Futility in the Practice of Community Psychiatry

The experience of futility among frontline clinicians in community psychiatry is produced by the temporal structuring of their work. All health care providers share the disposition to intervene in the course of disease. Specific notions about the course of severe mental illness are woven into the mission of Assertive Community Treatment (ACT) as well as the treatment plan, a key paperwork tool used to stage daily activities. The treatment plan demands a narrative of progress that ACT workers often find impossible to supply. The gap between the ideal of progress and the realities of practice produce distinctive kinds of demoralization. Drawing from an ethnography of a single ACT team in the United States, this article explores how clinicians encounter, articulate, and attempt to resolve such experiences of futility. It explores their practical strategies to reframe the time horizons of work and thereby restore the sense of their own therapeutic power.

This article provides an ethnography of futility among frontline providers in a U.S. community psychiatry agency. The way that they encounter and talk about futility depends fundamentally on the time frames that structure their clinical tasks. Some of the key time frames are implicit in the apparatus of treatment, including specific paperwork requirements. Others emerge from broad notions about the course of severe mental illness. By examining how such elements orchestrate everyday work, this article situates clinicians’ sense of futility within the temporal structures of care.

These temporal structures form the background to clinicians’ efforts to secure the lives of community-dwelling individuals with severely debilitating conditions, chiefly schizophrenia, major depressive disorder, and bipolar disorder. The routine tasks in this line of work are unglamorous, the pace is rushed, and the resources inadequate. The agency staff remains immersed in the short-term horizon of moving clients to the next stage of treatment and managing crises with the symbolic and technical resources at hand. But when the habitual forward motion of work grinds to a halt, people grapple with the baseline temporal structures of their job. They express doubts that their work helps clients improve, or at least not to deteriorate. Such talk reveals the deeper moral contours of clinical work, usually hidden beneath...
everyday routines, and how staff members interpret the mandate to act in therapeutic
time.

The mandate to act has many roots in the work group described here: a ten-person
agency based on the model of Assertive Community Treatment (ACT) and located
in a poor neighborhood in an older industrial city in the United States. According
to biomedical doxa, diseases follow a natural course, and timely interventions can
slow it down, minimize its effects, or restore the prior state of health. Contemporary
biological psychiatry offers several different models of the course of severe mental
illness, and such conceptions combined with the historic mission of ACT (see below)
also shapes the temporal structure of work. In a more visible fashion, the tempo
of action derives from the treatment plan: a crucial piece of paperwork that staff
members must fill out to stage their interventions and measure the outcome. These
various frames—biomedical, psychiatric, organizational, and bureaucratic—exist at
different levels of awareness for frontline providers. The staff members do not need
to recognize or think theoretically about the layered temporal structures to do their
work effectively. Nevertheless, this background helps explain how people articulate
their futility when treatments fail.

The data come from a two-year ethnography of the pseudonymous Eastside
Services, a small agency operating under the basic principles of ACT.1 The nine
social workers and one part-time psychiatrist follow the historic ACT mission
of providing all necessary medical, social work, and psychiatric services to peo-
ple with severe mental illness who have had extensive prior hospitalizations (see
Allness and Knoedler 2003; Stein and Santos 1998). Although all 75 clients of this
agency currently live in community settings (independent apartments and room-
and-board facilities), they would have enormous difficulty obtaining medical and
social services on their own. Without the help of case managers, they would likely
lose their housing and welfare benefits, miss appointments, and not renew or update
their prescriptions for psychiatric medications. Many risk falling into a downward
spiral of worsening symptoms, alcohol and drug abuse, homelessness, and arrest or
incarceration. Case managers spend most of their time conducting home visits where
they deliver medications, watch as people swallow them, and assess symptoms and
side effects. As mandated by the ACT blueprint, case managers also provide (or bro-
ker) other services that increase people’s residential and psychiatric stability. They
help clients plan their budgets, negotiate on their behalf with landlords and police,
drive them to the emergency room, advocate for them to state welfare officials,
and provide informal counseling and supportive psychotherapy. (For further details
about case manager’s daily tasks, see Brodwin 2008 and 2010.)

In the United States, ACT is one of the best known and well-researched models of
outpatient treatment for people with serious mental illness (see Breakey 1996; Dixon
2000; Thompson et al. 1990). It arose as a small experimental program during the
1970s in Madison, Wisconsin, in the wake of the deinstitutionalization movement.
By the mid-1990s, at least 340 ACT teams operated across the country (Deci et al.
1995), and the approach was officially endorsed by the National Alliance for Mental
Illness, the nation’s leading lobby and advocacy group for severe psychiatric disease.
In 1996, the federal Substance Abuse and Mental Health Services Administration
(SAMHSA) proclaimed ACT one of six evidence-based treatments for severe mental
illness (Torrey 2001). Over the past twenty years, ACT services have been introduced
to Australia, England, several European countries, and Japan. Not surprisingly, the
reception to ACT varies considerably because of divergent cultural contexts and national health care policies. The model has rapidly disseminated in certain settings. In 1999, mental health policy in England mandated the provision of “assertive outreach teams,” and five years later there were 263 such programs (Killaspy et al. 2006). Introduced to the Netherlands in 2001, at least 55 teams were soon in operation (Van Dijk et al. 2007). Other settings have seen a mixed or even hostile reception (Burns et al. 2001). The rate of deinstitutionalization, and hence the very development of community psychiatry, differs across national borders. The fragmentation between social welfare and health care services also varies, so the notion of a single point of services does not offer the same marginal value in all countries. Finally, the ideology of psychiatry and the expertise claimed by social workers is culturally specific, and ACT can appear as an elitist U.S. import (Burns et al. 2001).

At one level, international variations in psychiatric case management services limit the applicability of the present ethnographic case. At another level, however, all mental health providers risk experiencing despair when their patients do not improve. Futility among U.S. ACT providers thus reflects both the specific context of this mode of treatment as well as a core disposition of clinical work: the mandate to act in therapeutic time. Although the mandate never appears in a pure form, it always sets in motion the expectation that patients will improve, and hence the challenge to professional self-regard when improvement seems out of reach.

The Mandate to Act and the Moral Logic of Care

Clinical practice has an intrinsically temporal framework, explored from different angles by philosophers and anthropologists of medicine. Early 19th-century French biologists classified the abnormal as distinct from the anomalous in part by the chronological nature of disease. They defined an anomaly as a stable trait, whereas disease interrupts the progress of the individual’s life, splitting it into periods of before and after. An anomaly represents deviation by comparison with other people. We are sick, however, “in relation not only to others but also to our [prior, healthier] selves” (Canguilhem 1989:138). The classic theory of pathology developed by Robert Koch strengthened the chronological framework; it asserted that each disease conforms to fixed laws of development (see Faber 1930; see also Cassell 1991:6–7). That disease follows a natural course has by now become a self-evident and unstated truth of biomedicine. Every intervention aims to substitute improvement for decline, that is, a better outcome (cure, amelioration of symptoms, less disability, less suffering) than would result without treatment. The natural course of disease makes all clinical work a performance in time: continuous and active interventions into a forward-moving pathological process.

Medical training inculcates the mandate to intervene by teaching innumerable recipes for action and making students’ skills embodied and habitual (Good 1995; Muller and Koenig 1988). The pressing and unquestioned goal is to prevent, reverse, or modify the next stage in the disease’s natural course, which is otherwise indifferent to human affairs and individual agency (Gordon 1988). Clinicians sometimes regard the temporal structure of their work as manifestly keyed to the disease’s unfolding trajectory and other times as a more creative “emplotment” that organizes future action (Mattingly 1994). But in all cases, the imperative to intervene in the course
of disease constitutes a core disposition of health care workers that applies equally to high-tech and low-tech settings.

The most recent book-length examination of the logic of care continually circles back to the temporal dimension of clinical work. “What characterizes good care,” writes Annemarie Mol, “is a calm, persistent but forgiving effort to improve the situation of a patient, or to keep this from deteriorating” (Mol 2008:20). The logic of care acknowledges the “fleshiness and fragility of life” (Mol 2008:11) in sickness, disease, and the ambiguous intermediate zone of chronic conditions. In Mol’s analysis, therefore, care is a matter of daily action, of trying, adjusting, and trying again that ends only when the patient dies. The core task of care thus obligates health professionals never to abandon their patients. Simple continued engagement over time fulfills the requirement of care, even if improvement is not possible. (In the consumerist logic of choice, by contrast, clinical work takes place in episodic transactions: selling a product, prescribing a medication, or performing a billable procedure.) Caring relationships demand active, ongoing work by both patients and providers. Patients themselves must creatively manage the twists and turns of their disease and stubbornly strive for improvement. The crucial moral act of care is to engage continually in practical activities and to discover what constitutes “good” or “better” during the real-time trajectory of individual cases of disease (Mol 2008:73ff).

The imperative to act in therapeutic time lies near the center of health care as a moral enterprise, and it forms part of the disposition of frontline clinicians. When treatments seem guaranteed to fail, therefore, clinicians find it hard to do what they were trained to do and hence to live up to their core occupational ethos. They may become demoralized, question their commitment to the job, and complain about futility. The ethnography of futility examines just this sort of impasse. Futility, from this angle, is the clinician’s sense of ineffectiveness or even despair about improving the patient’s situation. But futility is not inherent in the task of treating objectively grave conditions. It is an artifact of people’s orientation to their clinical work as well as the treatment apparatus itself. Futility is produced by the mismatch between one’s professional training and the current opportunities to apply it.

The mismatch recalls Bourdieu’s analysis of the habitus (see Bourdieu 1977, 1996). The mandate to act in therapeutic time is a “lasting, transposable disposition” within individual clinicians: their trained propensity to perceive the world and to act on it in certain ways. Disposition here means an orientation to action that lies, most of the time, below the level of consciousness and language. It operates through automatic gestures and ways of evaluating the social world. Dispositions are created during socialization (of a child in her family, or a student in a formal educational institution). As long as the world that created the habitus does not change, or as long as people do not move to a radically different setting, they experience a harmony between their internalized disposition, built up during their formative years, and the opportunity to express it in the present. Their aspirations and skills (habitual practices of perceiving and acting) seem calibrated to the objective tasks at hand.

Sometimes, however, the pace of social change quickens. People confront conditions that differ in crucial respects from the world of their upbringing or training. The types of strategic action that come most easily to them no longer make sense or have the intended effect. Instead of harmony, people experience a mismatch
between their (internalized) past training and the demands and hard limits of the present situation. Bourdieu labels their impasse as the “hysteresis effect,” a phrase he borrows from physics. Hysteresis refers to the retention of the values of physical materials as their environment changes. The actual properties of a given material (such as magnetism) often lag behind its expected properties, given the current surroundings. Bourdieu discerns a sociological analogue of the hysteresis effect when people’s current categories of judgment and types of strategic action remain calibrated to a prior state of the world (Bourdieu 1996:219). When social structures change, the beliefs and practical strategies of an entire cohort can become anachronistic. Their habitual ways of engaging with the world and pursuing their interests seem fruitless and irrelevant (see King 2000).

Clinicians’ experience of futility recalls the hysteresis effect. Although inspired by Bourdieu’s use of the term, this article pushes his metaphor in a different direction. Bourdieu’s model concerns long-term historical shifts in the social structure, such as class struggles or the change in outlook from one generation to the next. Groups whose characteristic disposition is out of step with current-day opportunities lose out in the contest for power and prestige (Swartz 1997:117ff). The ethnography of medical futility unfolds on a more microscopic scale. It concerns the mismatch between the disposition of frontline clinicians and their possibilities for action in the present. The stakes for clinicians involve not power and prestige, but professional self-regard and the immediate sense that they are doing worthwhile work. History also plays a different role in the study of futility among U.S. community psychiatry providers. The mismatch occurs here not because of long-term historical shifts, but because of contradictions woven into the mission and apparatus of this treatment mode from the very beginning.

Bourdieu’s metaphor is compelling for the ethnography of futility because it highlights the bewilderment and frustration of people who cannot operate in the social world as their disposition would direct them. People feel unmoored when their tacit presumptions and practical training do not fit the available paths of action. At the scene of work—where the ethnography of futility properly begins—clinicians’ trained tendency to improve clients’ lives runs up against numerous obstacles, some of which are inherent in this very mode of treatment. Their sense of therapeutic confidence or futility hangs in the balance.

**Treatment Planning: A Mandatory Story of Progress**

The following ethnographic vignettes from an ACT agency explore how clinicians encounter, articulate, and attempt to resolve the blockages in their work. Estroff (1981) laid out the model’s core contradictions for the lives of clients, but the vignettes below focus on how clinicians negotiate the recurring difficulties of their job: in particular, how they respond when pushed to endorse the narrative of progress, even as they watch their treatments fail. The staff at Eastside Services meet in a cramped conference room every morning at 8:00 AM, where they bring into focus a handful of clients and make decisions about them through ad hoc discussions as well as standardized routines (writing treatment plans, reviewing medications, filling out symptom checklists, etc.). These staff meetings function like morning rounds in a hospital ward. People provide updates on clients who have recently required more
than the usual amount of attention: people whose troubles, in a sense, the entire team is following. However wide ranging the discussions, clinicians aim in the end for few concrete steps that push the client in the desired direction of fewer symptoms and more stable community living.

Treatment planning is a key activity of these staff meetings, mandated by the formal ACT model and carried out at Eastside Services at least twice a week. The treatment plan itself is a paperwork technology that people use to orchestrate their core clinical activities. To write the plan, the staff must assemble background knowledge about clients, identify their present problems, and then map out their future treatment. The manual by Allness and Knoedler (2003:44, 77–96) provides a template that Eastside Services tries to follow, and in this textbook ideal, all the components of the plan fit together as a seamless whole, each one justifying and paving the way for the next. The client’s diagnosis and main problems logically generate the goals of treatment and then the specific plan of work to accomplish each goal.

Allness and Knoedler illustrates how to operate this paperwork technology with the case of the pseudonymous Laura Michaels: a married 31-year-old mother of two, with previous hospitalizations for suicide attempts and psychotic depression. The textbook plan diagnoses her with Schizoaffective Disorder and formulates her three problems: a recent suicide attempt related to persistent psychotic problems, health problems including anemia and weight loss, and the inability to perform childcare activities. This exemplary treatment plan, like the real ones prepared at Eastside Services, is written in the two legitimated discourses of ACT; psychiatry and social work. Even the opening diagnostic narrative transforms Laura Michaels into a client, an object of work whose needs fit the expertise built into the ACT model. The plan exemplifies the disciplinary writing characteristic of many modern institutions (see Foucault 1979:190ff). It locates an individual in the categorical schemes and vocabulary endorsed by a specific professional cadre. It describes her as a recognizable case, and it documents her features in ways that enable clinical action in the future. She is, in other words, disciplined according to professional norms and set on the mandatory path toward better health and independence.

In the next step, the writer of the treatment plan must connect each problem to specific goals. These goals conform to a standard formula, and they employ certain stock phrases, precise divisions into short-term (three months) and long-term (six months) increments, and quantified benchmarks to measure progress. Laura Michaels’s first problem (suicide attempts) generates the short-term goal to “report any thoughts of suicide (thoughts of overdosing on her medications) and work with staff to set up a plan for intervention (supervised medication) as measured by staff report after each contact.” For her long-term goal, she “will record in a notebook acute psychotic symptoms during the daily support contact and will assess in one-to-one contacts with the social worker and psychiatrist” (Allness and Knoedler 2003:94).

Explicit and concrete goals lay the groundwork for the face-to-face dealings between client and case manager. For each goal, the treatment plan must supply a specific intervention. The list of interventions details who delivers which services and in what setting, and it effectively generates the client’s full seven-day schedule. For example, Laura’s case managers arrange for meetings Monday through Friday at
her house at 9:30 AM “to provide emotional support and assistance with activities of daily living.” Weekly appointments with her psychiatrist serve to “establish a relationship and to provide suicide assessment, symptoms and side-effect education and assessment,” and so on (Allness and Knoedler 2003:94).

This model treatment plan sets the stage for everyday clinical routines and supplies them with an orderly, almost transparent rationale. The client’s diagnosis, problems, goals, and services line up in a single logical chain, each link justifying the next. The plan unfolds according to an intuitive—and intuitively appealing—clinical logic. The suffering in her life gets transformed into a list of discrete problems; each problem is linked to a concrete, attainable goal; and each goal calls for a bundle of visits, relationships, “support,” assessments, medications, and monitoring. To operate the paperwork technology of treatment plans, the staff necessarily plots an arc of ever higher achievements for the client. Every six months, the client supposedly takes two incremental steps to address each problem. Ultimately, the very act of writing treatment plans demands a story of progress.

The treatment plan is a pivot of the ACT model. It marries the generic imperative to intervene common to all clinical work to the specific patient population and mission of ACT. How do front-line staff members put this paperwork technology to use? How does its operation on the ground differ from the textbook instructions? In fact, Eastside clinicians sometimes encounter enormous problems as they draw up treatment plans. The required narrative of progress runs up against multiple obstacles implicating the client, the agency, and the public mental health system as a whole. The staff, however, must avoid admitting defeat. They are forced to conform to the categorical scheme of the treatment plan, hence to supply a narrative of progress for each client. The requirement reflects the particular place of Eastside Services within the U.S. public mental health bureaucracy. Eastside Services depends entirely on public monies, and every two years the state sends an auditor to certify it for continued funding. On his site visits, he combs through the treatment plans and checks to see if the goals are quantified, if they chart a feasible route of progress over time, and if progress notes line up with the goals. Incomplete or disorganized paperwork endangers the continued existence of the agency. The pervasive “audit culture” of public sector health services powerfully affects how people fill out these forms. The clinical and bureaucratic rationales for treatment plans thus both enforce the mandate for a measurable and continual story of improvement.

Routines: The Treatment Plan in Practice

The team as a whole makes the key decisions about problems, goals, and interventions. Much of the time, discussions unfold smoothly. People confidently link the client’s needs to feasible interventions in the future. Nothing blocks the ideal therapeutic trajectory, and the meaning and mission of everyday work seems secure. The process begins with the case manager announcing the clients’ previous problems and goals. It is a dry and telegraphic recitation, filled with insider jargon:

Case manager: Justin’s treatment plan is due next Wednesday. Last time, he had one problem which was psych–voc [combined psychiatric and vocational]. The short-term goal was to complete the initial application at
the Department of Vocational Rehabilitation. That was not met. His long-term goal was to discuss two times with case manager what he likes and dislikes about receiving his IM [intramuscular injection of antipsychotic meds]. That was partially met.

After the short summary, the supervisors usually take over and direct the rest of the discussion. Long or short, simple or convoluted, the team must eventually generate a new list of up to four problems, each with a short- and long-term goal. The problems and goals form the nucleus of the treatment plan. In the vast majority of cases, the ultimate aim is simply for clients to accept more of the team’s recommended interventions. Although most clients entered the program years ago, their engagement (the team’s preferred term) still wavers, and lack of engagement typically means refusal of medication, as in the following exchange:

Case manager: The problem that I'm having with Randall, when I tell him his shot is due, he’s not at his apartment. I have to chase him down.... He’s resistant to getting his shot.... He’s playing the game, “chase after me, and then maybe I don’t have to get the shot.”

Supervisor: You should discuss the pros and cons of his med regimen. What does he like and dislike about it? Because you don’t want to ask just what he dislikes.

CM: He says that when he takes his Risperdol, he likes that he can’t understand what the voices are saying. ...

S: Say for the goal, “discuss what he likes and dislikes about receiving an IM.”

Choosing goals means plotting a series of stepwise changes in clients’ behavior. Sometimes, as with Randall, the goal is quite modest: simply a shared perspective that lays the ground for future attempts at persuasion. The team can also craft more direct and targeted goals:

Case manager: Because Tyrell takes his meds in the evening, I can never see him. Dr. Young is working on him to take the shot, and he’s agreeable.... He’s willing to go on a shot. Dr. Young’s working up to it. He’s getting close.

Supervisor: Make the short-term goal, that Tyrell will be agreeable to a shot.

Make the long-term goal, that he will keep two Young appointments in six months.

The supervisor here pushes the client in the desired direction. Tyrell has already agreed to oral medications, but the team questions whether he takes the full prescribed amount and wants to scrutinize him more closely. Switching from daily oral doses to a biweekly or monthly injection is the standard strategy of adherence in such cases. If James Young, the Eastside Services psychiatrist, administers “the shot,” people know exactly how much medication a client receives, and they can properly adjust their overall approach accordingly. The goals inscribed in Tyrell’s treatment plan move him incrementally toward fewer symptoms and a more stable life.
The routine use of treatment plans show how a simple decision at staff meeting rests on a complex layering of temporal frames. Clinicians do not question the step-wise schemes for more engagement, better adherence to medication, or increased social interaction. Their implicit endorsement of the standard ACT goals is produced on at least three levels. First, they share the fundamental disposition of all clinicians to intervene in the course of disease. Second, they operate inside this particular treatment assemblage, which is a hybrid of social work and outpatient psychiatry. Every conceivable intervention offered by these professions requires a succession of home visits, conversations, office appointments, and other face-to-face encounters. Finally, the treatment plan itself is a paperwork technology that enforces an explicit narrative of progress. Staff members’ disposition to act, inculcated during professional training, seems perfectly adjusted to the general ACT mission and the treatment plan’s specific instructions for use.

Emergencies: The Impossible Narrative of Progress

Mental health treatment plans are banal and generic bureaucratic documents. No matter what the setting, they all resemble each other, and they demand to be used in the same way. Indeed the standardization of treatment plans exemplifies the demand for accountability and the rational use of time and clinical resources that is transforming U.S. health care. The writer must imagine the patient’s future, inscribe it through standard formulae, and on that basis determine the appropriate interventions. At Eastside Services, however, this simple, ready-made procedure often breaks down. At such moments, staff members need to figure out exactly how to use the paperwork technology for the case at hand: how to insert a chaotic life into an orderly storyline that justifies continual intervention. When a client’s life starts to spiral out of control, clinicians become painfully aware of the limits of goal setting, and by extension, their own therapeutic power. The frustration appears in the give and take of staffroom discussions, when the stark limits of clients’ lives collide with the demands for a narrative of improvement.

The case of Matthew Holmes exemplifies the problem. Matthew stands over six feet tall, but when he went on an alcohol and cocaine binge several years ago, he stopped eating and his weight dropped to 85 pounds. The team realized that he faced imminent death, so they stopped the drug use by cutting off his spending money and started to deliver fast food to his apartment twice a day. Matthew eventually recovered and gained back some weight, but two years later the cycle began again. His case manager presented the emerging crisis at a treatment planning session:

When he answered the door yesterday, I didn’t recognize him. I said, Where’s Matthew Holmes? And he said, it’s me. He looked horrible, he was so thin, and he was wearing a t-shirt that made it worse. He had huge bags under his eyes. He was probably doing crack all weekend.

The supervisors proposed two problems (AODA/housing and psych/medical), but the case manager was still stymied:
Case manager: I don’t know a goal for AODA. He won’t go to group. There are always people in his apartment, so we can’t monitor his use. . . . I could talk with him one time a month about his drinking.

Supervisor: What’s our role? It’s so limited with him. You can at least say something to him, or have the landlord come over and tell him he might be evicted.

CM: For psych/medical, he never takes his medications on the weekend. Because his pills are always in the cassette. We are still telephoning him, but it doesn’t work . . .

The discussion dragged on, but the team could not find a way to intervene in Matthew’s downward slide. Moreover, the drinking and drug use made his apartment so dangerous that the supervisor shifted all future contacts to the building lobby. They finally settled on three main goals: that Matthew take his medications five days a week, that he maintain his current housing, and that he agree to being weighed once a month. But by the meeting’s end, the team was frustrated. Capturing the mood, the supervisor sarcastically rephrased the formal goal of medication adherence: “Take these, stay in your housing. Take these, here’s your food. Take these, don’t die.”

Even with their long experience with Matthew and their arsenal of clinical tools, the clinicians had lost control. If they cannot enter his apartment, they cannot monitor his drinking and drug use, and they cannot watch him take medication. Matthew resists all attempts to move him along the standard therapeutic trajectory. Nevertheless, the team must write something in the treatment plan, so people retrenched to the minimal goal of treatment adherence (“Take these . . . ”), pessimistic about their chances of success.

Case managers face essentially the same conundrum for the large group of clients who show no desire to alter their current life situation. Such people are not teetering on the brink of disaster, and they do not especially resist the team’s interventions. But they frustrate all attempts to place them on a trajectory of progress. Alex Moore exemplifies the dilemma. After a psychotic break during graduate school in his mid-twenties, Alex experienced a long period of homelessness before admission to Eastside Services 12 years ago. Since then, he has lived in a dilapidated room-and-board-residence. He spends his days in the same solitary routine of breakfast at a church-run meal site followed by long walks between various coffee shops and diners across the city. During treatment planning, Alex’s case manager reviewed his past six months:

Case manager: The short-term goal was, he will discuss one time with his case manager his internal preoccupations. He did state what was on his mind with Dr. Young. He talked about heroin and sex. Long term, he will be seen by a medical provider. Nope, that will never happen. The only way to do something for him would be so coercive . . .

Supervisor: Is there anything that bothers him? Stresses him out? No. He’s like Teflon. He leads a crappy life, but he just sails along. He doesn’t talk to anyone since his mother died. . . . You should do the recovery questions.
The supervisor then darted into her office and retrieved a printed list of 29 questions entitled “Achieving Personal Recovery: Outcome-Based Assessment and Planning,” published by the state Bureau of Community Mental Health. This list functions like a plug-in technology, or an add-on tool, that people deploy when goal setting (demanded by the original instrument) grinds to a halt. Some of the items on this list are open-ended questions about selfhood and emotions:

No. 1. How do you see your life different 3–5 years from now?
No. 2. If you could wave a magic wand and change one thing in your life, what would it be?
No. 3. When are you most happy? Sad? Angry? Frightened?

Others invite people to report specifically on their experience of illness:

No. 19. When things are not going well for you, how do you know? What is happening around you? Inside you? What are you doing? Not doing? Who is there? Not there?
No. 20. When you went into (crisis) (hospital) in the past, what was happening just before? What do you think might have prevented that situation?

Browsing the list, the supervisor suggested a few other approaches to take with Alex:

Supervisor: Why does he think he’s on meds?
Case manager: To control his urges for sex.
S: Why does he think you come out?
CM: For the money. It’s all business. [Each month, Eastside Services receives Social Security disability monies for many clients directly from the government, and then disburses it daily or weekly during home visits.]

The supervisor told the case manager to bring some coffee to Alex’s apartment and tell him, “Let’s sit in front of the building and talk.” This innocuous idea became inscribed as the long-term goal “Client will discuss one time how he knows things are not going well,” a version of recovery goal no. 19. This list of broad recovery goals, of course, could apply equally to all 75 clients. The list gets used mainly as a last-ditch effort to insert clients into the requisite narrative of progress, when the case manager cannot come up with any other option.

What can the team do when faced with someone like Alex? He has hardly progressed at all since admission, and he wants no agency resources other than his government check. Consequently, the team retrenches to “recovery questions” but uses them for purposes far removed from their original intent. The questions themselves grow from the broader recovery movement that has influenced formal mental health policy nationwide (see Jacobsen 2004). Inviting clients to explore their dreams and fears fulfills the movement’s mission to put clients’ own needs and perspectives at the center of treatment. Asking how they cope with their situation or know when to call for help promises to renew people’s sense of possibility and to
repair the damage to selfhood caused by severe psychiatric illness (see Hopper 2007). But in most cases, Eastside Services staff use the list in ways that contradict that movement’s egalitarian and hopeful ethos. Case managers ask the questions not to encourage recovery—that is, a full life despite disabilities—but instead simply to keep clients minimally connected with the agency. “Recovery questions” are essentially placeholders that case managers use when they despair of other ways to push clients toward reduced symptoms and greater residential stability.

Contradictions in the Groundwork of Practice

Staff room discussions about Matthew and Alex show how goal setting can reach a dead end. Immersed in the demands of the day, people rarely take up why it reaches a dead end, but the reasons are implicit in the mission of the agency. ACT was developed during the 1970s in the wake of deinstitutionalization. As state psychiatric hospitals closed or were radically downsized, many ex-patients entered the “revolving door” (the contemporary journalists’ phrase) of brief hospital stays, stabilization via antipsychotic medication, discharge to the community, resumption of isolated and disorganized lives, and subsequent readmission. People in this group began to live in marginal, often dangerous surroundings and to depend on a fragmented collection of outpatient medical and social services. The pattern endures into the present for many people with the most disabling symptoms and the least resources. They find it enormously difficult to recover or to establish independent lives because of the severity of their illness, the patchwork services, and the realities of urban poverty, including easy access to alcohol and street drugs. Deinstitutionalization produced not the dream of community integration, but instead continued dependence on welfare, medical, and criminal justice systems. Even worse, such systems do not communicate well with each other and they have conflicting priorities, so people continue to fall through the cracks (see Human Rights Watch 2003; McLaughlin and Pepper 1990; Schwartz and Goldfinger 1981).

The architects of ACT aimed explicitly to solve this problem. They argued that a single work team should provide the entire range of medical, psychiatric, and social needs that used to come bundled together in brick-and-mortar hospitals (Stein and Santos 1998). Facing the bitter outcome of deinstitutionalization, they crafted ACT to include round-the-clock services of indefinite duration aimed at chronic diseases. Most elements of this clinical model—its staffing profile, program standards, reimbursement scheme, menu of rehabilitation services, and so forth—endorse long-term support, not cure, as the ultimate mission. In fact, Eastside Services clients are rarely discharged because of improved functioning. They leave only because of incarceration, relocation to another state, or death. By design, moreover, ACT staff do not transfer clients to any other agency or program (except for admissions to the local public psychiatric hospital, where the average length of stay is eight days). Eastside Services remains the sole source or broker for clients’ medicosocial needs, for as long as necessary, no matter how symptomatic or unstable they become.

The very mission of Eastside Services, therefore, makes it hard for clinicians to act according to the core disposition of health care providers. This disposition rests on the promise of therapeutic progress in the future. But so many elements of the ACT apparatus contradict this promise and hence frustrate the frontline staff.
The ACT mission (in line with the dogma of contemporary psychiatry) assume the relapsing and remitting course of severe mental disorder. Keeping people out of hospital and out of jail is the chief criterion of success, given the problems of deinstitutionalization that ACT originally meant to solve as well as the promise to solve them without a net increase in public expenditures. The minimal goal for clients is “engagement,” and in practice this means simply meeting with case managers on a regular basis. The minimal gesture of care is the “med and money drop”: the provision of maintenance pharmacologic treatment and welfare monies (see Brodwin 2010; Floersch 2002). Finally, many clients regard the home visits as enormously coercive, and they reject the services offered to them. The logic of care assumes a reciprocal effort by both patient and provider (Mol 2008), but in the words of one case manager, “They do not want anything we have to give.” The treatment plan, with its requirement for a story of continual progress, contradicts the agency’s mission and the realities of practice. Not surprisingly, people find it unworkable. Providers caught in this contradiction continually complain of futility.

Articulations of Futility among Frontline Clinicians

Case managers must use the tools they are given, no matter how poorly they fit the job at hand. In the end, the staff retrenches to pro forma minimal goals for treatment plans, unsure that even these will succeed. People aim simply to keep alive the connection between client and case manager. They hope that somehow circumstances will shift, but they must accept that the client has fallen off the standard trajectory of progress. The staff articulates the impasse through black humor (“take these meds, and don’t die”) and the almost cynical use of recovery questions. These are the experience-near expressions of futility. People find themselves ejected from the usual temporal frame that defines clinical work, and they cannot maintain the most basic orientation of care. Case managers’ frustration indexes the gap between the narrative of improvement—a paperwork requirement as well as an implicit ideal for all medical work—and the concrete details of practice. The imaginary future collides with the possibilities for action in the present, and the outcome is an acute dilemma over how to frame one’s actions as worthwhile.

Case managers at Eastside Services articulate this dilemma in practical, not theoretical terms, because they know little about the successive trends in U.S. mental health policy or the particular history of ACT. Eastside Services staff occupy a relatively low position in the mental health hierarchy. They are poorly paid and have at most two years of postgraduate education in social work or counseling. They typically take the job soon after graduation as a stepping stone to private practice. Many do not have significant prior experience with severe mental illness. Case managers nonetheless articulate futility in ways every bit as subtle and perceptive as professional bioethicists. To label their style of reasoning as practical and not theoretical does not mean that case managers are passive or unreflective. It simply situates their encounters with futility in the logic of everyday practice.

Emphasizing the way that frontline providers reason about the situation immediately at hand suggests one way to advance the dialogue between anthropology and bioethics (see Kleinman 1995). Frontline providers do not and cannot adopt the view from nowhere. They do not make their reactions conform to the dictates
of moral philosophy. The ethnography of futility, therefore, should continually return to their real-time experience of frustration. As generations of anthropologists and sociologists have shown, ethical decision making in health care is a culturally embedded process, and the relevant contexts include the social organization of work, its temporal structure, and the technologies that silently shape people’s action without their direct consent (see Brodwin 2008). The anthropologist’s job in the study of clinical futility is to get past the “official account” (in this case, formal bioethics) and look at the skills and techniques that people use to solve emergent dilemmas (cf. Jenkins 1994). Some of these techniques are mandated by the ACT blueprint as the only acceptable way for them to carry out their job. In a snapshot of daily work, therefore, case managers may appear as passive automatons. But their comments prove that they remain self-reflective practitioners, acutely aware of the straightjacket of administrative routines. Their comments point precisely to the gap between what the formal model directs them to do, and what they can actually accomplish.

During staff meetings, they voice the problem through sarcasm and cynicism, and during private interviews, they use somewhat different registers. But their commentaries all issue from within the time horizons of clients’ illness and their own activities of care. Some case managers trace the dilemma to their clients’ static lives:

Do we look at them as having goals which they move toward, or do they just have good or bad parts of the year? . . . The problem with our clients is that they have no goals. So, why not use drugs and drink?

From this standpoint, clients go through life without a meaningful temporal narrative. They seem impervious to the logic, engineered into treatment plans, that unfolds from problem to goal to intervention. Whether or not this attribution is correct, it strongly shapes clinicians’ experience of frustration on the job. The seemingly static lives of clients push case managers to question the legitimacy of their therapeutic efforts, which by definition must project some sort of improvement into the future:

I feel like I’m not doing anything for them. I feel like I’m stuck. . . . You don’t get to see them get a job. So, what are we doing for them? This business of knowing what’s best for somebody, I hate it. There’s no job satisfaction here. It’s the most expensive paycheck I’ve ever received. . . . We don’t help people, we just maintain them.

These case managers get “stuck,” in their words, precisely because the clients are stuck. Such experience-near framings of futility capture the way that therapeutic time grinds to a standstill for both parties. Perhaps the darkest portrayal came from Carl Heiser, a case manager who actually quit the agency not long after expressing his frustration in the following terms:

If I woke up tomorrow as Vicky Inger [his client with active delusions, a lifelong cocaine habit, and no family or friends], I would simply say, “Go ahead. Shoot me.” This is not a life worth living. Is just living, sheer
biological survival, worth it? ... It’s an exercise in futility. You’re going to keep them psychiatrically stable until they die. But where do you go with it then? Just line ‘em up in a ditch?

Carl’s remarkable admission veers from empathy with his client’s plight to the virtual collapse of his professional identity. Simply maintaining Vicky with her current disabilities runs against his vision of the baseline worth of human life as well as the worthiness of his activities as a case manager. He knows that he is on a slippery slope, and the next step is too brutal to contemplate. He nevertheless invokes the conventional English idiom “an exercise in futility” to refer to both the bare life of his client (Agamben 1998) and to his own absolute alienation from therapeutic time. Carl regards his client has having tragically slipped out of the definitionally human time horizon. Survival, not progress, is her only possible future. For that reason, he finds himself slipping out of the core disposition of clinical work, which inherently imagines that that treatment will produce future improvement.

Most clinicians at Eastside Services do not reach this level of alienation. They avoid it not by dodging the difficult cases, but by reframing the time horizon of their work. For example, they justify their interventions in the present by imagining clients’ likely future without any services at all. The psychiatrist explained, “When I feel demoralized, I think that they’re better with us than without us. What would happen to Tom Harris? He would be homeless. He would be spending $200 a month on crack, instead of just $50 a month.” One case manager drew back from futility as she discussed her client, a young man facing possible eviction because of his lengthy refusal to clean his apartment. Her present activities seem fruitless, but she contains her frustration by imagining a worse alternative in the future:

It makes me ask, “What are we doing?” It’s not that I question the agency. It’s just that the clients are so frustrating. And then I think, if it weren’t for us, these clients would be on the streets, or on drugs, or dead. We’re what stands between them and all that.

This strategy has its counterpart in the recollection of the past suffering of clients before they entered the agency. A backward-looking perspective, of course, requires long-term knowledge of particular clients or of the evolution of mental health services as a whole, so it comes easier to psychiatrists than the younger case managers. According to Ronald Diamond, a psychiatrist involved with ACT since its inception, the benefits are obvious; people formerly caught in the revolving-door pattern of multiple hospitalizations now have reasonable lives with apartments and friends (Diamond 1985:92). The Eastside psychiatrist James Young has also worked in community settings his entire career, and he drew an even starker contrast between past and present:

I never am bothered by a sense of futility. I am convinced that what I do is helpful to people. Maybe it’s because I have the medical background. When I’m sitting with a patient, I think of a person in a back ward or long-term care facility, staring out the window or rocking back and forth.
The case manager’s and psychiatrists’ comments do not deny the common experience of frustration in the short term. But they array the past, present, and future of clients in such a way that therapeutic time survives the evidence that today’s interventions are failing. Indeed, the moral risk for clinicians in this setting is that the current impasse corrodes the fundamental disposition of clinical work. Case managers know the risk, of course, and they describe how their short temporal perspectives can make them vulnerable to demoralization. People sometimes reflect that the first few years on the job are especially difficult, before they had experienced clients’ cycles of stability and relapse. Newly hired case managers may have textbook knowledge of severe mental illness, but they have not witnessed someone over several months falling into a downward spiral of worsening symptoms, isolation, and drug or alcohol binges. When this universal rookie experience comes up during morning meeting, veteran staff often repeat mininarratives of clients who eventually made progress. They recall, for example, someone who agreed to see a doctor after refusing appointments for five years, or another client who spent ten years as a prostitute and cocaine user before “just a drop of Risperdol” transformed her life. As another antidote, the psychiatrist also brings up the mismatch between the temporal perspectives of client and case manager. He often reminds the young staff members, for example, that they are working with the first few clients of their career, whereas the clients have already gone through a hundred case managers.

In general, the psychiatrist seems better guarded against futility by both his longer time horizon and his expertise in biopsychiatry. Although he rarely articulates his knowledge in the rush of work, James Young takes a clear position in unsettled scientific debate about the course of schizophrenia. He regards it as a progressive degenerative disease, affecting numerous areas of the brain and worsening with each psychotic episode. He implicitly rejects the static lesion model of its pathophysiology, which posits a single abnormality or biological insult as the cause of symptoms (see Rund 2009; Salisbury et al. 2007). If schizophrenia is a neurodegenerative disorder, timely treatment is crucial. Pharmacological intervention that delays or arrests psychosis will lead to better outcomes, with less disability and higher quality of life (see Tranulis et al. 2009). This model of the course of disease anchors James’s justification of his work. He strongly disagrees that Eastside Services simply maintains people in their disabled state:

No. We also minimize their deterioration! It’s a degenerative disease. The breaks are toxic. So imagine the degree of baseline degeneration if were weren’t there. And I was reading recently the new research on the toxicity of breaks in depression, too. After each depressive episode, there are fewer connections in the brain.

The psychiatrist’s neurological view of the course of severe mental illness helps him to ward off a sense of futility about his work. The strategy succeeds, however, only for clients who carry an uncomplicated Axis I diagnosis. His confidence drops away when he cannot situate people in the neurodegeneration narrative. He admits the limits of his effectiveness for people who also have Axis II personality disorders: long-standing character difficulties that frustrate psychiatrists no matter what the setting (see Luhrmann 2000).
I feel more useful giving Haldol to a schizophrenic than an antidepressant to a borderline. Because schizophrenics literally can’t have a life without their Haldol. Because I just have this sense that it’s helpful work. But I don’t have this sense when I work with character disorders. I feel like they’re just playing me, and God knows what I’m doing.

To say “I just have the sense that it’s helpful work” epitomizes the harmonious adjustment of subjective disposition and objective circumstances (see Wacquant 1989). The clinician’s habitual practice (in this instance, writing a prescription for antipsychotic medication) seems perfectly calibrated to the patient’s need. James Young’s conviction that his actions are patently useful is made possible by a certain view of the disease’s course (degeneration with each successive acute episode) that is woven into the apparatus of treatment, combined with his own authoritative mastery of psychopharmaceutics. This happy combination of personal disposition and objective possibilities for action, however, is completely out of reach for case managers. The latter group cannot prescribe medication, so they cannot enact the single most powerful clinical gesture in this setting. Moreover, they do not share the psychiatrist’s training in theories of severe mental illness. They work with a simpler model of cyclic relapse and remission. This model leaves open the possibility that the cycles will continue indefinitely and thereby undercut the case manager’s positioning in therapeutic time.

Conclusion

The ethnography of futility demands close attention to the temporal structures that orchestrate clinicians’ everyday routines. The practical mastery of psychiatric case management demands a sure knowledge of the tempo of work. That tempo, however, reflects a complicated play of subjective and objective factors. At the subjective level, it emerges from the pervasive disposition of all health care providers: their trained readiness to intervene in the course of disease and to move clients one step further in the desired direction. That propensity or habitual orientation to work is itself structured by the baseline biomedical notion of the natural course of disease. Much of the time, it successfully meets the demands set by the paperwork technology of the treatment plan. Simply to get their job done, clinicians must produce a mandatory story of progress and continually measure, update, and reinscribe it every six months. Unfortunately, they sometimes cannot bridge the gap between this imposed temporal structure and their immediate experience with clients. It is no surprise that case managers can run into dead ends with treatment planning. This bureaucratic instrument substitutes a linear, mathematically divided, and continuous time for the rhythms and recursive loops of practical time, as the latter is inhabited by frontline providers. The mismatch between these two temporal structures, and the impossibility of fitting events unfolding along one time into the categorically precise requirements of the other, helps to produce the sense of futility.

Outside of treatment planning, however, clinicians selectively draw from two other temporal framings of severe mental illness to justify their work as worthwhile, even when it is not visibly effective. The psychiatrist invokes the neurodegenerative model, which calls for timely medication to forestall future deterioration. Both
psychiatrist and case manager also carry out a less formal staging of people’s lives that portrays clients’ present status as patently healthier than their preadmission past or likely future without treatment. Clinicians’ efforts to conceive of their everyday work as worthwhile thus takes place on top of a complex layering of temporal structures. By placing their clinical practice in the appropriate framework of therapeutic time, they maintain confidence in their own clinical power, in a setting where such confidence is continually endangered.

Notes

1. Participant-observation at Eastside Services from 2004 to 2006 involved attending 120 staff meetings and accompanying six case managers on their daily visits to clients’ homes. Other sources of data included observation of medication management and counseling sessions between clients and the agency psychiatrist and 30 semistructured private interviews: 20 with case managers, five with the program director, and five with the psychiatrist. Background information about the mission of Assertive Community Treatment was obtained by attending training sessions for new case managers sponsored by the State Department of Mental Health as well as several regional continuing education seminars for ACT social workers and psychiatrists. Transcribed interviews and field notes were coded with NVivo 2.0 software for qualitative data analysis. Institutional Review Board approval from the University of Wisconsin–Milwaukee was obtained before beginning research. Funded by National Science Foundation (Cultural Anthropology Program) grant BCS-0522263.

2. Supervisors keep current with the movement through daylong seminars offered by the county mental health department, and they store on their bookshelves practical recovery-oriented handbooks.

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