporting or opposing them) as well as the prevalence of terms in transcripts that would challenge or confirm the emerging typologies. We developed the concept of *target ecologies* to link contextual factors and variation in these constructions.

POLICY DEVELOPMENT: INVOLUNTARY TREATMENT AND HOMELESSNESS IN CALIFORNIA

California's 1967 Lanterman-Petris-Short (LPS) Act was considered a "revolution" for the new civil rights protections it offered to people with mental illness against involuntary hospitalization (Barnard 2022). Combined with fiscal pressures and the expansion of community mental health care, the Act drove a dramatic reduction of California's state hospital population from a peak of 35,000 in 1955 to fewer than 10,000 by 1970 (Scull 1984). Early accounts of "de-institutionalization" almost never described former state hospital patients as "homeless," emphasizing instead the poor conditions of boarding homes where many landed (Shuit 1972). For their part, contemporaneous reports on Skid Row highlighted alcoholism, not mental illness, as common among its marginally-housed residents (Eide 2022).

As homelessness spiked nationwide in the 1980s, commentators and policymakers began observing high rates of mental illness among PEH, linking this to barriers to forced treatment. For example, in 1982, a feature article in the *LA Times* mused, "Why are there so many mentally ill people on the streets, shambling hopelessly though downtowns when, in an earlier time, they would have been locked up in mental hospitals?" It answered its own question: "mental health policymaking" and, particularly, the "good intentions gone bad" of the LPS Act (Boyarsky 1982). In 1984, the legislature convened hearings to discuss potential reforms. Senator Alan Short—one of the original sponsors of LPS—called for change, lamenting, "A grievous situation faces our state administration, the Legislature. It is the unhappy plight of the homeless mentally ill."[2] Claims that barriers to forced treatment were a major driver of homelessness were ubiquitous among supporters of unsuccessful attempts to reform LPS in 1987 and 2000 (Barnard 2022).

Starting in 2014, a decade-long decline in homelessness in the state reversed. The number of PEH increased 42 percent by 2020 (Office of Community Planning and Development 2021). The number of bills introduced around involuntary care accelerated dramatically from four in 2012 to nineteen in 2022. A lobbyist who had worked on the topic for decades noted, "Mental health legislation has become sexy. Everybody wants a bill [to reform LPS]." A legislative staffer added that the push was particularly visible among "representatives of... the bigger cities in California" who saw medicalization "as a means of simultaneously providing aid... but also as a way of combatting... homelessness that they view as problematic."

Key politicians invested significant political capital in involuntary treatment. In 2020, Governor Gavin Newsom devoted his entire "State of the State" speech to homelessness, declaring that the "thresholds" for forced treatment in the state were "too high and needed to be revisited" in light of the "realities of street homelessness today" (Newsom 2020). Given Democratic super-majorities in the legislature and control of the governorship, the most successful proposals came from self-identified liberal or progressive lawmakers. Scott Wiener, a State Senator from San Francisco, argued that involuntary treatment was a humane alternative to criminalization and that, absent forced intervention, many would wind up in jail or dead: "Allowing someone to deteriorate and die on or streets, allowing someone to sleep in their feces, that's not progressive, that's not compassionate, it's frankly the opposite" (Knight 2019).

[2] Subcommittee on Mental Health. 1984. *Civil Commitment in Mental Health: A Review of the Lanterman-Petris-Short Act.* California State Legislature:5.

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Critics of the legislation argued that coercive medicalization risked crowding out alternative responses to homelessness. A lobbyist from Disability Rights California explained his group's opposition: "Until we get a handle on housing costs that have forced the massive homelessness that we've had, we're not going to find solutions to get people off the street." Debates about medicalization were thus debates about epidemiology: UCSF researcher Margot Kushel cited Federal statistics estimating that only about 20 percent of people experiencing *chronic* homelessness had a severe mental illness, arguing, "This is a very small segment of the population. This [involuntary treatment] is not going to end homelessness" (Wiley 2022a).[3] Politicians and media reporting countered that mental illness and addiction were ubiquitous among PEH (Smith and Oreskes 2019), and, whether or not they caused homelessness, were leading people to refuse housing and services that would get them off the street.

Yet, while a framing of "the homeless mentally ill" as "dying in the street" dominated policy debates, it left ambiguous who, exactly, was dying, from what, and what kind of involuntary intervention would prevent it. As we show in the following sections, the contours of who would be subjected to coercive medicalization differed depending on the specific target ecology policymakers sought to address (see Table 2).

RESULTS: THE CONSTRUCTION OF TARGET POPULATIONS AND ECOLOGIES

AB 1971 and the "Chronic and Contained" of Los Angeles' Skid Row

Under the Lanterman-Petris-Short Act, a person could be placed under a "conservatorship"—a legal arrangement that allows a third party (usually a county official) to order involuntary medication and

Table 2. Legislation, Targets, and Interventions

Legislation	Proposal	Target Population	Key Target Ecology	Key Intervention
AB 1971: Grave Disability	Expanding "grave disability" criteria to include someone's inability to meet their medical needs due to mental illness	*Chronic and Contained:* people who have deteriorated due to a long period without services, to the point where they can no longer consent to services when offered	Skid Row (Los Angeles): concentration of chronic homelessness, rising deaths	Involuntary long-term hospitalization
SB 1045: Housing Conservatorships	New pathway onto conservatorship for people with repeated emergency detentions for substance use and mental illness	*Disruptive and Visible:* people engaged in disruptive behavior attributed to meth; repeat users of emergency services	The Tenderloin (San Francisco): highly visible, centrality of overdoses	Forced sobriety followed by independent housing
SB 1338: CARE Courts	Court-ordered treatment and housing plan for individuals with a schizophrenia-spectrum disorder who are untreated	*Service-Resisting and Underserved:* people who counties have been unable to treat and who are unwilling to accept services, but theoretically could with incentives	Statewide expansion of homelessness, including places with limited-service provision, like San Diego County	Persistent, coercive incentivization towards engagement in outpatient services and housing

[3] U.S. Department of Housing and Urban Development. 2020. *Continuum of Care Homeless Populations and Subpopulations*. files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2020.pdf.

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place a conservatee in a locked facility—if a court found they were "gravely disabled," or "as a result of a mental health disorder... unable to provide for his or her basic personal needs for food, clothing, or shelter."[4] In 2018, Assemblymember Miguel Santiago—having (according to staff) recently seen a report on the number of homeless people dying on the streets—introduced AB 1971, which would create a pilot program in Los Angeles to expand "grave disability" to include, along with these three criteria, an inability to provide for one's "medical treatment."

The bill's key proponents all hailed from Los Angeles, and its contents reflected their focus on Skid Row, located in Santiago's district. Sometimes referred to as the "homeless capital" of the United States, Skid Row concentrates at least 4,400 unhoused individuals in only fifty blocks (Tu 2022). This clustering is by design: in 1976, the city dubbed the area a "containment zone" and pushed homeless services to relocate there (Stuart 2016). Anthony Ruffin, an outreach worker, characterized the chronic abjection of the typical Skid Row resident: "He has been sitting there or laying there for more than a year.... We don't know where he came from. We don't even know if his name is Mr. Murphy. We suspect he came from a psych ward or some type of jail ward" (Morain 2018). An outreach clinician elaborated in an interview with the authors, "There are thousands of people [in LA] who aren't attracting any attention, just clumped in blankets... and if we did a body check on them, there would be sores, heinous medical conditions that aren't being treated."

Supporters of the bill emphasized humanitarian concern for a *chronically* ill population living in squalor and in extreme physical distress. Diane Shinstock, an LA resident with an adult son suffering from schizophrenia and living in Skid Row, testified to the Senate Health Committee, "Would you want your family and everyone else to walk away to allow you to sleep under bushes, dig through dumpsters for food, urinate, defecate, and possibly die on the streets ... ?"[5] Santiago echoed Shinstock's lurid description with his own, "The eyeball stabbed, broken legs... I mean, it is horrific what you see." Assemblymember Laura Friedman, AB 1971's co-author, recounted a recent trip where you could "point out the people that we know will be dead within a year... [not just] because they have health issues and co-morbidity issues, but because of their mental illnesses, they cannot address those needs."[6] Official documents, like the LA County Board of Supervisor's motion supporting reforms to grave disability, emphasized that 800 homeless people had died on the streets in the previous year.[7]

These individuals' chronic distress was doubly *contained*: explicitly by Skid Row's above-mentioned design, and effectively, because, having been left to languish on the street for so long, many developed physical disabilities that kept them in place rather than bouncing between jails, shelters, and hospitals. Proponents of reform also argued they suffered from "anosognosia" (see Gong 2017): a psychotic symptom that rendered them unable to understand their mental illness. This led to what John Sherin, Director of the LA County Department of Mental Health, called a fatal "self-neglect" of medical needs.[8] Opponents of the bill, such as the American Civil Liberties Union (ACLU) or Disability Rights California (DRC), described it as "dangerously expansive at the expense of individuals rights" in a formal opposition letter.[9] Proponents countered that, for individuals so sick as to "not even know what civil rights are," forced treatment was the only "humane" thing to do.[10]

What kind of forced treatment? The bill's authors were hesitant to accept DRC's characterization of the bill as a way to "[bring] individuals back into an institutionalized setting."[11] Yet, others clearly interpreted it this way: LA city councilmember Joe Buscaino embraced the overarching goal of "find[ing] a way to bring back institutionalization" (Curwen 2018). Senator Susan Eggman (D-Stockton), who

[4] California Welfare and Institutions Code 5008(h)1(A). https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=5008.&lawCode=WIC.

[5] Senate Health Committee. June 20, 2018. *Hearing: AB 1971: Mental Health Services*. Hearings were identified through the state legislative website and relevant committees. Some of the following notes refer to hearings which the authors transcribed; others are legislative documents put together for lawmakers (see, for example, note 13).

[6] Senate Judiciary Committee. June 20, 2018. *Hearing: AB 1971: Mental Health Services.*

[7] That number increased to 1988 in the first year of the pandemic. Most deaths were from chronic medical conditions and overdoses; the extent to which mental illness contributed to either is unspecified in the data. County of Los Angeles Public Health. 2022. *Mortality among People Experiencing Homelessness in Los Angeles County*. publichealth.lacounty.gov/chie/reports/.

[8] Senate Judiciary Committee. June 26, 2018. *Hearing: AB 1971: Mental Health Services*.

[9] Disability Rights California. May 9, 2018. "AB 1971: Oppose." disabilityrightsca.org/system/files/file-attachments/AB1971SantiagoMentalHealthInvoluntaryDetentionGravelyDisabledOppose2018May9.pdf.

[10] Senate Judiciary Committee, *Hearing: AB 1971.*

[11] Senate Judiciary Committee, *Hearing: AB 1971.*

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would later co-sponsor CARE Court, similarly explained the bill's revision to grave disability as "expanding categories of how we can institutionalize people."[12] The extreme deprivation of the bill's target population seemed to justify an extensive curtailment of their civil rights via long-term custodial care.

The bill's construction of its target as the chronic and contained of Skid Row ultimately contributed to its failure, in two ways. First, proponents' relentless focus on people who were going without treatment for both mental and physical health challenges implied that reform would impose a new, complex population on treatment providers. The California Hospital Association, for example, lamented that the bill would "place unrealistic and ill-defined expectations on hospitals" and exacerbate already "significant delays" in ERs.[13] A representative of the county Public Guardians, who would serve as conservators, noted that they were "already in triage mode with our current caseload."[14] Unions of public employees opposed the measure.

Second, the bill's ability to meaningfully impact its target ecology—as opposed to saving individual lives—was unclear. In response to critiques, Santiago accepted amendments that specified that a failure to accept needed health care would constitute a "grave disability" only if it would "more likely than not, lead to death within 6 months."[15] A member of Santiago's staff explained that the bill had been envisioned as a major intervention to address homelessness, but at this point, seemed small-scale. Although backed by families of people with mental illness and county supervisors, the bill's humanitarian promise of extracting vulnerable individuals from the "containment zone" of Skid Row never attracted active support of business or neighborhood groups.[16] Senator Henry Stern, in an interview, explained that "it didn't make sense to have a battle with ACLU without some cavalry behind you," which, given the lack of backing from providers or the wider community, they lacked. The sponsors pulled the bill.

That same year, community and business groups vigorously pushed for SB 1045, which sought to constrict rather than expand the use of services by a target population around San Francisco's Tenderloin. This proposal, in contrast, ultimately made it into law.

SB 1045 and the "Disruptive and Visible" in San Francisco's Tenderloin

In 2018, State Senator Scott Wiener declared that San Francisco, too, was in a "midst of a crisis... a life-or-death situation, and it is beyond inhumane to sit back and watch as these people die."[17] He introduced a bill that would create a new pathway onto conservatorship for people "suffer[ing] from chronic homelessness accompanied by severe mental illness [or] drug addiction." Rather than qualifying based on being gravely disabled, the bill would apply to people who were "repeated...or exceptionally frequent use[rs] of emergency services."[18]

SB 1045's design was closely tied to the ecology of San Francisco's Tenderloin District. Unlike the "containment zone" of Skid Row, the Tenderloin has always had a porous (and contested) boundary with the city's adjacent downtown tourist district (Gowan 2010:66). Housed residents became less tolerant of the juxtaposition during the city's tech boom: between 2013 and 2017, complaints related to homelessness to the city's 311 line increased 781 percent—with an overwhelming proportion of them centered on the Tenderloin—even though the total number of unhoused people in the city was static (Herring 2019:778). In interviews, city officials rejected the idea of the Tenderloin as a Skid Row-style space of neglect. One told the authors, "It's a little bit of Sweden and Tijuana. There are encampments everywhere, but you can also find a social worker anywhere you go. We are dripping with services."

From the beginning, advocates for the bill focused on a small group of people whom they portrayed less as chronically ill and more as addicted. In a document prepared for the State Senate, the Office of

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[12] Assembly Floor. May 18, 2018. *Hearing: AB 1971: Mental Health Services.*
[13] Senate Floor Analysis. 2018. *AB 1971: Mental Health Services:*7.
[14] Assembly Health Committee. April 10, 2018. *AB 1971: Mental Health Services*.
[15] California Legislature. *AB 1971: Mental Health Services*. Version 7/3/18 (Amended).
[16] They instead focused on a lawsuit that would eliminate this ecology entirely, by obligating the city and county to move its residents into shelter *en masse* (Oreskes, Reyes, and Smith 2021).
[17] State Senator Scott Wiener. February 1, 2018. "Press Release: Senators Wiener and Stern Announce Bill to Expand Conservatorships." sd11.senate.ca.gov/news/20180201-senators-wiener-and-stern-announce-bill-expand-conservatorships-help-mentally-ill-and.
[18] California Legislature. "SB 1045: Housing Conservatorship." Version: 2/18/18 (Introduced).

Mayor London Breed explained, "The definition of grave disability... does not account for the effects of psychoactive substances." This made the law "insufficient in today's San Francisco in which many... individuals end up cycling in and out of crisis because they are released [from the ER] upon clearance of the substance, usually back into a triggering environment where the substance use starts again."[19] The target population of SB 1045 was dying, but not from untreated medical conditions (as in AB 1971) but as part of a 50 percent increase in overdose deaths in the city from 2010 to 2018.[20]

Addiction was not just causing death among the target population of SB 1045, but driving *disruptive* behavior. As one doctor providing street medicine in the Tenderloin explained, "The narrative is 'we have all these people with mental illness,' but the reality is what people [in the public] are responding to is 'we have all these methamphetamine users who are acting bizarrely and behaviorally highly dysregulated.'" When asked in an interview about how much community pressure his office was receiving about this group, Supervisor Rafael Mandelman replied that it was "constant.... A mixture of fury, sadness, angst, [and] concern" about high-profile homeless people in his district, which abutted the Tenderloin. Supporters such as the city's Travel Association and Hotel Council were concerned with individuals like one woman who "came every day to plant herself outside the front door" of an "upscale salon near Union Square... to strip her clothes off and scratch herself violently" (Knight 2018).

As these cases suggest, individuals' disruptive behaviors were *visible* in both community complaints and the overconsumption of city services. The final criterion for the new conservatorships was a mental illness and substance use disorder that led to eight involuntary "holds" (in which a person is detained and brought to an ER for evaluation) in the previous year. In county supervisor hearings in San Francisco, politicians hammered on the target population's heavy use of ERs, ambulances, and jails. Supervisor Mandelman brought up "nine people who have visited [SF General Hospital's] psychiatric emergency room 168 times in the last four months," noting that "aside from the human cost... there's also a public cost."[21] A spokesperson for the Fire Department evoked a "meth user who has an abscess in his spine and sits in his wheelchair in excrement all day....We had 122 calls to 911 about him in the last year, and in 99 meetings, offered him shelter, assistance activating benefits, and an ID—he refused it all."

The quote highlights how framings of the justifications for SB 1045 differed from those offered for AB 1971. Rather than being incapable of accepting help, the disruptive and visible were, according to Mayor Breed, actively "refusing what we're offering" (Fracassa 2019). As Mandelman concluded, these individuals would get off the "the merry-go-round" of shelters, ERs, and the street only with a "time out" period of "forced sobriety" after which "we can have a conversation... about whether they want treatment." SB 1045 was dubbed a "Housing Conservatorship" program because, according to Senator Wiener's assembly testimony, once the drugs cleared out of their systems, the target population could go into "housing and services, not locked facilities."[22]

This construction shaped the legislation's ultimate trajectory. A "Voluntary Services First" coalition of civil liberties and homeless advocacy groups claimed that placing unhoused people onto conservatorship was unfair, because many could not get housing, drug treatment, or mental health services voluntarily.[23] Senator Wiener countered that for the bill's narrow target population—he stated that "approximately one percent of the homeless population meet[s] the criteria"[24]—this concern was "inaccurate in the extreme... the people most in crisis, we're investing huge resources in them."[25] City officials claimed that conserving these individuals would actually *reduce* the burden on hospitals who were already seeing them. The California Hospital Association (which opposed AB 1971) supported the bill (Wiener 2018). By focusing on the most visible and expensive, Breed argued the bill could contribute to "tak[ing] back the Tenderloin" with only a modest expansion of services. When she

[19] Mayor's Office. January 2019. *Overview of Mental Health Conservatorship.*

[20] Department of Public Health. 2022. *Substance Use Trends in San Francisco Through 2021*: 81.

[21] San Francisco Board of Supervisors. May 1, 2019. *Hearing: SB 1045.*

[22] Assembly Judiciary Committee. June 28, 2018. *Hearing: SB 1045: Conservatorship.*

[23] See, Coalition on Homelessness. 2020. *Stop the Revolving Door: A Street-Level Framework for a New System.* https://www.cohsf.org/wp-content/uploads/2020/11/Stop-the-Revolving-1.pdf.

[24] Assembly Judiciary Committee. June 28, 2018. *Hearing: SB 1045: Conservatorship.*

[25] Senate Judiciary Committee. 2018. *SB 1045: Conservatorship: Chronic Homelessness*:18.

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pledged to create 100 new dual diagnosis mental health-substance use treatment beds, several supervisors who had been withholding support because they feared there were insufficient resources available switched their vote (Thadani 2019). Only one Supervisor of twelve opposed implementation.[26]

This emphasis on a narrow group of people who were generating both complaints and costs fit with how commentators have portrayed acutely-disruptive substance users as a stand in for the broader homeless population (see Shellenberger 2021). Yet, this targeting made it less appealing to policymakers concerned about different ecologies. Los Angeles noted that only about 150 to 180 people in the county would qualify, which made a complex new conservatorship program difficult to justify given the scale of homelessness.[27] San Diego certainly had ultra-high utilizers of emergency services—one clinician described an individual with methamphetamine use disorder who visited an ER 500 times in one year—but, as one state assemblyperson admitted, the county was "so far off from having the services necessary" for expanding conservatorships, even for these individuals (Warth 2018).

The next section turns to a proposal designed to address this problematic: homelessness in places where individuals were not just refusing services, but where counties had failed to serve them.

CARE Courts (SB 1338) and the "Service Resisting and Underserved" of San Diego County

In 2022, Governor Newsom proposed CARE ("Community Assistance Recovery and Empowerment") Courts, which he claimed was a "new and revolutionary" alternative to reforming LPS.[28] Under the law, each county would be obligated to set up a civil court system that could order individuals with untreated psychosis to follow a "care plan" and "housing plan," with the threat of being referred for conservatorship for non-adherence to either.[29]

The centrality of homelessness to CARE Courts was clear from the beginning: "There's no compassion with people with their clothes off defecating and urinating in the middle of the streets, screaming and talking to themselves," Newsom told one journalist, adding, "There's nothing appropriate about a kid and a mom going down the street trying to get to the park being accosted by people who clearly need help" (Knight 2022). Senator Susan Eggman, one of the bill's sponsors, also emphasized the impact of these individuals on the community around them, calling to "step back a little bit and look at the larger public health issue. It's a danger for everybody to be living around needles or have people burrowing under freeways" (Bluth 2023).

The much larger scope of the CARE courts bill vis-à-vis AB 1971 and SB 1045—the administration predicted it would affect 7,000-12,000 people—reflected the scale of Governor Newsom's national political ambitions, which many interviewees assumed would require that he make a visible dent in the homeless population statewide. This meant expanding his initiative beyond Los Angeles and San Francisco. San Diego City Mayor Todd Gloria, one of the bill's earliest and most visible backers, declared, "These people are deathly sick and ill. They are vulnerable. They are not making a choice to be homeless... [But] we've decided that somehow it's OK if they tell us, 'No,' to leave them on the sidewalk. [That's] unacceptable" (Wiley 2022b).

Soon after his statement, San Diego County and city banded together to issue a joint letter in support of CARE Court, making it the first city-county to do so.[30] As the Behavioral Health Director of San Diego explained, the city expected the bill to address homelessness in "downtown retail areas" that presented similar, if less extreme, problems than the Tenderloin. The county, on the other hand, envisioned addressing expanding encampments in "canyons or ravines" in between housing tracts in suburban areas, adding, "It's definitely not just like an urban core problem" (see McCumber 2023).[31]

[26] Supervisor Shamann Walton dissented, arguing that "policies that force individuals" into treatment "tend to affect black people... disproportionately." Half of people with eight involuntary holds were Black. The city is 5 percent Black. Harder & Co. 2022. *Housing Conservatorship*. Sfdph.org/dph/files/.

[27] Department of Mental Health. 2020. *Disrupting the Cycle of Chronic Homelessness*. Los Angeles:9.

[28] Office of Governor Gavin Newsom. September 14, 2022. *Governor Newsom Signs CARE Court Into Law*. https://www.gov.ca.gov/2022/09/14/governor-newsom-signs-care-court-into-law/.

[29] SB 1338: Community Assistance Recovery and Empowerment Court Program, Section 5972. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB1338.

[30] City/County of San Diego. June 7, 2022. "SB 1338 (Umberg/Eggman): Support." Sandiego.gov/sites/default/files/2022.06.07_sb_1338_san_diego_regional_support_final_signed_0.pdf.

[31] A 2022 count placed the number of unsheltered individuals in San Diego County at 8,427, with 57% residing in the city of San Diego and 43% in the surrounding suburban and rural areas. County of San Diego, 2022. "2022 Point-in-Time Data." https://www.rtfhsd.org/wp-content/uploads/2022-San-Diego-Region-FINAL_05192022-1.pdf

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The breadth of support for CARE courts from the mayors of small cities, tourism and business groups, and neighborhood associations reflected expectations of its broad scope.

As with previous bills, legislators argued that these individuals were *service-resistant,* which justified a coercive approach. Dr. Mark Ghaly, California's Secretary of Health and Human Services, described the targeted individuals as "the most at risk, sick Californians... who clearly lack some of the decision making and insight challenges."[32] Yet, this construction of "challenges" also did not present the target population as completely overwhelmed with disruptive addiction, as in SB 1045, or so sick as to be essentially "untreatable" without institutionalization, as in AB 1971. They needed, in effect, a nudge from the courts. As Senator Tom Umberg, a sponsor from Orange County, described, "People are schizophrenic, it doesn't mean that they're absent their faculties at all times. They can agree to a [CARE court] treatment plan... [and] with the assistance of behavioral health professionals... make the right choices."[33]

The design of CARE Courts reflected a targeting of service-resisting individuals who were *underserved* in ecologies like San Diego or Orange County, which had traditionally manifested a "not-in-my-backyard" reticence to providing services. The Governor's explanation of the bill noted that "many of the most impaired and vulnerable individuals remain under or un-served." This could be because they are "so impaired they do not seek out services" but could also stem from a "lack [of] coordination among providers and services" or "little accountability at various levels of the system."[34] Mayor Gloria in San Diego, for example, noted, "We don't know how many people are going to be impacted" by the courts, which "shows how disengaged we have been from this population" (Wilson 2023). The final bill created a mandate not just on individuals to accept treatment, but on counties to provide it: courts could fine local governments up to $1,000 a day for failing to offer the services ordered in a CARE plan.

Targeting all of California, the bill introduced a geographic dimension to the notion of an underserved population. When describing the daily challenge of those families with members experiencing homelessness and mental illness, lawmakers frequently referred to the difficult task of having to "look" and "search" for their loved ones "under bridges" or on "the freeway offramp."[35] Senator Eggman emphasized that this population was no longer clustered in a small number of downtown districts, arguing, "We need to find another way to be able to reach those folks who are so incredibly difficult to reach."[36] The Director of Behavioral Health in Orange County described her concerns with the bill on the same discursive terrain: "The difficulty with CARE is the amount of time I have... 14 days [the time frame for an initial evaluation], I won't even be able to find someone in that amount of time."

This portrayal of the CARE courts' target population as service-resisting and underserved helped the Governor thread a narrow political needle. Civil liberties groups filed suit against the plan, claiming that "court orders... rob unhoused Californians of their autonomy to choose their own mental health treatment and housing and threatens their liberty."[37] But as Mayor Gloria and Nathan Fletcher, chair of the San Diego County Board of Supervisors, explained in a co-authored commentary, CARE Court would not actually allow for forced medication or placement in a locked facility; court-ordered care plans would rather offer "support... to properly manage their mental health and get on a better path" (Gloria and Fletcher 2022).

This targeting elided some of the concerns about the availability of treatment beds that had dogged AB 1971, especially in places like San Diego that had traditionally invested even less in their mental health system. For example, when the association representing directors of county behavioral health departments argued they did not have "the level of funding and housing" for CARE courts to "be successful," Newsom replied he was "exhausted" by that claim, having offered an "unprecedented" $15 billion to localities for housing (Hart 2023). Policymakers asserted that less-intensive housing and

[32] Senate Judiciary Committee. April 27, 2022. *Hearing: SB 1338: CARE Court Program.*

[33] Then There's California (Podcast). February 1, 2023. "California's CARE Courts." Thentherescalifornia.libsyn.com/californias-new-care-court-senator-susan-eggman-senator-tom-umberg.

[34] Assembly Judiciary Committee. 2022. June 21, 2022. *Hearing: SB 1338: CARE Court Program.*

[35] Assembly Judiciary Committee. 2022. June 21, 2022. *Hearing: SB 1338: CARE Court Program.*

[36] Assembly Health Committee. June 16, 2022. *Hearing: SB 1338: CARE Court Program.*

[37] Disability Rights California. January 26, 2023. "Petition for Writ of Mandate": 20. https://www.disabilityrightsca.org/system/files/file-attachments/Care_Court_Writ_Filed.pdf.

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treatment services, combined with court pressure to accept care, could meet the needs of this underserved and service-resistant population, even without more locked facilities.

DISCUSSION AND CONCLUSION

Our focus in this paper has been on disaggregating proposals for involuntary treatment across distinctive homeless ecologies. However, 2023 saw a "re-aggregation" of these target populations with the passage of SB 43, the most significant reform to the Lanterman-Petris-Short Act since 1967. Like AB 1971, SB 43 would expand "grave disability" to include "medical care" (as well as "personal safety").[38] As in SB 1045, it would extend conservatorships to include people with a "severe substance use disorder." And as with CARE Courts, it would mandate a statewide program required of all counties by 2026.

The bill's sponsor, Susan Eggman, frequently evoked a single individual in explaining the need for the legislation: Mark Rippee. A native of Solano County, Rippee was blind, lived with schizo-affective disorder, and had been experiencing homelessness for a decade. He was a "visible and disruptive" ultra-high user of city "services," having been arrested 100 times. He both refused treatment and was "underserved," insofar as Solano repeatedly declined to conserve him, citing a lack of an appropriate locked facility that could meet his needs. And as with "chronic" individuals dying on Skid Row, his neglect of a treatable infection ultimately caused his death. Drawing on her meeting with Rippee before he died, Eggman insisted, "We can't do it all through voluntary care....We need [conservatorship]... so the sickest of people don't fall through the cracks and splatter on the sidewalks" (Curwen 2023).

This re-aggregation reflected ongoing political shifts that have made homelessness "the most pernicious crisis in our midst" (Newsom 2020). Senator Eggman noted that "the consequences [of previous failed reforms]... are middle-class people seeing homeless people on the streets... it's right at their doorway. It has crept into living rooms" (Bathen 2021). In polling, 76 percent of California voters supported expanding involuntary treatment to address homelessness (Wiley and Willon 2022) and all the Mayors of California's thirteen largest cities backed SB 43. The Governor addressed the concerns about resource availability leveled at previous expansions by proposing a $6.4 billion bond to pay for 10,000 new beds, including in locked facilities.

As we have argued, understanding the nature of these proposals to medicalize homelessness requires looking beyond the more "classic" epicenters, like Skid Row, to a wider range of political economies (see Willison 2021). It also entails recognizing important shifts in the justification and politics of these proposals. Past pushes to expand forced treatment have been closely tied to representations of people with mental illness as dangerous (Pescosolido, Manago, and Monahan 2019) and attempts by politicians, such as former President Trump, to divert blame for mass shootings from gun policy onto the mental health system (Carey 2018). Yet the discourse around forced treatment in California—whose state government is under complete Democratic control—has reframed involuntary care as a kind of coercive compassion, necessary to addressing the suffering and self-neglect of the homeless, as well as crime and disorder. Notably, politicians such as Senator Wiener or Governor Newsom have pushed legislation to expand voluntary services and independent housing alongside CARE Courts and conservatorship. Other coastal, Democratic states like New York, Oregon, or Hawaii have considered a similar mix of proposals (Kaufman 2023).

Nonetheless, as scholars of social problems have shown, the "ascendance" of one solution likely means "the decline of... other" potential solutions (Hilgartner and Bosk 1988:61). Research suggests that the most effective response to homelessness is the unconditional provision of affordable housing (often with voluntary mental health services attached, known as "Housing First") (Raven, Niedzwiecki, and Kushel 2020). A narrow focus on insight and illness may crowd out attention to other reasons PEH might refuse to go into crowded shelters or take heavy psychiatric medications (Ricciardelli and Huey 2016). Indeed, an ascendant emphasis on forced treatment is problematic, given that research showing its positive impact on mental health is contested (Morris and Kleinman 2022). Moreover, as civil rights groups repeatedly emphasized, bills expanding forced treatment

[38] SB 43. *Behavioral Health.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB43.

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would "disproportionately place many [Black, Indigenous, and People of Color] Californians under state control.[39] Yet, concerns about the efficacy and unequal impacts of forced treatment were left largely aside in policy discussions.

In addition to its empirical contribution, this paper builds on the broader literature on social construction and framing in the policy process. Our findings fit within a body of scholarship that emphasizes the close relationship between the design of social policy and the classification of the people those policies target (Starr 1992; Stone 1988). On one hand, California policymaker's adoption of coercive interventions seems to conform to expectation that, for "deviant" groups, even nominally "beneficial policies" like "rehabilitation programs... ordinarily attempt to change the person through authoritarian means, rather than attack the basis of the problem itself" (Schneider and Ingram 1993:339). Other work has challenged this depiction, showing an increasingly hands-off form of "palliative governance" or "tolerant containment" towards people defined as homeless and addicted (DiMario 2022; Gong 2019).

Our focus on target *ecologies* alongside target *populations* helps explain variation in these strategies. Scholars have already documented how criminal and regulatory interventions into homelessness (such as sweeps or forced seclusion in encampments) have a spatial dimension (Herring 2014; McCumber 2023), but this paper offers a novel, comparative picture of how medicalized approaches do as well. The failure of AB 1971, for example, reflects how Skid Row's homeless ecology seemed at once contained—limiting the support of community or business groups, who called for a more forceful response in San Francisco's less-segregated Tenderloin neighborhood—and insurmountable in scale given the disjuncture between the size of the population and LA's available treatment beds. Coercive medicalization likely takes distinctive forms in other spaces, such as the use of restraint and seclusion on children with disabilities in schools or solitary confinement for people with mental illness in prisons. Targeting may reflect efforts to mitigate the perceived impact these individuals have on the ecologies in which they are embedded, as much as a moral evaluation of the group itself.

Previous researchers have argued that storytelling in politics often involves transforming a subset of individuals into a "metonym" for an entire population (Polletta 2006). Stories told about the encampments of Skid Row, drug markets of the Tenderloin, or ravines of San Diego have come to stand in for the much more complex reality of homelessness statewide. If California's 1967 Lanterman-Petris-Short Act made it a "trendsetter" in ending the "inappropriate, indefinite, and involuntary commitment of persons with mental health disorders" (Appelbaum 2003:26), it remains to be seen if the state is a bellwether of a national shift towards a more coercive, medicalized approach to homelessness. Whether this takes place will depend, in important part, on how policymakers frame the impact people experiencing homelessness and mental illnesses have on the broader social ecology they inhabit. A more productive question might be to ask about the impact that social ecology—whether a lack of public housing, inaccessible healthcare, or community resistance to providing voluntary substance use treatment—has on them.

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