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THE PARADOXES OF POVERTY:
URBAN SPACE AND IDEOLOGIES OF INTERVENTION IN THE "COMPASSIONATE CITY" OF SAN FRANCISCO

by

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DISSERTATION

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ABSTRACT

This dissertation examines a subset of urban poor women who live at the nexus of poverty and housing instability and who are exposed to multiple forms of violence and intense bodily suffering. I conducted two years of ethnographic research with a cohort of unstably housed women who have long histories of illicit drug use and who cycle between multiple single room occupancy hotels in two San Francisco neighborhoods. In this dissertation, I take as my analytic object the examination of the key institutional sites (what I call the local geography of hypermarginality) and the strategies for intervention deployed by the state in an attempt to ameliorate the conditions of extreme poverty. This dissertation has three central findings. First, even in a relatively rich resource context such as San Francisco, significant structural deficiencies and grave fragmentation of services limit the effectiveness of well-intentioned interventions. Second, institutional interventions administered by the "left hand of the state," even as they draw on compassionate principles, are contradictory in nature and simultaneously deploy compassion and care with punitive and moralistic logics. Finally, this configuration results in a situation where women's hypermarginality is reinforced by the institutions tasked with helping them.

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Chapter 1

INTRODUCTION

Statement of the Problem

This dissertation examines a subset of the urban poor who reside in particular socio-spatial contexts where daily life is characterized by intense bodily suffering, multiple forms of potential and actualized violence, and an acute struggle for the most basic survival. The experiences of extreme poverty, addiction, mental health issues, trauma, and chronic illnesses such as HIV and Hepatitis C in these urban spaces are what Singer and Clair (2003) refer to as the "syndemics" of the urban poor—that is, these conditions become inseparable, or to use language from the public health lexicon, "co-occurring" or "co-morbidities." In a subjective sense, the confluence of these factors creates what Benjamin (1968) calls an "everyday state of emergency," a concept that has subsequently been adapted to describe the experiences of street-based drug users (Bourgois 2011; Bourgois and Schonberg 2009; Lopez et al. 2013). This dissertation examines those that live in the extreme edges of US urban poverty—in a state of hypermarginality—and how this configuration is manifested and maintained within particular socio-spatial and structural contexts.

According to US Census Data (San Francisco Health Improvement Partnership 2014), estimates of the percent of people below the poverty level between 2008 and 2014 hovers around 13%. However, San Francisco has one of the highest costs of living in the nation, with rental prices increasing at three times the national average. The current technology boom has radically transformed the city as young technology company

employees with six-figure incomes from Google, Facebook, and Twitter, among others, flood the city's neighborhoods. Paradoxically, amidst all the wealth of the technology and tourism industries, the city is often credited with having one of the most visible homeless populations in the county, with local estimates at up to 15,000 people—3,000 of those which are classified as "chronically homeless" (San Francisco Ten Year Planning Council 2004). In San Francisco, which is only geographically seven by seven miles wide, there are more chronically homeless people than in New York City, a city many times its size. The rest of that 15,000 are more accurately described as "unstably housed"—that is, they routinely cycle between sleeping nights on the streets, in shelters, drug treatment or transitional housing programs, and between time in jail and single room occupancy hotels (SROs). The city is estimated to spend 200 million dollars annually to address this "homeless problem" in the form of programs, supportive services, and housing subsidies (San Francisco Ten Year Planning Council 2004; Knight 2014). To be sure, San Francisco, known for its legacy of social progressivism and radical politics, has a relatively comprehensive safety net of social services for the poor compared to other US cities. Yet, there is widespread visible street-based suffering and an unremitting "homeless problem" that is the subject of constant debate.

I conducted two years of ethnographic research with a cohort of unstably housed women who have long histories of illicit drug use and who for years have cycled between multiple SROs largely concentrated in two San Francisco neighborhoods. For these women, hypermarginality has unique gendered manifestations. In addition, I interviewed a small cohort of police officers and service providers who routinely interact with the urban poor and I chronicled may more peripheral characters and their stories. Despite the

fact that drug use was a prominent aspect in women's daily lives, my dissertation is grounded, not in drug use per se, but in the broader context of extreme poverty in a contemporary US setting, of which active drug use is but one pronounced manifestation.

The conditions of hypermarginality are well documented in the epidemiological literature on homeless and unstably housed populations. Victimization is common (Kushel et al. 2003). Drug use and mental health issues (e.g., depression and post-traumatic stress disorder) are intertwined with routine experiences of violence (El-Bassel, Gilbert, Vinocur, et al. 2011; El-Bassel, Gilbert, Witte, et al. 2011; Gillespie et al. 2009; Jacobsen, Southwick, and Kosten 2001; Kilpatrick et al. 1997; Schumm, Hobfoll, and Keogh 2004). The urban poor have high rates of emergency department use, due to elevated unintentional injuries, assaults, poor health, and high rates of morbidity (Brickner et al. 1986; Hibbs et al. 1994; Hwang et al. 1998; Kushel et al. 2003; Padgett and Struening 1992; Padgett et al. 1995). Being a victim of a crime is recurrent (Kushel et al. 2003). Self-reported psychiatric hospitalization, chronic health problems, and drug or alcohol dependence are common (Kushel, Vittinghoff, and Haas 2001). This population has a lack of access to insurance, transportation, a telephone, and has high unmet subsistence needs (Kushel et al. 2003; Riley et al. 2011). In a cohort of women recruited in San Francisco, 97% screened positive for one or more psychiatric conditions and reported experiences of multiple forms of violence (i.e., emotional, physical, and sexual) by both primary partners and non-primary partners (Riley et al. 2014). Through the lens of epidemiological measurement, these are the "behavioral" manifestations of poverty, which when decontextualized from the structural contexts in which they are embedded, can function to pathologize the poor.

Goode and Maskovsky (2001) explore how "the poor" have been an object of what they call "obsessive contemplation," both in national policy arenas and within U.S. urban social science. Urban ethnography is particularly implicated. Owing to the circulation of the "dark" and "mysterious" "inner-city," researchers still problematically produce versions of what Victor Rios (2011) calls "jungle book" ethnography; that is, sensationalized images of deviance and criminality that mask the political, economic, and cultural contexts of hardship and erase the multitude ways in which the poor *negotiate* within broader structural and institutional constraints. The compulsion to document the micro-dynamics of violence and hardship is problematically alluring, particularly because of the level of exceptional bodily suffering that is immediately visible on the streets, in housing of last resort, and in the public clinics of San Francisco. While this suffering cannot be ignored, I offer a reconceptualization of the structural violence and social suffering frameworks that are often applied to US-based ethnographic research with the hypermarginalized.

The concept of structural violence, as Farmer says, is, in short, to "inform the study of the social machinery of oppression" and our ethical duty as anthropologists to contextualize, within large-scale structural forces (e.g., economic, social, and political systems), the suffering that is "ethnographically visible" (Farmer 2004). In this dissertation, some of the key structural forces which have impacted the women I studied are: the fragmentation of wage labor, the disinvestment in the social safety net and lack of affordable stable housing, and the stigmatization of poverty. Despite critiques that the concept of structural violence is vague and totalizing (Bourgois and Scheper-Hughes 2004), the direct engagement with *violence* in the anthropology of poverty is salient

because the lived reality of unstably housed drug users, for instance, is indeed inundated by an unfathomable amount of practical uncertainty, daily violence, and devastating physical and emotional suffering. However, the analyses waged through the lens of violence has several critical implications.

First, the use of the structural violence framework contributed to a shift from an analysis of individual behavior (for instance, "risky" drug use behavior) often construed as pathological, to a lens on the broader processes that mediate behavior. This was an important intervention into the behaviorally-focused approaches of public health research. This, however, was a transformation in focus from a problematically singular "*drug using"* subject into a sometimes unselfconscious analytic obsession with a newly configured "*suffering"* subject. The concept of structural violence signals the ways in which researchers have sought to adapt their analytic frameworks in order to examine the "new era" or "new regimes" (Goode and Maskovsky 2001) of poverty in US cities, where abject suffering and hypermarginality became widespread. Wacquant (2014) suggests that the state has played a central role in the "social and spatial production of urban marginality" by ushering in an "urban precariat"—that is, people who perpetually exist in a state of instability and social marginalization. He cites three fundamental structural processes as contributors to this phenomenon: 1) the fragmentation of wage labor, 2) the retrenchment of social protections, and 3) territorial stigmatization (Wacquant 2014: 3-5). These intertwined processes are part of the larger historical trend of neoliberalism.

The real-world suffering and "everyday states of emergency" among the homeless and unstably housed represents decades of retrenchment of the welfare state and, out of urgency, has triggered complex institutional responses to address what is now the

ordinary-extraordinary (Bourdieu 1999) suffering of the urban poor. This phenomenon examined through the lens of structural violence, however, obfuscates the intense engagement that the urban poor have, both forced and as a matter of strategic survival, with the landscape of institutional interventions tasked with promoting life, and perhaps even more importantly, delineating the possibilities and parameters for life amidst the realities of structural violence**.** In this dissertation, I ultimately argue that when we examine the extreme edges of poverty ethnographically, we must go beyond merely chronicling suffering. We must too also consider how modes of seemingly compassionate intervention directed at poverty and social suffering, often driven by undercurrent humanitarian principles, can be paradoxical and reinforce and reproduce hypermarginality. This is a critical analytic angle in an ever-increasing context of limited resources and deepening inequality.

Thus, instead of focusing solely on the undeniable brutalities of structural violence, I take as my analytic goal, the examination of the key sites and strategies for intervention deployed by the state, whose objectives, in San Francisco in particular, are directed by a logic of compassion. In this reconfiguration, I attempt to problematize the construction and management of the "suffering subject" in urban ethnography and to grasp how people *negotiate* the conditions of hypermarginality in relation to the specific institutions tasked with "helping" them. This approach is by no means meant to negate the structural violence framework, nor to minimize the interpersonal, symbolic and structural violence that play out in visceral ways in the lives of the urban poor. However, in this analysis I examine what are the possibilities and parameters for *living* that are

designated by the myriad institutional responses seeking, however problematically, to intervene into suffering on the basis of compassionate and humanitarian principles.

Neoliberalism and the Left Hand of the State

This research was conducted in the context of U.S.-style neoliberalism. Evans and Sewell (2013) characterize this era as being one where the ideology of the "Reagan Revolution" ascended at the time of the demise of the previous "golden era" of "welfare capitalism." This political ideology sought to erode the social protections that had been previously put forward by the state during New Deal and War on Poverty initiatives, in favor of protections for the financial sector. Harvey calls this an era of the "creative destruction" of previous institutional frameworks and welfare provisions (Harvey 2005) that also included a demonization of the "welfare-state," which facilitated its retrenchment (Goode and Maskovsky 2001). This ideology, as Bourdieu suggests, includes a:

> return of individualism, a kind of self-fulfilling prophecy which tends to destroy the philosophical foundations of the welfare state and in particular the notion of collective responsibility…The return of the individual is also what makes it possible to 'blame the victim,' who is entirely responsible for his or her own misfortune, and to preach the gospel of self-help… (Bourdieu 1998: 7)

It is beyond the scope of this dissertation to attempt a full exposition of the economic processes of the neoliberal era, especially as neoliberalism plays out in a broader global context. However, neoliberal political ideology and its accompanying policy trends has direct impact on the construction of hypermarginality that I examine ethnographically and the landscape of social services that arise in response. The particular level of deprivation that I observe ethnographically is the result of approximately forty years neoliberal ideology playing out in U.S. urban contexts

resulting in a new form of poverty as we know it (Goode and Maskovsky 2001; Wacquant 2014). As Evans and Sewell argue, one of main effects of this era has been increased income inequality, changing social provisions, and the social corrosion of already poor communities. Thus, as I examine the complex institutional interventions into the lives of the poor that are guided by a logic of compassion, I do so in what Goode and Maskovsky (2001) call a "postwelfare moment." That is, in a neoliberal era where the alleviation of poverty and social protections are not fundamentally prioritized.

Bourdieu provides a helpful metaphor for thinking about the particular state functions tasked with managing the consequent social suffering in the postwelfare era. He poses a model that differentiates between the "left hand" and "right hand" of the state, a model adaptable to the U.S context. The left hand includes those institutions and social actors within them who broadly do forms of "social work." In the French context, they are:

> the set of agents of the so-called spending ministries which are the trace, within the state, of the social struggles of the past. They are opposed to the right hand of the state, the technocrats of the Ministry of Finance, the public and private banks and the ministerial cabinets. (Bourdieu 1998: 2)

Bourdieu suggests that those who must now fulfill the left hand functions of the state do so with a certain level of "despair," since "the state has withdrawn, or is withdrawing, from a number of sectors of social life for which it was previously responsible" (1998: 2), including health, housing, and education. The "despair" felt by the left hand institutions is a consequence of "the failure of the state as the guardian of public interest" (Bourdieu 1998: 2) and the subsequent responsibility of the left hand to clean up the messes of this state failure, with pittances of resources.

Wacquant utilizes Bourdieu's metaphor similarly, but suggests that the despair and strain upon the left hand are interrelated with the amount of resources allocated to the right hand. The left hand of the state is "that which protects and expands life chances, represented by labor law, education, health, social assistance, and public housing"—that is, the "social functions of the state" (Wacquant 2009: 6, 289). These functions are increasingly "supplanted" via "regulation through the "right hand," but what Wacquant suggests must now also include the police, justice and correctional administrations, "increasingly active and intrusive in the subaltern zones of social and urban space" (Wacquant 2014: 6, 289). As I situate my research on left hand institutional interventions within a context of neoliberal poverty, I emphasize a critical nuance: that what I am examining are the responses to an ongoing situation of emergency ushered in by the neoliberal era. The so-called "helping hands" of the state in this era are not, in fact, examples of a flourishing welfare state, but rather, the strained state reactions to the conditions of hypermarginality. The institutional responses, then, are tasked to confront the most unimaginably dire circumstances in a prolonged era of duress, severe deprivation, and crisis among the most marginalized urban poor. Further, I argue that the double, yet distinct regulation of the poor via separate institutions of the left and right hands as Bourdieu and Wacquant conceived them, is, in the contemporary context, indistinguishable as the left takes on characteristics of the right and vice versa.

This dissertation engages with an exposition of the crumbled remains of the broader welfare state, the ways in which the contemporary left-hand of the state is activated in response to local manifestations of neoliberal crises, and how these institutions are navigated by the hypermarginalized. The interventions on the part of the

left hand within this structural context take place within these constrained parameters. Their function is certainly not about the full enactment of a "good life," as was promised by the previous welfare era, however, they seek to intervene upon and *salvage* life. The critical nuance is that they do so in a prolonged state of crisis and amidst the current precariousness of the lives of the urban poor. Further, these institutions become the only mechanisms through which the poor can mitigate their everyday struggles for basic survival. Thus, they are critically implicated in the practical, discursive, and subjective negotiation of what constitutes life within the context of hypermarginality.

The urban poor are, in general, subject to moralizing discourses about the antecedents of their suffering including notions that their individual behavior and choices are what is ultimately responsible for their hardships. They face stigma about their bodily ailments, drug use, and mental health status, which are seen as individual pathology, rather than socially driven. Women are subject to gendered discourses about their morality and salvation irrespective of class position or structural vulnerability. In the context of hypermarginality, however, the significance of these gendered moral discourses becomes heightened because what is at stake as women navigate the institutions tasked with ameliorating their suffering is, quite literally, life itself.

Thus, I specifically examine women's negotiation of the key institutional domains that are tasked with confronting their exceptional suffering because women's experiences make particularly visible the paradoxes of inclusion and exclusion that are entrenched in the dynamics of contemporary neoliberal intervention. The three key sites in what I consider to be the "local geography of hypermarginality" in San Francisco are: 1) the housing system of last resort, SROs; 2) the proverbial "streets" managed by law

enforcement and; 3) the large public hospital. For women in particular, these sites are defined by paradoxes—that is, they combine contradictory qualities. The hotels that should provide respite from street homelessness, instead confer danger and distress. Street-based law enforcement links women to social services at the same time that police arrest and incarcerate women. Finally, for the hypermarginalized, clinical care often blends punitive logics.

This dissertation has three central findings that I explicate in the ethnographic chapters. I find that even in a relatively resource-rich context, significant structural deficiencies and grave fragmentation of services limit the effectiveness of well-intentioned interventions. Second, institutional interventions administered by the left hand of the state—even as they may draw on an undercurrent logic of compassion—are contradictory in nature in this era of "new" poverty. They simultaneously deploy compassion and care with punitive and moralistic logics and subsequently, they at once administer help and harm. The result is that in women's interactions with these institutions, they must navigate bifurcated subject positions that are inherently defined by tensions—those of simultaneous inclusion and exclusion, being marked always as both criminal/victim, worthy of punishment/worthy of salvation, and always subject to both advocacy and adjudication. This is true in the hotels, on the streets, and in clinical interactions. Because of these subjective tensions, women are inserted into and must navigate a gendered moral economy under great material constraint. In their state of what Fassin (2005) calls "structurally imposed precariousness" women's negotiations of these institutional contexts, while mired in moralizing discourses and punitive logic, are nonetheless critical to their basic survival. Through these interventions, women are

forced to substantiate a gendered biolegitimacy—that is, "the legitimization of rights in the same of their *suffering* body" (Fassin 2005: 372). Their social exclusion is so profound and so historically entrenched that, tragically, it is only their gendered suffering and not the potential for activation of their rights as full citizens that provides any glimmer of hope to minimize the daily struggles in their lives. By examining women's negotiations of these institutional interventions, it becomes clear how by having to "suffer" to get "saved," women's marginality is further reinforced. Here, "compassionate" interventions are just as implicated at brute violence.

From the "Drug Using" to the "Suffering Subject"

Indigent drug users in U.S. inner-city contexts are one of the few groups in the U.S capable of conjuring passionate, albeit paradoxical responses and who tread the line between being conceptualized as victims of their social conditions, diseased sufferers, and/or morally and lawfully criminal. The idea of their suffering, akin to that of global refugees, incites unique sympathy tinged with terror, since unlike less morally ambiguous categories of victims (e.g., a cancer patient or war casualty), drug users and sex workers are also seen as diseased bodies or threats to public health. Despite this duality, the conceptualization of indigent drug users as having a status of a suffering victim is a somewhat recent incarnation. There is a rich genealogy of research about hypermarginalized drug users from early ethnographic exploration of the emerging inner-city phenomenon to the eventual widespread integration of inner-city drug use into anthropological research on structural violence and social suffering.

In the early 1970s, anthropologists began to conduct formal ethnographic examinations of drug users in U.S. inner-cities (Agar 1973; Spradley 1999). Some were

commissioned by government agencies such as the Department of Health and Human Services (Feldman, Agar, and Beschner 1979) and tasked with uncovering the sub-cultural dynamics of what were perceived as emerging "drug user communities" in US cities. This era of research was characterized by a concern with the descriptive intricacies of drug user behavior, such as mode of ingestion and the perceived ritualistic practices of sharing and camaraderie among drug users. Ethnographic methods were seen as integral to revealing the growing, yet seemingly obscure underground cultural activity of drug users that were largely missed in epidemiological surveillance reports. This promoted a sub-cultural conception of drug users and the notion that they enacted behavior as part of a "drug user community" (Singer 2006b). This cultural approach stressed the investigation of drug user norms and values (Finestone 1957; Preble and Casey 1969; Sutter 1969), and furthermore, suggested that drug use was the central organizing principle in drug users' lives (Singer 2006b; Waterson 1993). In early ethnographic investigations, drug users have the appearance of constituting an "authentic community" (Singer 2006b: 73), a conceptualization that undoubtedly impacted further public health/epidemiological conceptions of the category of drug user or injection drug user (IDU) as an assumed marker of community or population risk. In the late 1980s, this community/cultural framework intersected the emergence of the HIV/AIDS epidemic, as injection drug use was confirmed as a route of viral transmission. Thus the notion of the existence of a "drug user community" became one of the most prominent explanatory variables for the spread of HIV. By the early 1990s, conceptions of HIV/AIDS risk groups were constructed along explicitly cultural lines, such as "gay culture" or "drug user culture" (Schiller, Crystal, and Lewellen 1994).

Critics argue that federally-funded drug use ethnographies, which were originally tasked as interventions into deficient epidemiological methods, were "absorbed by the state and reshaped into a regulatory surveillance regime" (Campbell and Shaw 2008: 691). Anthropological notions of "culture" and "community," they argue, were instrumental in the creation of specifically delineated cultural others—that is, a "drug using" subject—to be confronted by public health and policy institutions. While this represents a relative victory over an approach which would cast people who use drugs as exclusively criminally deviant, the sharp focus on the behavioral ritual of drug use in early ethnographies has had significant impact on how services for "drug users" were designed over the last twenty years in order to engage with what became known as the quintessential "at risk" population. Critics argue that even harm reduction, an oppositional discourse in public health, has become intertwined with the federal public health agenda to disseminate guidelines for normative behavior within the "drug user community" (Campbell and Shaw 2008; Moore and Fraser 2006; Singer 2006b). They suggest that the harm reduction agenda of empowering drug users to reduce drug-related harm through safer injection practices, for instance, also serves to infuse the drug-using subject with neoliberal subjectivity. In this configuration, it is argued, drug users are required to become specific types of "autonomous, rational, independent, calculating" agents (Moore and Fraser 2006: 3036).

For decades, anthropologists have written correctives to this legacy of behaviorally-focused drug use ethnography, by urging vigilant attention to the broader political-economic structures that shape everyday experience of illness and disease. This has not been to the demise of attention to the micro-processes of drug use behavior

(Bourgois and Schonberg 2009), but in an attempt to link behavior, determinants of behavior, and local, national and even global social orders (Baer, Singer, and Susser 2003; Bourgois 2003; Bourgois, Lettiere, and Quesada 1997; Singer 2005b, a, 2006a, 2007; Waterson 1993). Medical anthropologists and drug use ethnographers have used the conceptual frameworks of structural violence and social suffering to link local experiences to broader contexts. The concept of "social suffering" is a tool to examine the brutalities enacted by structural violence as they play out on in specific ethnographic contexts. The literature on social suffering examines how large-scale processes become inscribed onto people's bodies as physical, psychological, and emotional affective states (Das 2000, 2007; Das et al. 2001; Kleinman, Das, and Lock 1997). This work captures how various social actors perceive, embody, and act upon social processes, both exceptional and mundane, in a variety of contexts, but typically with particular attention to violence; for instance, the political geographies of "violence prone areas" (Das 2000) and ethnographic explorations of both overt and implicit, everyday forms of violence (Hinton 2002; Scheper-Hughes and Bourgois 2004).

With regard to drug user research, this research has challenged the conception that drug use is an individually-oriented pathological behavior. Bourgois and Schonberg (2009) use the sometimes abstract concept of structural violence by building a theory of "lumpen abuse." This theory illuminates how "institutionalized brutalities" shape "violent and destructive subjectivities" observable among street-based drug users. Their assertion is that these large-scale processes of power translate into distinct subjective arrangements among particular groups of the urban poor for "whom the effects of biopower have become destructive" (Bourgois and Schonberg 2009: 19). Seemingly abstract

conceptualizations of indigent drug users have practical significance because they influence how people are consequently intervened upon by the state.

The Logic of Compassion

The concept of biopolitics is credited to emerging with Foucault's essay, *Right of Death and Power Over Life* (1990). Critics argue that the concept derived from Foucault was vaguely articulated. Consequently this has fostered an entire canon of social theory seeking to explore and sharpen the definition. In recent years, the conceptual flexibility of biopolitics has been embraced as an analytic strength. For instance, Campbell and Sitze suggest that biopolitics is "an expression of a kind of predicament involving the intersection, or perhaps reciprocal incorporation, of life and politics" (2013: 2).

In Foucault's initial rendering, the emergence of biopolitics signals a historical shift in how power is concentrated and deployed. In this shift "the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death" (Foucault 1990: 138). In this equation, the body becomes ensnarled in the political calculations that organize what constitutes life itself, such as the construction and management of the parameters for broad phenomena like health and welfare. This shift was significant because "it was the taking charge of life, more than the threat of death that gave power its access even to the body" (Foucault 1990: 143). In other words, the enactment of power shifted from the potential for actual confrontation with death through brute state force, to a condition where power is suffused in all aspects of how *living* is imagined and enacted through processes of subjectification. In Foucault's interpretation, "taking charge of life" and subjectification is accomplished through what he conceptualizes as "apparatuses," which he describes as:

> a thoroughly heterogenous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions …The apparatus itself is the system of relations that can be established between these elements…[a] formation which has as its major function at a given historical moment that of responding to an urgent need. (Foucault and Gordon 1980: 194-195)

Agamben (1998) suggests that one limitation of Foucault's analysis was that while he acknowledged the "juridico-institutional" forms of power (a term I define below) that preceded biopolitical technologies of the self, Foucault did not effectively highlight the links between the specific institutional mechanisms that mediate biopower. This was Foucault's specific intention, since he sought go beyond merely examining the operation of the "sovereign," totalizing power of the state. He was interested, instead, in considering how "power penetrates subjects' very bodies and forms of life" (Campbell and Sitze 2013: 137-138). Agamben, then, poses a question and offers an analytic intervention into Foucault:

> if Foucault contests the traditional approach to the problem of power, which is exclusively based on juridical models ("what legitimates power?") or on institutional models ("what is the State?"), and if he calls for a "liberation from the theoretical privilege of sovereignty" in order to construct an analytic of power that would not take law as its model and code, then where, in the body of power, is the zone of indistinction (or at least the point on intersection) at which techniques of individualization and totalizing procedures converge? (Agamben 1998: 6)

Agamben offers the notion that with regard to marginalized populations, there is always a simultaneous operation of juridico-instituional power in operation, even in the context of modern biopower. This becomes evident because, as Agamben says, "placing biological life at the center of its calculations, the modern State therefore does nothing other than to bring to light the secret tie uniting power and bare life" (Agamben 1998: 6).

Bare life is the concept advanced by Agamben to grapple with the idea of life potentially reduced by juridico-institutional power to its physicality or mere fact of being alive, in contrast to one's potential "political existence" or "social presence in the world" (Agamben 1998; Fassin 2005). Agamben constructs a parable in which he uses the metaphorical figure of homo sacer to demonstrate the potential for one's reduction to the condition of bare life. Comaroff interprets this figure as a shorthand to consider "how modern government stages itself by dealing directly in the power over life: the power to exclude, to suspend law, to strip human existence of civic rights and social value"—thus, a sort of repoliticization of Foucault (Comaroff 2007: 208; Kistner 2003: 152) that can be put in service of analyzing situations of inequality and injustice. The contemporary urban poor are subject to both forms of power—one which produces brute control on the body and the other, modern biopolitics. What is most salient to the ethnographic data I will describe in future chapters is that Agamben proffers a conceptual framework that accounts for the tensions, paradoxes, and contradictions that are characteristic of how hypermarginality is produced and operates in the contemporary context of U.S. urban poverty. As he says:

> …the realm of bare life—which is originally situated at the margins of political order—gradually begins to coincide with the political realm, and *exclusion and inclusion*, outside and inside, bios and zoē, right and fact, enter into a *zone of irreducible indistinction*…When its borders begin to be blurred, the bare life that dwelt there frees itself in the city and becomes both subject and object of the conflicts of political order, the one place for both the organization of State power and emancipation from it. (Agamben 1998: 9 emphasis added)

In sum, the concept of "bare life" is a way to think about a subjective state, which by all appearances seems to be a state of total relegation to basic physical being, almost animality. This subjective state seems to be the erasure of social and political existence

and the reduction to the mere maintenance of corporeality—human life reduced to a mere state of survival. The notion of bare life, for instance, may elicit images of the suffering street-based "addict" who seems to have been totally excluded from "normal" social life. However, the condition of bare life, is in fact, a subject position that is simultaneously about extreme exclusion and a particular form of forceful inclusion into the modern biopolitical order. These complicated theoretical concepts and how the hypermarginalized negotiate these subject positions are, in reality, quite visible ethnographically.

Comaroff utilizes the concept of bare life in her analysis of subjects of the AIDS epidemic as a means to "account for the struggles currently underway over the definition of life itself, over the ways that it is mediated, interpreted, abstracted, patented" amidst people's "entailment in webs of signs, relations, and affect" (Comaroff 2007: 209). As I will explicate through the ethnographic data, the tensions that I expose between inclusion/exclusion and control/abandonment reveal the nature of subjectification that plays out through contemporary institutional interventions that target the urban poor. These tensions are the defining characteristics of contemporary hypermarginality.

The widespread use of lens of violence in research among the hypermarginal who inhabit this biopolitical space represents an ethical responsibility to direct our attention to the harsh realities of poverty and social exclusion that are immediately visible in ethnographic contexts, which are indeed profound and agonizing. However, if we rely solely on the lens of violence (and its corollary, the suffering subject) as a way to make sense of the subject positions I outline in subsequent chapters, it directs us to an analysis that is too reliant on an idea of totalizing oppressive power. This is not to say that

violence—interpersonal, symbolic, and institutional—does not happen routinely in this context, nor to absolve perpetrators of violence of their responsibility. In this dissertation, I certainly do not shy away from describing the realities of emotional anguish and bodily misery. However, I seek to foreground the negotiations that happen at the nexus of what Agamben calls the "zone of indistinction" between biopower and juridico-institutional power.

Drawing from this model, I examine the institutional interventions administered by the left hand of the state, which as I will demonstrate, are filtered through what Fassin (2012) calls "humanitarian reason." The socio-spatial contexts that I conducted research in have been subject to decades of neoliberal ideology and thus, are characterized by resultant widespread social suffering and instability as a result of the crumbling welfare state. In the context of widespread deprivation and the everyday emergencies of the poor, the "urge to help" becomes a matter of obligation because the crises of the poor cannot be ignored. Thus, interventions are driven by rationales based on a humanitarian logic. Paradoxically, in this context, people become simultaneously subject to a condition of abandonment by the state fostered by neoliberal political ideology and are called to participate in a moral economy of care and compassion administered by the state.

As I will show in the ethnographic chapters, the circulation of a logic of compassion as a particular manifestation of biopolitics is a critical site for analysis, especially as it intersects the gendered subject positions I will subsequently outline. Fassin reminds us that "the moral economy defines the scope of contemporary biopolitics" and is "particularly crucial when it governs the lives of the undesired and suffering others." With respect to these populations, sentiments always oscillate between

"sympathy on the one hand and concern for order on the other hand, between a politics of pity and policies of control" (Fassin 2005: 366). In sites characterized by paradoxical discourses of compassion (as I will show San Francisco to be), humanitarianism can ascend to a dominant mode of governing where moral sentiments are activated in the "procedures established and actions conducted in order to manage, regulate, and support the existence of human beings" (Fassin 2012: 1). Fassin draws our attention to a key paradox inherent within humanitarian government, which keeps with the model advanced by Agamben regarding the interrelation between inclusion and exclusion:

> On the one hand, moral sentiments are focused mainly on the poorest, most unfortunate, most vulnerable individuals: the politics of compassion is a politics of inequality. On the other hand, the condition of possibility of moral sentiments is generally the recognition of others as fellows: the politics of compassion is a politics of solidarity. This tension between inequality and solidarity, between a relation of domination and a relation of assistance, is constitutive of all humanitarian government. (Fassin 2012: 3).

Thus, within a context where humanitarian reason is activated and individuals are drawn in to humanitarian government, there is an accompanying consequence—the production of what I call bifurcated subjectivities. As I will show, within this context, women must negotiate being defined simultaneously as: criminal/victim; deserving/underserving; hooker/soiled dove; monster/diseased; worthy of punishment/worthy of salvation; and human/inhuman. These are the paradoxical manifestations of humanitarian reason in the context of U.S. neoliberal poverty.

Outline of the Dissertation

This dissertation is based on long-term ethnographic field work with hypermarginalized women in two primary neighborhood field sites in San Francisco. I explicate three key sites in the geography of hypermarginalization—the domains of

housing, street-based law enforcement, and clinical care at the public hospital—where critical interventions by the "left hand" of the state play out in response to the everyday emergencies of the poor. In Chapter 2, I outline my field sites, methods, and positionality.

In each subsequent chapter I show that while modes of intervention by the left hand of the state in the neoliberal spaces of urban poverty are implemented with the intention of responding to or alleviating the suffering of the urban poor, when examined ethnographically, their paradoxical natures become visible as does the specific mechanisms through which hypermarginality is reinforced and reproduced. In Chapters 3 and 4, I examine the housing system of last resort in San Francisco, SROs. In Chapter 3, I outline what I call "*quasi-institutional*" SRO housing—the unregulated, daily rate hotels that function as the local defacto housing system for the most socially vulnerable with addiction, mental health issues, and chronic illnesses, who may have barriers to interfacing with social service institutions and are intertwined with the illicit drug and sex economies. I examine the multiple forms of violence that are endemic there, including everyday, exceptional, and gendered violence, in spaces that should provide some relative respite from the dangers of street homelessness, but are only regulated by the penal arm of the state. In Chapter 4, I consider San Francisco's attempt to convert SROs into *institutionalized* housing for the urban poor, drawing from the evidence-based intervention known as "Housing First." I show how in these socio-spatial contexts, a well-intentioned municipal intervention of converting SROs into supportive housing environments also results in purposeful and problematic concentrations of people with addiction and mental health issues. I grapple whether these spaces, created through city policy through well-intentioned public health and humanitarian logics, are capable of

conferring the "ontological security" that is a premise of the Housing First model. In these two chapters, by contrasting the two types of SRO, I demonstrate the broader processes of how the urban poor are relegated to spaces defined by perpetual transience and liminality and the implications for their health and affective states. Nonetheless, women strategize within these challenging contexts to mitigate exposure to violence and maintain survival.

In Chapter 5, I examine the street-level left hand interventions of the state into the lives of the hypermarginalized. In San Francisco, street-based police officers have been tasked as being front-line interventionists into the routine crises of the urban poor, through the institutionalization of a municipal model of hybrid policing, which mandates both punitive intervention and social service provision in street-based encounters. I examine the unexpected negotiations that are forged between street-based police officers and women as officers activate of a discourse of gendered salvation relative to the women. Further, I show how women's interactions with the "helping hands" of the state are mediated by the penal state and the implications for this configuration. In Chapter 6, I examine this dynamic from the perspective of women who actively negotiate a gendered moral economy where they are simultaneously cast as criminals and victims in their everyday interactions with police. These interactions become critical sites for resources that ensure basic survival and relationships where women must establish some measure of biolegitimacy in the eyes of street-based law enforcement in order to access social services. In Chapter 7, I use case material to contrast the experiences of two women as they negotiate their subject positions as "addicts" in the midst of attempts to access care for chronic health crises and the management of their extreme bodily suffering. Here their

seemingly compassionate clinical care, also includes undercurrent punitive logic, which results in extreme bodily suffering. Finally, in the Chapter 8, I conclude by considering the overall subjective consequences of my findings for hypermarginalized women, the implications of this research for urban ethnography and poverty research more broadly, and the potential practical policy implications of these findings.

In sum, in each ethnographic chapter I attempt to go beyond merely documenting suffering by analyzing the critical spaces in the geography of hypermarginality in San Francisco. Within these spaces, I consider the left-hand interventions of the state charged with responding to the crises of the urban poor and show the paradoxes embedded within them than reinforce and reproduce hypermarginality. I show how within the context of neoliberal poverty, interventions administered by the left hand of the state are tinged with moralizing discourses and undercurrent punitive logic. This reality frames women's navigation of these institutions and creates a context where women's subject positions are defined by tensions—help and harm are blurred and care comes alongside punishment. Within this this configuration, women are inserted into a gendered moral economy, where they are expected to suffer to get saved.

Chapter 2

FIELD SITES AND METHODS

The City of Saint Francis

San Francisco is often thought of as a place which is imbued with the legacy of its namesake, Saint Francis of Assisi. This legacy, now brought to life in the global imaginary by the current pope, is premised on his commitment to engaging with the poor, social outcasts, and the suffering—even those who have been driven to supposed moral transgression by their social conditions. This legacy exists too in the local and national imagination, as San Francisco has been historically conceived of as a countercultural sanctuary and bastion of socially progressive policy. This is rooted in the sexual freedom and drug experimentation of the 1960s, the ongoing gay rights movement, and HIV/AIDS activism which started in the 1980s and remains to this day. These various social movements and ongoing activism have had practical policy implications, coalescing over several decades into a relatively robust network of social services for marginalized populations. These include city-run and non-profit programs that target a range of issues impacting indigent populations: health inequities, the unique needs of marginalized sub-populations (e.g., transgendered people and sexual minorities), the unique needs of stigmatized populations such as those with HIV, and people with addiction and mental health issues.

The story of Saint Francis offers a metaphoric roadmap with which to explore the notion that within San Francisco, there operates a unique undercurrent logic of

compassion with regard to marginalized populations that policy makers and social service providers routinely deploy and in which important symbolic elements are embedded. The city can be analyzed, as Jacobs (1961) suggests, as a discursive realm in which complicated "social relational processes" (Low 1996) within a particular historically constructed and socially produced space and place coalesce.

One of the most famous stories of Saint Francis is particularly illustrative. Francis, a 13th century wealthy merchant's son, known for his love of indulgence and excess, was one day forced to confront the face of suffering and to substantiate the moral positioning that would eventually grant him sainthood. As the story reads, Francis was walking along a wooded path outside his village. As he turned a bend in the road, he encountered a leper—a man covered in skin lesions. Given Francis' social positioning and the total social exclusion of those with leprosy at the time, the predicted reaction for someone like Francis would have been not only avoidance, but derision. In this moment, conventions dictated that Francis was encountering what was perceived of as a "non-person" or even a beast who he had every social permission to scorn. But in this encounter, another sentiment inexplicably washed over Francis and he dismounted his horse, walked up to the man, and not only gave him money, but embraced the man and kissed him.

In the narration of Francis' pathway to sainthood, this story signifies the moment when Francis boldy confronted social stigma and his own engrained visceral reaction to the monstrous social outcast. Francis embraced this supposed "non-person" who had not only been subject to social exclusion, but relegated to a mutant status. Through his actions he symbolically humanized the outcast. Onwards from that encounter, Francis

continued to demonstrate his commitment to engaging with social outcasts, the suffering, and the poor. This was the central legacy of Saint Francis, one that is being reactivated globally with the contemporary progressive Pope, who chose his papal name to honor that legacy and has pushed the boundaries of what constitutes duty in the Catholic Church. At the end of his life Francis even chose to be buried in a place called "Hill of Hell"—the name given to the nearby burial ground for thieves, murderers, and lepers (Murray 2008). In this symbolic act, Francis extended his ongoing sympathy for those who suffered at the hands of poverty or disease to include even those who were socially excluded because of moral transgression. These sentiments are captured in the prayer of Saint Francis:

> *Lord, make me an instrument of your peace;*
> *Where there is hatred, let me sow love;*
> *Where there is injury, pardon;*
> *Where there is doubt, faith;*
> *Where there is despair, hope;*
> *Where there is darkness, light;*
> *And where there is sadness, joy.*
> *O Divine Master, grant that I may not so much be consoled as to console;*
> *To be understood, as to understand;*
> *To be loved, as to love;*
> ***For it is in giving that we receive; it is in pardoning that we are pardoned…*** (Murray 2008 emphasis added)

This legacy of engagement with the socially marginalizaed resonated with me deeply as I grappled with the paradox that is San Francisco—a place with unrivaled social services and progressive policies, yet with intensely concentrated and pronounced social problems related to homelessness/housing instability, addiction, mental health issues, and chronic diseases among the poor. In this story of Saint Francis, the "helper" and "helped" are both implicated in a symbolically rich web of social relations, the nuances of which I

outline in subsequent chapters regarding urban poor women's engagement with housing, street-based law enforcement, and health care.

The network of services and resources for the homeless are under constant contestation both in relation to municipal budgetary constraints and also ideological debates which allege that the services actually function to fuel the "homeless problem." In popular debate in San Francisco, two extremes of sentiments routinely battle each other regarding the "homeless problem": 1) a demonization of the poor who are seen as overly entitled, an unreasonable drain on municipal resources, and the source of "quality of life" issues (e.g., public inebriation, public urination/defecation, and open drug use), and 2) a humanitarian and political obligation to provide compassionate care to the indigent whose problems would only worsen if the safety net were disrupted.

In the last two decades, the city had implemented a series of policies in response to the growing "homeless problem," in particular to address the interface of homelessness, drug use, mental health, and chronic illness. In 1997, the San Francisco Health Commission (SFHC), the policy-making body of the San Francisco Department of Public Health (SFDPH), endorsed a "Treatment on Demand" agenda that would provide expanded services for drug users seeking treatment. This resolution signaled the city's commitment to treating drug use as an urgent public health issue. In 2000, the SFHC passed a "Harm Reduction Mandate" for drug use and HIV-related services delivered by SFDPH providers and contractors. This resolution requires that health services incorporate harm reduction treatment modalities into their service delivery, meaning that wrap-around services should be provided to drug users without the assumption that people would or should be abstinent from drugs. It is widely known anecdotally among

direct service providers that these two initiatives came with little to no agency oversight and so have had limited impact citywide.

In 2007, Mayor Gavin Newsom instituted *Healthy San Francisco*, a citywide universal healthcare program managed by the SFDPH. *Healthy San Francisco* had been designated a "reinvention of the San Francisco health care safety net" and promised access to primary care physicians, preventative and specialty care, mental health, and substance abuse services to the poor and uninsured. Though their implementation is always subject to examination, these types of policies. in addition to the supportive housing programs I outline in Chapter 4, has dictated that the unstably-housed poor are always emplaced within complex institutional networks of safety net health and social service bureaucracies to meet their basic needs.

Having worked in direct service provision in San Francisco (drug treatment, needle exchange, and street-based outreach programs), it is not my intention to paint on overly rosy portrait of the functionality of the social safety net in the city. It is robust relative to other US cities (and certainly relative to the city of Oakland right across the bay), but it is still grossly underfunded and many barriers exist to people accessing services when and in the form they need them. But it is critical to consider its relative strength and a progressive undercurrent to the provision of services for the poor, especially those targeting issues of homelessness, drug use, and HIV "at-risk" populations, which draw on particularly socially progressive principles, such as harm reduction. Thus, it is true that, for instance, in San Francisco, one can get unlimited clean syringes on any day of the week as part of basic public health practice and there are many options for free meals and primary medical care. However, these services largely exist in

response to the everyday crises of the hypermarginalized and operate in the context of extremely high demand for services.

In this analysis, I draw from Low (1999) by using a heuristic device to shape my examination of the unique social relations that develop in this context. I find it analytically productive to consider the ways in which San Francisco can be characterized as a "compassionate city," that in local and national imagination is the quintessentially politically liberal outpost and the namesake of Saint Francis of Assisi. Throughout this dissertation, I explore how this legacy is activated in both contemporary discourse and practice to address the syndemics of urban poverty, especially in the context of high need and the everyday visceral realities of hypermarginality. Using ethnographic data in the specific socio-spatial contexts where "care" for the hypermarginalized driven by compassionate and humanitarian principles is deployed, I consider the gaps between the intentions driving interventions, their real-world implementation, and the consequences for hypermarginalized populations.

Defining the Research Population: Gender and Hypermarginality

This dissertation takes as its subject, women's negotiation of hypermarginality. The way that this term is operationalized in this dissertation is by the shared characteristics of the women with whom I conducted research: 1) they have histories of or are currently experiencing housing instability, 2) they have histories of current or previous drug use, 3) they reside in social contexts where the only options for basic survival are through meager state entitlements or through the illicit drug and sex trades and 4) they have frequent interaction with "left-hand" state institutions in order to negotiate their basic needs. However, rather than conceiving of my research population

via singular demographic categories, I seek to spatialize my conceptual lens so that instead of relying on imprecise variables that have their roots in how a population would be defined and analyzed epidemiologically, in each chapter I explore the complicated intersubjective positions that arise in particular socio-spatial contexts.

Spatial analysis, Soja (1989) suggests, has been historically marginalized in social theory due to a desire to reject any sort of potentially essentializing explanations for social processes. However, Soja urges us to distinguish between "space" as merely concrete measurable contexts and "socially-based spatiality"—that is, the constructed spaces of social organization (Soja 1989: 79). Thus, borrowing from Bourdieu, rather than conceiving of this research as a study of a particular population defined by key demographics, I see it as an exploration of socio-spatial analytic fields—in this case, the sites where poverty, drug use, and social suffering converge. The two specific neighborhood field sites which I will describe shortly are sites for the enactment of social relations in dynamic urban spaces that are produced through historical, political, and economic processes and constructed through people's everyday practices and interactions (Low 1996).

I want to be reflective about how and why I came to center this analysis on women's experiences of hypermarginaliy and be critical about an impulse to use the category of "woman" as a marker of a singular subject position in this dissertation. I recognize the violence that is enacted when dimensions of identity such as race, ethnicity, sexuality, and ability are erased in the service of analytic convenience. Thus, I acknowledge Crenshaw's (1991) conception of "intersectionality" and the responsibility "to account for multiple grounds of identity when considering how the social world is

constructed" (Crenshaw 1991: 1245). However, in this dissertation, I purposefully focus on the intersection of gender and a conception of class that I conceive of as defined by severe deprivation and hypermarginality, the characteristics of which I elucidate throughout the ethnographic chapters.

My rationale for this focus is driven by the goal of examining the particular institutional engagements that are a function of this expression of poverty, where gender, deprivation, drug use, mental health, and stigmatized chronic diseases converge. Thus, my use of the categorization "woman" in future chapters is meant to signify a subject position that intersects, as I will demonstrate, a uniquely gendered system of classification and gendered subject positions. Examination of the circulation of this gendered category is particularly critical because women in the socio-spatial contexts that I conducted research are subject to particular moralistic narratives of redemption amidst their everyday struggles to survive and the complex institutional responses to "addiction," violence, crime, and "mental illness." Thus, this dissertation is most concerned with women's navigation of the gendered subject positions that are imposed upon them by both the structural context (neoliberal poverty) and institutional mechanisms of compassionate intervention (the left hand of the state). In analyzing these gendered subject positions, I draw from Butler (1999) who suggests:

> The question of 'the subject' is crucial for politics, and for feminist politics in particular, because juridical subjects are invariably produced through certain exclusionary practices that do not 'show' once the juridical structure of politics has been established. In other words, the political construction of the subject proceeds with certain legitimating and exclusionary aims, and these political operations are effectively concealed and naturalized… (Butler 1999: 3)

This dissertation hinges on the examination of the paradoxical expressions of exclusion amidst a political climate of compassion and care. The subsequent chapters elucidate some of the key characteristics of discursive dynamics, violence, and moral sentiments that circulate at the intersection of gender and hypermarginality. Seminal ethnographies on people living at this nexus of hypermarginality in US urban contexts focus on women more peripherally (Bourgois 2003; Bourgois and Schonberg 2009), rather than taking them as their central line of inquiry. Doing so for me revealed and facilitated my focus on the gendered moralistic discourses that are activated and negotiated in these contexts.

On a more plainly methodological front, I came to do dissertation research with women because of my own professional trajectory and hybrid subject position as researcher and direct-service provider. For the last 15 years I have worked in a volunteer or professional capacity with unstably housed or homeless women who use drugs. At the age of 19, a year after I moved to San Francisco, I became a peer advocate and street-based outreach worker at a women's drug treatment and counseling program in the Mission District. I volunteered at a syringe exchange program dedicated exclusively to anyone who identifies as a woman, and served for many years on an outreach team that provides health supplies and referrals to women in single room occupancy hotels. My own familiarity with many of the issues that women confront and my unique access to these socio-spatial contexts also facilitated my research with this particular sub-category of the urban poor.

The Mechanisms of Data Collection: Positionality and Methods

This dissertation is based on two years of ethnographic research (2010-2012) with a cohort of 30 women. Their ages ranged from 19 to 55 years-old and included twelve Caucasian women, seven African American women, eight Latina women, one Asian woman, and two women who identified as mixed race. Ten were part of a core ethnographic cohort, whom I interacted with multiple times both formally and informally, while the others I interacted with regularly in particular SROs as part of an outreach team. I also conducted semi-structured interviews with a cohort of ten police officers and service providers who worked directly with hypermarginalized populations. For a detailed outline of all participants, see Appendix 1. I conducted research intensely from January 2010- December 2012, but had conducted preliminary research in San Francisco for my dissertation since approximately 2008. Though I did not live in either of the two neighborhoods at the time I conducted research, I have lived in each of them for many years before (I lived in the Mission District between 1999 and 2005 before going to graduate school and in the Tenderloin in 2007) and so had familiarity with both of them as a previous resident, in addition to my research role.

I initially met women and conducted data collection in multiple contexts. These included: on the streets of two San Francisco neighborhoods (the Mission and Tenderloin Districts), in SRO hotels, at community-based needle exchange sites, at community-based field sites where other studies were taking place, in community clinics, and at the County Hospital. I collected multiple types of data which is representative of my hybrid positioning and the unique access it afforded me to various spatial contexts: 1) one-on-one audio recorded qualitative interviews in private or semi-private spaces (e.g., offices, coffee shops, or SRO hotel rooms), 2) participant observation and ethnographic

interviewing in various settings that I audio-recorded when it was appropriate (e.g., on the streets, on buses en route to doctor's appointments, during routine trips to the store, to run errands, or on walks around the neighborhood), 3) observation and extensive field noting during outreach shifts and any time I worked in the neighborhood field sites in any capacity, and 4) photographs of contexts in which women lived and at community events.

Over the course of the study, I tracked women through various means. If they had a cell phone, we exchanged numbers and I would call them to schedule appointments. However, since women's phones were frequently turned off or stolen, in order to locate particular women enrolled in the study, I would either find them on the blocks where I knew women congregated, connect with them at the social service sites where they frequented and I also volunteered (e.g., the local needle exchange), or see them on my regular volunteer nights as part of the SRO-based outreach team, which entered select hotels twice a week on Monday and Tuesday nights.

I have hundreds of pages of field notes from participant observation and transcripts of audio-recorded interviews in my files. However, for this dissertation, I have chosen intensive case material from seven women, whose cases are most illustrative of the typical issues that women confront in these socio-spatial contexts and who are representative of the larger ethnographic cohort as a whole. These women include:

- Jenai, a 55 year-old mixed race woman who lives in a large city-run SRO and who has a history of drug use, sex work, and mental health issues. (Chapter 4)
- Liliana, a trangendered Latina woman in her mid-40s who lives in a city-run SRO. When we met she had just been released from a drug treatment program and was resisting doing drugs and sex work. She had zero income. (Chapter 6)
- Lilah, a 44 year-old African American women who has cycled between daily-rate hotels for over a decade and who was actively using drugs and doing sex work over the course of my field work. (Chapters 3 and 7)

- Lucia, a 51 year-old, mixed race, HIV positive women who often drank alcohol to the point of blacking out and suffered from intense anxiety and debilitating paranoia. She cycled between sleeping on the streets, being incarcerated, and being housed through a drug treatment program. (Chapter 6)
- Monica, a 53 year-old HIV positive Latina woman who lived in a city-run SRO. She was on methadone and still occasionally used heroin and crack to self-medicate for debilitating chronic pain. (Chapter 7)
- Natasha, a 35 year-old Caucasian woman who lived in the daily-rate hotels and worked as a drug runner for her partner. She had a serious heroin habit throughout the duration of my field work. (Chapters 3 and 6)
- Sheryl, a 45 year-old HIV positive woman with a long history of incarceration and previous sex work. She cycled between transitional housing programs and city-run SROs and maintained frequent heroin and crack use and occasionally used methamphetamine. (Chapters 4 and 6)

My role in interactions with women was blurred by the fact that in addition to being an ethnographer conducting dissertation research, I also engaged with women in a formal advocacy or service provision capacity through my various positions on outreach teams, needle exchange programs, and at community events about overdose awareness and violence against women. So I was indeed able at any moment to know where to secure a referral to a methadone maintenance program, for instance, or provide insight about what services may be available to them and where to secure them. My participation on the outreach team was a source of regular participant observation and I took extensive field notes after each outreach shift. I was also formally employed at the HIV/AIDS clinic at the County Hospital, where many women went for their primary care and they would often see me in clinic hallways or on bus rides headed to the hospital. Additionally, I worked on several other community-based public health studies in the Mission and Tenderloin during the time I did field work. This afforded me a certain level of immediate trust and access into certain institutional environments, but also complicated the ways in which women made sense of our relationships. When women

would introduce me to people in their social networks, they would either say I was their "worker"—an easy shorthand used to indicate that I was a case manager or that we were doing a "health study."

I was always seen, however blurred that role may have been from my perspective, as being associated with "health" in some way, and this no doubt impacted how women communicated the issues in their lives. I have also been staff on numerous research teams that conduct research in the same communities where I did my dissertation fieldwork. Thus, women also recognized me as a "researcher," and in fact, many had previously done epidemiological surveys with me as part of other health studies in which they were enrolled. My hybrid subject position, in summary, included: student researcher, professional health researcher associated with the County Hospital, direct service outreach worker, and needle exchange service provider.

The reality is that research with hypermarginalized urban poor women is rife with ethical ambiguity, given the intense levels of historical and contemporary violence, trauma, and that every day is a struggle to survive. So, seeking to insert myself into these women's social realities in order to extract information from them as they navigated situations where what was at stake was their basic survival, weighed heavily on me. As an anthropologist conducting dissertation research and as a professional behavioral health researcher, I often felt fairly powerless to help women fully in their everyday emergencies related to physical and mental health because of my lack of clinical training (e.g., bug bites and injection-related abscesses, emotionally abusive partners or predatory relationships, unmanaged anxiety and hypervigilance), I was often asked for advice or sought to leverage my social and cultural capital for them in particular situations. When

possible and appropriate, I referred women to appropriate community agencies or helped to facilitate their access to social services. Because of my hybrid position, during this ethnographic research I was very much part of a community of people who worked in these environments in various capacities, including other researchers, direct service providers, and community organizers. Thus at times, I would go into "the field" alongside a friend, for instance, who distributes the opioid antagonist naloxone for the Department of Public Health, community organizers conducting surveys regarding tenant's rights, or other researchers working in these contexts.

On a more personal level, several of the women that I grew close to over the course of fieldwork had children who were not raised in their care, having either lost them to Child Protective Services or having had them raised by other relatives because of their housing instability, incarceration, and/or history of drug use. Many women had a profoundly deep sense of loss about not having raised their children and their relationships with their adult children in the present were often heartbreaking and filled with emotional turmoil. During the time of my field work, I was very close in age to many of these women's adult children—many of whom they were either completely out of contact with or with whom they had painfully volatile relationships. As a young woman without children of my own, many women assumed a maternal relationship with me, worried about my safety, and were invested in my plans for the future. However, I suspect this dynamic also functioned so that women sometimes hid or did not always want to discuss many of the darkest moments in their lives that took place when I was not with them (e.g., the intensity of their drug use or the violence that they perpetrate on partners or other women).

Over the course of dissertation field work, I went through two major crises. My mother was diagnosed with breast cancer and went through chemotherapy and radiation while I was doing research and I had an intense abdominal surgery. During this time the fragility of life was squarely on my mind, particularly as I watched my mother struggle through brutal surgeries and intense treatment. I would fly between my hometown and San Francisco, to spend time my mother during her illness, while I also managed my own recovery. Upon my return I would suddenly find myself sitting in a small SRO hotel room with a women who, for instance, had decided to stop taking her prescribed HIV medication and rather than going to scheduled clinic appointments, sat in front of me for hours smoking crack and injecting heroin. In these moments, as I was making sense of my own personal health crises, I watched my compassion ebb and flow amidst the anger and terror of my own personal situations. Interestingly, my personal confrontation with the fragility of life provided a point of relatability for many women. Of course, the differences in our class positions framed our entire experiences of crises—my mother and I were both insured at the time and received care in institutions that serve middle-class patients—and though the women with whom I did research and I both acknowledged these differences, these experiences nonetheless deepened our relationships as we were "suffering" in some capacity together. In fact, before one visit home, one woman sent a card and package to my mother—a prayer card and medallion of Saint Peregrine, the patron saint of those with cancer.

Despite the fact that my hybrid positioning shatters the image of the lone ethnographer conducting exclusively ethnographic research, I believe that these various roles of mine functioned as a strength and facilitated the thick description I attempt in

subsequent chapters. In particular, my roles as both outreach worker in various SROs and employee at the County Hospital provided me unique insight into the operation of the institutional and quasi-institutional environments tasked with responding to the everyday emergencies of the urban poor.

Neighborhood Field Sites

My initial interest in SROs as specific socio-spatial sites of analysis prompted my selection of the two neighborhood field sites where I subsequently focused my research—the Tenderloin and Mission Districts. I will give brief introductions to each neighborhood here, but expand greatly on them in the ethnographic data chapters. The notorious Tenderloin District is geographically small, yet is the most densely populated neighborhood in San Francisco with approximately 25, 000 people per square mile. It is a mix of large and midsize apartment buildings, single room occupancy hotels, social service agencies, schools, and churches. In popular discourse, the Tenderloin is conceived of as the infamous "vice" neighborhood of city, plagued by a long legacy of crime and violence.

It has long been alleged that the Tenderloin functions strategically as the city's "zone of containment" (Bulwa 2007) for the problems associated with homelessness and street-based drug use, in order to keep these social problems out of the purview of tourists and more privileged residents. But ironically, the neighborhood sits flush against the busy tourist and high-end shopping district. As I will show in Chapters 3 through 5, the notion that the Tenderloin is a zone of containment circulates among both police officers and the unstably housed women with whom I did research. But, I also will demonstrate how many of the associations attached to the Tenderloin regarding visible drug use and

supposed quality of life issues are also a function of the city's reliance on the dense concentration of SRO buildings in the neighborhood used to house the hypermarginalized. While these narratives can be conceived of as sensationalized accounts of a poor urban neighborhood, indeed other data demonstrates alarming trends in health outcomes there. For instance, a study that was published near the time that I started fieldwork found that most drug overdoses in San Francisco happen within a one-eighth mile radius of a certain intersection in the neighborhood (Davidson et al. 2003), a corner notorious for its drug activity and intense street scene.

At the time I started field work, the recently formed Tenderloin Community Benefit District initiated and succeeded at having the neighborhood added to the National Park Service's register of historic places. With this addition, the community organization sought to rebrand the neighborhood by installing banners on light posts throughout the blocks proclaiming that the neighborhood was now the "Uptown Tenderloin Historic District." The organization was also instrumental in the installation of historic plaques on various SRO hotel buildings to assert that this neighborhood, often conceived of as a site of rootless transience, was, in fact, a place with authentic history and worthy of pride.

Near the time I started fieldwork, the New York Times published a disturbing article about the burgeoning "reality tourism" industry in the rebranded neighborhood. The article opened:

> Visitors know all too well this pretty city's sights, what with the Golden Gate Bridge, Fisherman's Wharf and the clang-clang-clangy cable cars. But now San Francisco's civic boosters have decided they want to add a highly unlikely stop to the tourist itinerary: the Uptown Tenderloin, the ragged, druggy and determinedly dingy domain of the city's most down and out" (McKinley 2010).

The article discussed the idea that the very characteristics of the neighborhood that make the Tenderloin "one of the most stubborn challenges" in San Francisco—its visible poverty, drug use, and street-based social suffering—could be flipped from a detraction into a spectacle that would bring tourism revenue to the area. In particular, it was the concentration of SRO hotels within the Tenderloin's dense sixty blocks that allowed for the most visual fodder. Tourists would have an opportunity to tour en vivo the impoverished realities of residential hotel life because the hotels in the Tenderloin, unlike New York's Lower East Side tenements, are still being actively used as housing stock for the urban poor. The unique concentration of hotels and their accompanying abject poverty, suffering, and criminal activity were framed as a relic of the past alive in the present, something that should be considered of "great visual interest for those walking down the community's streets." This spatial arrangement plus the overlying drug economy were the unique elements comprising a sensationalized dramaturgical scene:

> The district's drug trade is so widespread, and so wide open, that the police recently asked for special powers to disperse crowds on certain streets. Deranged residents are a constant presence, and after dark the neighborhood can seem downright sinister, with drunken people collapsed on streets and others furtively smoking pipes in doorways. (McKinley 2010)

In contrast to the Tenderloin, the city's Mission District was afforded a different sort of cultural authenticity, given its decades-long history as the thriving Latino enclave in the city. The Mission District's main thoroughfare is a busy shopping district served by multiple cross-town bus lines and two major subway stops. Though the neighborhood had been known for its Latino-owned shops and restaurants, through the 1980s and 1990s it remained a working class neighborhood with its share of crime and violence, which also served as a lower-rent area for artists, bohemians, and punk rockers. The multiple waves

of technology booms in the San Francisco Bay Area slowly began chipping away at the local economy that served the working class and Latino families. The dot-com boom of the late 1990s brought in young, college educated entrepreneurs who still maintained some sense of counter-culture maverick identities and so relished the grittiness, quaint neighborhood bodegas, and street cred afforded by living in a relatively high crime area. This dot-com boom prompted the first wave of rental price surge in the Mission District. At the time that I moved to San Francisco in 1999 at the age of 18, with my coffee shop wages, my only option was to share a bedroom with another young woman in a 2-bedroom apartment in the heart of the Mission with five other people. This trend of young, hip, college educated artist-types in the Mission continued through the first decade of the 21st century at a steady pace, forcing displacement of longstanding Latino families and creating a contested space as community groups organized against evictions, gentrification, and the commodification of Latino cultural events, like the annual Day of the Dead procession.

The second era of pronounced gentrification is currently underway, with a massive explosion of wealth among thousands of young technology workers employed by social media and technology companies such as Facebook, Google, Apple, and Twitter, among countless others. Two factors, in particular, resulted in unprecedented gentrification and overall cultural shifts in the city. First, giant technology companies recognized the cultural cache that the young tech workers saw in living within the city proper. Yet, available land for their massive campuses had been historically located down the peninsula in the Silicon Valley area, about 45 minutes outside of the city. So, these technology companies started a massive bussing program for their potential workers.

Each day the city is flooded with luxury charter buses, which transport employees to their campuses, without the hassle of commuting on their own. The irony is that municipal leaders granted permission for these luxury buses to use the same stops as the problem-ridden municipal bus system. This provides deeply symbolic snapshots of the growing income inequality in San Francisco as working class people experience long waits for dirty and dysfunctional buses, while the luxury, wi-fi enabled, double-decker tech buses flow seamlessly through the same stops.

The second factor unique to this wave of gentrification is that even in the first dot-com boom, there remained a sense that people moved to San Francisco seeking the socially progressive political climate and creative radicalism that had been a draw of the city since at least the 1950s. However, this is the first mass-migration into the city that is prompted by pure economic opportunity and not political or social idealism. The neighborhood is currently a contested space, where the remaining Latino community, intersects a thriving drug economy centered near a remaining cluster of single room occupancy hotels, and increasingly rapid gentrification ushering in luxury condominiums and fine dining. Thus, the locales in which I conducted research remain highly contested spaces and, in the process of gentrification and ever-elevating cost of living, the hypermarginalized are particularly vulnerable as the remaining housing of last resort is further encroached upon.

Chapter 3

SROs AS QUASI-INSTITUTIONAL HOUSING

In San Francisco, SROs operate as the *defacto* housing system for the most marginalized poor. The residential hotels form a patchwork of housing of last resort in a dense, yet spatially small city whose borders are geographically bounded and affordable housing options are limited. The large still in-tact network of residential hotels was originally used for the masses of migrant workers cycling through the San Francisco in the early 1900s and, in contrast to other major US cities, was not demolished over the course of 20th century urban redevelopment (Groth 1994). There are 530 privately run SROs in San Francisco, largely concentrated in three neighborhoods (Fribourg 2009). The preserved SRO hotel housing stock actually outnumbers current public housing units in the city. Thus, in terms of the local built environment, the hotels are one of the most critical material sources of affordable housing.

Further, in San Francisco, through housing and health policy at the local and national level, SRO hotels have come to operate as the primary low-threshold housing *system* for the very poor and socially marginalized who would otherwise be street homeless. These hotels fulfill their function along a continuum, ranging from the privately-owned and managed "daily-rate" hotels that I classify as *quasi-institutional* to the publically managed "supportive housing" SROs that have been converted through city policy and are now *institutionalized*. The daily-rate hotels function as spaces of extreme relegation—the catchment zones for the everyday crises of urban poverty, funneled through broader processes of exclusion, and regulated only by the penal state.

The supportive housing hotels are sites where the already-marginalized urban poor are implicated in the enactment of left-hand state interventions seeking to respond to the housing instability crisis of the last four decades. The range of hotels on this continuum provide rich opportunities for comparison of the paradoxes of social exclusion and state intervention into the lives of the poor in the post-welfare 21st century.

In the following two chapters I argue that across the continuum, ranging from quasi-institutional to institutionalized, these hotels are contradictory spaces and are at once sites of respite and harm, chaos and control, stability and placelessness. In the daily-rate SROs, there is little direct state intervention beyond law enforcement, but nonetheless this housing stock is a critical resource for housing the indigent. The supportive housing hotels represent a formal attempt by local government to ameliorate some of the issues endemic in the daily-rate hotels, yet as I will show ethnographically they too nonetheless function to reinforce and reproduce hypermarginality. Given their unique characteristics and the differential levels of state intervention into these spaces, one would expect radical differences between them in terms of resident's quality of life, experiences of violence and trauma, and the negotiation of drug use, chronic illness, and social support systems.

While my ethnographic research in a range of SROs indeed reveals some critical differences, it also sheds light on the phenomena of SROs as sites where the urban poor are both *contained* and *cared* for, but with critical nuances. I find that these spaces promote a complicated socio-cultural phenomenon, which relegates a segment of the urban poor to perpetual transience and liminality and low parameters for what constitutes living, as residents must weigh risks of living in these hotels against the dangers of living

on the streets. My research reveals the broader subjective realities and health and mental health for those who must live there. In this chapter I will outline the key issues women face in the *quasi-institutional* housing environments of the privately-owned daily-rate hotels. In the following chapter, I will focus on the publicly-run supportive housing hotels that are *institutionalized*.

SROs as a Component of Housing Instability

The term "homeless" does not accurately capture the transient experience of the segment of the urban poor in San Francisco who regularly cycle between sleeping on the streets and through an "institutional circuit" (Hopper et al. 1997)—that is, staying in shelters, incarceration in county jail, doing mandated or voluntary in-patient drug treatment programs, being hospitalized, and moving between multiple SROs. For many SRO residents, constant movement through these institutional circuits is a defining factor of their lives. In the case of the daily-rate hotels, people are routinely displaced by their ability to pay hotel fees, relationships with hotel management, and especially for women, to mitigate exposure to violence and trauma. In the publically-run hotels, people are delayed housing or displaced because of complicated bureaucratic systems and program requirements. SROs become key concentrated sites where the urban poor are channeled through processes of either relegation or program pipelines and then are disproportionately exposed to and bear the burden of the syndemics of urban poverty. They manage their own drug use, mental health, chronic pain, and chronic diseases in environments that often enhance their suffering. In these spaces, the illicit drug trade flourishes, multiple forms of violence are routine, people fear assault, and live daily under the surveillance of law enforcement.

In a paper by my colleagues and I (Knight et al. 2013), we argue that SRO housing environments function as "mental health risk environments" and demonstrate how macro-level factors (policy) and meso-level factors (social relations and the built environment) exacerbate women's mental health issues and result in particular gendered coping strategies within SROs. Our analysis builds on (Lazarus et al. 2011) who show that the violent and exploitative social scenes often found within SROs are sites of particularly gendered risk for poor physical and mental health.

Despite the fact that I have created two analytic categories of SROs for analysis, it must be emphasized that while these hotels have distinct characteristics, they are all interwoven socially and spatially in the neighborhoods where they are located. All the hotels that I did research are concentrated in two neighborhoods and most located within a few blocks of each other, in parts of the city with pockets of poverty and vibrant drug economies. Despite the level of intra-neighborhood transience, residents become integrated into a neighborhood social scene comprised of relationships that span many years.

The Private, Daily-Rate SROs: Quasi-institutional Housing

The private, daily-rate hotels are quasi-institutional housing environments—that is, while they exist outside of the formal network of safety net social services, they fulfill a critical social function as the spaces of last resort to house the very poor who are largely self-managing drug use and mental health issues and who would otherwise be living on the streets. They are a critical site in the local geography of the hypermarginalized. Despite a lack of direct state intervention into these spaces, with the exception of the penal state, they are intricately intertwined with neoliberal poverty and the management

of the “everyday states of emergency” of the poor. Thus, the daily rate hotels are both unregulated, zones of abandonment (Biehl 2013), where people are subject to deplorable conditions, and receive minimal municipal intervention beyond the police. However, they are quasi-institutional because they fulfill a critical function in the continuum of housing and are implicated in the broader landscape of survival strategies for the poor.

Staying in the daily-rate hotels is known to have potential major health consequences. In a large community-based cohort study (N=2574) in Vancouver’s Downtown Eastside area (a city whose SRO housing system is similar to San Francisco’s), HIV infection, emergency room use, cocaine injection, heroin injection, methamphetamine injection, crack-cocaine smoking, recent incarceration, and having been physically assaulted were all found to be independently associated with living in private, unregulated SROs (Shannon et al. 2006). In this chapter, I focus on three key issues within the daily-rate hotels: 1) hotel conditions, 2) access to a room and the characteristic instability, and 3) hotel and surrounding neighborhood violence. What is most visible ethnographically within these unregulated housing environments is that routinized, exceptional, and gendered violence is pervasive.

In the privately run SROs, people typically pay between $35 and $60 per night in cash to stay in these hotels. Rates can vary based on the rapport people have with management. In these hotels, people may have varying degrees of welfare entitlements, but by and large the people staying in the daily-rate hotels are immersed in the illicit drug economy and women “hustle” each day for the day’s rent, either through sex work or petty drug running. People staying in this network of hotels are at times able to accumulate debt to the managers if they are unable to secure payment for a night.

However, not everyone is granted this privilege, and the debt relationships, especially for women who do sex work, can be extremely complicated. For that price, one has access to a small room with a bed, sometimes a small night stand or table, and on rare occasions, a room will have a small pedestal sink with running water. There is typically a communal bathroom on each floor, with a shower stall. The hotel entrances are blocked by steel gates and each person entering must be granted entry and buzzed in by the managers. All visitors are required to check in with the desk clerk before going to a room. I conducted research primarily in ten daily-rate hotels that are concentrated in a two-block radius around the subway stop, which is also the location of one of the city's open-air drug markets.

I gained access into these daily-rate hotels as part of an outreach team that enters the hotels two nights per week to provide door-to-door low threshold services to women residents. Our team, largely consisting of young women involved in harm reduction service provision for drug users more broadly, distributed hygiene supplies and wound care supplies, sterile syringes, food, and social service referrals to women only because of funding stipulations. Our ability to do outreach, amidst the very active illicit economies within the hotels themselves, which were often facilitated by the hotel managers' complicity, was the result of a carefully cultivated relationship of respect over many years. On each shift we witnessed countless drug transactions and women's interactions with sex work clients. The managers and hotel residents largely believed that "the Condom Ladies," as we were known in the hotels, were not "snitches," nor there to necessarily take note of building code violations to report to the City.

For the women, we represented long-time, trusted allies and the only people who entered these spaces and advocated for their needs, even within our actually minimal power. We did many things covertly so as not to disrupt our relationship with the management, who could at any moment (as some did) revoke our access to the spaces without explanation. We distributed syringes subtly to avoid the stigmatizing gaze of the management upon the injection drug users we served. We secretly brought in an embedded community organizer from a local non-profit organization, who counseled women on their legal rights as San Francisco tenants. Our relationship of mutual tolerance was somewhat sinister. We smiled broadly and made polite small talk with the managers to maintain our access, even though we knew well their multiple transgressions against the women, including their often predatory and abusive transactional relationships.

The management welcomed that we provided women with supplies to meet their basic needs because it meant that women approached the managers less frequently with demands. Yet we still endured harsh gazes from the management if we stayed talking to a particular woman for too long in a far corner of the hotel. Occasionally the manager would send a clerk down the hall "to get something from a closet" when they wanted to eavesdrop on our conversations. We were keenly aware that when one hotel clerk told us that she kept a small stock of our supplies in the hotel office to "help women stay safe," she also wanted women to have condoms when a "trick" came looking for sex. This ensured that women would not lose clients, thus endangering their ability to pay rent for the next day or reflect poorly on the vibrance of that hotel's sex economy, a major income generator for the management.

These hotels are all on the upper floors of Victorian buildings, with various retail stores, restaurants, or evangelical churches on the ground floor. Most were storied to be owned by one mythical figure whom residents always had grandiose fantasies of taking down with a lawsuit about the squalid conditions. When I started my fieldwork, this informal network of hotels, with the exception of the Prachi, was managed by South Asian families who lived in small apartment compounds near the entrance to each building. Each evening we went in for outreach, the smell of curry and other spices wafted through the hallways as these families prepared dinner. These families attempted to live as cordoned off as possible from the broader hotel social life. They had elaborate locks on the windowless wooden doors that separated their home spaces from the chaos of the hotel hallways and we typically only interacted with the front desk clerk—young men in their 20s who never made any attempts at additional conversation when we entered the building.

The exception was the Prachi Hotel, which was unique in many respects because of its location a few blocks up from the subway station, deeper into the Latino-dominated part of the neighborhood and at one primary corner where *Sureño* gang members congregated. In fact, this corner was actually one of the supposed boundaries between *Sureño* and *Norteño* territory and so young men dressed in blue often posted themselves in front of the *taqueria* on the ground floor of the building as patrols of the territory line. This hotel was run by a large Latino family and residents included single men who were recent immigrants as well as those involved in the drug economy. The management kept their living space visible and somewhat open to main hotel hallway through a large glass window that was often kept wide open. As we entered, one could always hear the TV

blaring and see family members relaxing on multiple couches in their living room space. Several young children played in the front hallways of the hotel, often sweet-talking us into sneaking them extra peanut butter and jelly sandwiches. This is the only hotel where I was able to initially forge somewhat of a relationship with hotel managers, since I was the only outreach worker at the time who spoke Spanish and could converse casually with the family.

Conditions in the Daily-rate Hotels

By and large conditions in the daily-rate hotels provoke a lot of anxiety and disgust from the residents and the buildings are poorly maintained. In many of the daily-rate hotels, the walls are covered with graffiti, the colorful carpets are caked with dirt, and the mattresses are soiled or infested with bed bugs. Given the architecture of these old Victorian structures, buildings are typically narrow and deep and so if there is a window in the room, it will likely face an airshaft, thus limiting the light that enters the room and the air circulation. The lack of fresh air can be intolerable, given that there is often garbage piled in hallways, dust and vermin, and smoke from cigarettes and crack cocaine circulating in these small spaces. Carpets were frequently soiled with leaking water, urine, or even vomit. On one of my first outreach shifts, I bent down on one knee to pack a paper sack full of supplies and the fabric of my jeans was quickly soaked through by a puddle of urine near the bathroom entrance. I never balanced on my knee again, but learned how to crouch down and hover while I distributed supplies. As women told me, it was common for the shared bathrooms to be converted into shooting galleries through the course of the night and then littered with used syringes or spattered blood from “missed shots” (when someone misses a vein during the injection process). One

hotel had made an attempt at HIV risk reduction by installing a biohazard bucket in hallway for safe syringe disposal, but the bucket was rarely emptied and would overflow with bloody, used syringes. On our outreach shifts, it was common for women to request antibiotic ointment to treat bed bug or spider bites that they had received while staying in the various daily-rate hotels.

Additionally, the daily rate hotels are very active nighttime drug scenes. People stay up all night in the hotels using crack-cocaine or speed together, watching television, and socializing. People bounce from room to room at all hours of the night to share drugs, "bum" cigarettes, and borrow each other's lighters. Thus, the rooms and hallways are sometimes littered with trash from the previous night's partying. Women often opened their hotel room doors widely to reveal that they had been sleeping on a mattress spattered with plastic wrappers and spilled food. In one hotel, the Diamond, the building's trashcans are stored in the hallway near the hotel rooms. On every outreach shift here, the stench of garbage was unbearable and I often held my breath and swatted my way through swarms of flies as I moved through the hallway. Because of the level of transience in the daily rate hotels, people's belongings were frequently removed from hotel rooms and dumped in the narrow hallways. It was not uncommon for there to be piles of electronics, clothing, bedding, and mattresses soiled with urine and blood clogging up the hallways after hotel managers cleared out a room. We became skilled at shimmying by all this debris with our bulky outreach bags, without making physical contact.

One older woman, Joanna, who lived at the Prachi, was no longer using drugs, but had debilitating mental health issues. She had a special arrangement with the

management and was allowed to stay in her room indefinitely, which was downstairs in an isolated hallway near the manager's office. This spatial arrangement was preferable because it brought her some distance from the very active drug scene upstairs, but she lamented that her window opened to an airshaft shared with many of the hotel rooms above. She said that the women upstairs partied all night using drugs and actually threw their soiled tampons and maxi-pads down into the airshaft, which meant she would never dare open her window for air circulation. This was a huge issue for Joanna because she herself was a severe hoarder and her room was musty, the air stagnant, and filled with a stench of rotting food. These intense physical conditions had emotional implications for women, including stress and discomfort. They also presented acute sanitary issues which impacted women's physical health. Many women were forced to manage and self-treat abscesses, cellulitis, HIV, and even breast cancer and liver failure in these spaces.

Forced Internal Displacement- Musical Rooming

Most of the women who stayed in this network of daily rate hotels had been doing so for years and were intertwined with the illicit drug and sex economies within and surrounding the hotels, both because they were long time drug users and because these economies were the only prospect of income generation needed for basic survival, either through sex work or small-time drug running. Furthermore, the women were subject to a phenomenon unique to the daily-rate hotels known as "musical rooming" (Carr and Kollmann 2010). In this illegal practice, hotel managers limit residents' continuous stay in any given room to 28 days, then force people to move out for at least one night. This practice is enforced to ensure that residents do not live in any one room for 32 days consecutively, after which in the city of San Francisco, people are entitled to legal rights

as tenants with “residency.” These rights include protections against unfounded evictions and specific institutional channels for airing grievances about unfair management practices and housing conditions. Plus, technically once a tenant gains residency, they are also entitled to move away from the daily-rate payment structure and can pay rent in monthly installments, which is typically more affordable.

In the Mission, three hotels—the Prachi, the Yash, and the Diamond—were operated by the same owner and thus formed an established network of forced internal displacement and were together a complicated, dramatic social scene within which women regularly cycled. For instance, if one woman had reached her 28 days at the Prachi, even if she had money, she could be forced to move into the Yash or Diamond for one night to restart the residency clock. But if, for instance, she found the conditions at the Yash or Diamond unacceptable, her only recourse would be to either find another hotel altogether, or stay outside. The phenomenon of musical rooming ensured that women could not maintain any measure of stability or cultivate domesticity, as they could never accumulate things needed for everyday life, nor ever live with a sense that their room was guaranteed. This also meant that they never were able to maintain a stable address to get mail, another major barrier to acquiring and maintaining welfare entitlements, and also a barrier to maintaining relationships within the health care system. Further, being forcefully displaced for only one day could drive women into risky partnerships with men who had a room for the night so they might avoid the hassle or impossibility of securing a new hotel room on the block. The significance of this forced internal transience between daily rate hotels is that women live perpetually in a state of acute housing crisis.

Hotel and Neighborhood Violence

Violence in the daily-rate hotels, both within interpersonal relationships and violence associated with the drug economy or sex trade is a near daily occurrence. The constant threat of violence means that women live in a state of hypervigiliance—what one woman so aptly referred to as "war mode"—in an attempt to channel their fear and mitigate their risk for assault. On the night of my very first outreach shift in the daily-rate hotels, I walked down Mission Street and into a chaotic street scene. A woman named Denise had (according to the various stories we heard from women that night) either jumped, fell, or had been pushed out of the 3rd story window of the Yash and onto the concrete sidewalk below. Denise was rushed to the County hospital in critical condition. On the night of the accident, women were overwhelmed and traumatized. People stayed in their rooms with the doors shut, as nobody really wanted to discuss what had happened, but multiple accounts quickly emerged. We deduced that Denise's sister, Marla, was staying at the Diamond Hotel on 16th Street. The next day I went to the Diamond with another outreach worker and we managed to find her. She opened her door wearing a white sleeveless top, a skirt, and black tights. She was extremely high on heroin with her lids heavy as she spoke. She invited us into her barren room, which had nothing else in it except for a bed piled with tampons, condoms, and syringes that she had gotten from the outreach team the night before.

Even though Marla had a few more details on what had happened, even she did not know the full story and had not been out to the hospital to visit Denise yet. Apparently, Denise had been doing some petty drug dealing and owed around $200 in back debt. The dealer sent someone to the Yash, where Denise was staying, to collect the

debt. According to Marla, either 1) Denise panicked and tried to climb out the window onto the slim ledge to escape, 2) the people who came to collect the debt pushed her out or, 3) in the midst of their physical altercation, Denise accidentally fell out of the window. Marla had heard that Denise's back was broken in three places, she was likely paralyzed from the waist down, and would be hospitalized for at least six months. Despite the fact that the hospital was in walking distance of the Diamond, or just a short bus ride away, Marla was holding off going to visit Denise. At this point, Marla was deep in her heroin addiction and did not want to leave the hotel corridor where she could predictably make a little money, cop drugs, and inject. Their mother had come to San Francisco from Santa Rosa to visit Denise, but did not want to spend the night at the Diamond with Marla. Their mother is in recovery from drug addiction and it would be too risky for her to stay in a place where she could so easily get drugs. Marla was hoping that she and her mom could get a "regular," i.e., tourist hotel together for a few days. She had already made plans for how she could "do her thing" (use heroin to avoid withdrawal), without her mother having to witness her injecting.

The high level of violence against women in the daily-rate hotels, though incredibly traumatic and anxiety producing for the women, was quite normalized. On outreach shifts, women frequently reported that they had been assaulted in the last week since we had seen them. Unfortunately, because of the insularity of the social scene, the perpetrator often continued to live a few doors down from them after the assault. One night at the Yash, Betty, told us about how a man down the hall had assaulted her by choking her and actually lifted her three feet up into the air with his hand around her throat. She showed us the bruises and handprints around her slim neck. We offered

referrals to get Betty into an emergency domestic violence shelter for the night, but she said she would rather just stay in the hotel and use drugs to try and get some sleep.

Because of the complex gendered hierarchies in the drug and sex trade, men were routinely verbally and physically abusive to women in the daily-rate hotels. We as outreach workers were not exempt from men's enactment of violent control over the hallways, the sites that were critical to their income generation in the drug and sex trade. If we stayed too long in a particular area of a hotel, men would occasionally ask us to "move on" or shout at us to get out of the hallway. As we were distributing supplies and talking to women in the Thomas Hotel one night, a man opened his door and angrily screamed at us, "What the fuck is all the noise out here? This is fucking bullshit noise! Get the fuck out of here!" We were occasionally cornered and intimidated in the back hallways of hotels by men we were told were pimps, who demanded to know what supplies or information we were giving to the women. As we were packing outreach bags for women out on Mission Street in front of the hotel one day, a woman was reflecting on the violence towards women in the hotels. She proudly declared her strategy to maintain safety within earshot of the group of men standing a few yards away from us on the street: "They don't fuck with me because they've seen me stab people! Seriously! I've stabbed people so they don't fuck with me. It's crazy out here!"

"Routinized" Violence: A Crack Deal Gone Bad

The drug trade in the daily-rate hotels is so ubiquitous and so open, that drug transactions were routinely conducted over our heads as we were crouched down to fill bags with supplies for women. Perhaps this was strategic, since we offered some human camouflage from the gaze of hotel management or other residents while people

exchanged drugs for money. The following ethnographic story elucidates how seemingly mundane drug transactions can quickly escalate in hotels that are at once sites of respite from the streets, but also sites of potential violence. It also demonstrates my experience as a researcher/outreach worker in an escalating situation and my visceral reaction in the cramped spaces of SRO hotels.

One night, after we distributed supplies in the busy Yash, which consistently had the most women inhabitants, we were conversing with the hotel clerk near the top of the stairs. The manager's mother, Lorena, a Latina woman in her late 50s, cleaned the hotel and she and I typically conversed. She began to enact a maternal role with me every time she saw me in the hotels, urging me to be careful about staying out too late and warning me about avoiding the most dangerous places in the neighborhood. When we were ready to leave on this night, I was nearest the staircase and turned to descend the stairs to head down to Mission Street. At this time, the Yash only had one steel door at the bottom of the stairwell that opened directly onto the street and not the second steel gate that most other hotels have at the top of the stairs. I peered down the staircase and paused because two people were assembled at the bottom of the steps. It was immediately clear that they were involved in a drug sale and so with the cumbersome outreach bags on my shoulders, I directed the rest of the outreach team to take a few steps in reverse so we could let the men downstairs finish their transaction before we descended the stairs.

As I was backing up, I happened to see one of them, a man with light skin and long gray-blonde hair (a hippy-type who I had never seen staying in the hotels), light up his crack pipe and "take a hit." The other man, a slender African American man named Benny, who was always very put together and who I saw regularly in the hotels, just

happened to glance up at me at this moment. Seeing that I had witnessed the hippy outsider light his crack pipe, Benny immediately started screaming at him and letting the hippy know that he had broken a social convention that I had not known existed—that it was not acceptable to smoke crack in the hallways in front of the Condom Ladies. I also felt that Benny's reaction was part diversion from the fact that I, in my capacity as an outreach worker, had witnessed him selling crack. Benny shouted at him: "What the fuck you doing, nigger? We've got the ladies up there!"

The hippy started shouting back in his face and at this point, I decided to shuttle the outreach team a little further back down the narrow hallway in case the situation continued to escalate. As I was moving back, the grey-haired man provokingly lifted the crack pipe to his mouth to take another hit and Benny reached over, slapped the guy in the face to knock the pipe out of his mouth. The pipe hit the floor and broke. Down with it went the hit of crack that the grey-haired hippy had just bought from Benny. With this, they were immediately shoving each other and tumbling around the tiny four by four foot space at the bottom of the stairs. I could see Benny was trying to push the other guy out of the steel gate, so he could latch the lock behind him. But this agitated the hippy and the fighting intensified. Of course at this point, my fight or flight response was fully activated. I felt trapped—locked in by the narrow hallways that provided no other escape route—and wondered who would be first to take out a weapon. Admittedly, the limiting physical space was really what triggered my anxiousness. I was not initially fearful that we would be attacked in the scuffle, but being physically trapped in the tight space simply provoked a visceral response, different from being out on the streets.

This was one of the first shifts that Timo joined us on outreach—a former resident of the SRO hotel scene, who had recently started an internship with a local non-profit organization. Timo is a six-foot tall African-American man well-known to the SRO scene because he and his long-time boyfriend, who was a heroin user, spent years in the daily-rate hotels. Timo, who is now a close friend of mine, pushed me out of the way towards the manager's office, just as Benny managed to push the other man out of the gate. I heard the metal gate latch. But now, the hippy had flown into an intense rage and it became clear that maybe he was fairly high on stimulants. He started slamming into the gate with his entire body weight. He smashed numerous glass bottles from the street into the gate and the shards of broken glass shot through the gaps in the gate. For what felt like an incredibly long time, the man was slamming his entire body and anything he could find into the gate.

Timo descended the stairs about half way and the man flew into an even more intense rage, bashing himself into the metal gate over and over. Everyone's anxiety about the situation intensified, as it was clear that we would not be able to leave the building safely until he was gone. As he continued punching and kicking the door and we heard him making repeated contact with the gate, we all began to think it was only going to be a short time until he burst through it. At this point Lorena started pleading with me to bring everyone into her room and she could lock the door. But Timo was still down the stairs and would not come up and I did not want to leave him behind. With each time the man downstairs hit the door with his body, Lorena would grab the collar of my shirt and urge me to let her lock us in her room. She even showed me a small trap door in her closet that led into another room that she wanted us all to hide in. In this moment, I was managing

multiple considerations at once and things began to happen in slow motion. As the most senior outreach worker on the shift, I felt a responsibility to enact protocol that would prioritize the safety of the outreach team. I started to think about calling the police.

At this point, a young African-American man named Blue who we were well acquainted with came down the stairs to see what all the commotion was about. He went down the stairs and opened the gate to tell the guy to move on, but at this point the guy pulled out a knife. Blue walked back up the stairs, went to his room, and about thirty seconds later reappeared in the hallway with a two by four of wood. My head immediately flooded with all the potential violent scenarios that were about to take place—Blue bashing the man's head in, the guy stabbing Blue, Timo getting in between them and getting injured too—and with that, I reached for the receiver of the telephone hanging near Lorena's door and dialed 911. At this point I heard Timo screaming to Blue that I was calling the cops and that he should flee the scene or else, when they arrived and saw a young black man with a two by four, he could be arrested for assault with a deadly weapon. I put my ear to the phone and could barely hear a dial tone because the phone was so old. All I could hear was static.

The dispatcher picked up and the static was so bad that I could barely hear her. I shouted for everyone to keep their voices down. For some reason, it never occurred to us to try using our cell phones. The dispatcher asked me for the address. Surprisingly, none of us, not even Lorena, knew the address of the Yash. This, plus the fact that I could barely hear her, really seemed to irritate the dispatcher and she gave me a miniature lecture: "We wouldn't be able to find you unless you knew the address if you weren't coming in on a 911 call." I said, "Come on, but I am coming in on a 911 call! So you

know the address!" I imagined that she, seeing another call from a Mission SRO, was rolling her eyes on the other end of the line, doubting the severity of the call. I hung up the phone, aggravated that I was getting a lecture from the dispatcher as I was reluctantly summoning the police to the hotel. Despite the fact that the police station is only two blocks away, it took about seven minutes for the police to show up, all the while the man downstairs was still trying to break through the gate. The energy level was really high. Timo was shouting at me from the middle of the stairs, Lorena was understandably terrified and shouting commands at me in Spanish, and I was worried about checking in with the other two members of the outreach team. At the point I was also worried about Lorena's anxiety level relative to her immigration status. She had recently told me that neither she, nor many members of her family, "have papers." While San Francisco is indeed a sanctuary city, meaning that the police do not ask for proof of immigration status while on patrol, I knew that Lorena likely did not want to have direct contact with police nor manage the language barrier.

Suddenly I heard Timo open the metal gate, but then scream back: "Girls! Get down here! The cops are here and they think it's me!" Again, Timo, a six foot tall African American man who had been "jacked" by the cops many times, was opening the door to cops summoned on a 911 call at a SRO. He knew to fear that they would assume he was the assailant. I rushed downstairs to see between eight and ten police officers on the sidewalk in front of the Yash. Four cop cars were parked on the street. Two regular patrol cars parked facing south, one grey undercover sedan, and two more police cruisers parked facing the wrong way on the street. They must have just peeled down from the station going the wrong way for half a block. Timo screamed at the cops, "He went that

way!" But the police casually peered down the street to the busy subway entrance, where probably at least a dozen men lounging on the steps could fit the hippie's description. The police response, after all of the stress and anxiety we had experienced as a result of the situation, was almost laughable.

As I crossed the threshold of the metal gate from the Yash onto the street, with its mixture of Latino families and young hipster commuters, I was struck at how my own physical sensation of the impending danger was transformed. It was as though I was transported, with that step onto the street which was so familiar to me, to instant relief. Even the initial blast of cool, foggy air on the street gave me respite. I became aware that I had developed my own hypervigilance particular to the spatial contexts of the daily-rate SROs. The tightly cramped hallway had activated an intense emotional response that I may not have had in the same situation on the streets. Later I reflected, as we demonstrate in our paper on SROs as mental health risk environments (Knight et al. 2013), how women with long histories of violence and post-traumatic stress disorder confront situations such as this, which are everyday occurrences at the daily-rate hotels.

I approached the cop standing nearest to the gate, and attempted to have him walk with me to stand closer to the curb, hoping he might not feel the need to go upstairs into the Yash, which I knew could potentially bring headaches for Lorena and the other hotel residents. I scooted through all the debris that the hippy had smashed against the gate—piles of broken glass, smashed electronics that he had picked up from a pile on the street, and other trash. I expected for the cop to want to engage with me some way, to ask me a few questions about what had happened and why we called. But surprisingly, none of the officers were interested in taking anyone's statements, even informally. Instead, they

were making small talk with each other and scooting the piles of broken class towards the curb with their boots. Their disinterest, though not really surprising, angered me. The rest of the outreach team piled down the stairs with their bulky outreach bags in tow. One officer indifferently asked me, “Where you all headed?” I said we were parked two blocks away. To which he responded nonchalantly and gestured south as if to scoot us down the street. “You all should be allright,” he said. I felt bad that I did not go back up the stairs to talk with Lorena again, but after lingering for a few minutes to see that the cops were not interested in what happened, nor going up into the Yash, we needed to head back to the car to debrief as a team.

On our walk down Mission Street, Timo launched into what felt like a lecture about how what had just happened was nothing compared to the brutality he had regularly witnessed in the hotels. And I did not doubt that. For him, this was just another predictable situation with a “crack head.” When I got home my partner opened the door to our apartment with a worried expression on his face. Apparently only a few minutes after we had left the block there was a shooting right at the subway station, just a few doors down from the Yash. Shots were fired and five people were injured. The police’s indifference to our call made a little more sense. The comparatively “mundane” incidents, where no one was physically injured such as in the Yash that night, are nonetheless part of the broader continuum of everyday violence in the daily-rate hotels. These types of incidents have a cumulative effect on the general level of anxiety and hypervigilance of people cycling through the hotels because they demonstrate the always looming potential for physical harm and cumulative trauma from witnessing and experiencing violence and loss.

This incident demonstrates the sensorial experience in the hotels in a moment of crisis. Also, it sheds light on a telling moment of rumination that occurred, where I debated whether or not to call the police. A man had essentially trapped people in the building and was both threating violence and damaging property. In any other context, most would have immediately called the police. In this situation, however, we waited and contemplated. Our interpretation of whether something *actually* constituted an emergency was skewed. Our parameters had shifted to interpret this as "routinized" and not immediately exceptional enough to call the police. Further, when we finally called and the police arrived, their only real intervention into the situation was that their approaching sirens caused the man to move down the block, thus they too buttressed our interpretation.

"Exceptional" Violence: Murder in the Daily-Rate Hotels.

Exceptional incidents within the hotels and escalations of violence in the neighborhood more broadly, confirmed people's fears that their hypervigilance in the context of everyday, routinized violence was warranted. In the Fall of 2010, Julie, a 37-year old woman who had lived in the daily-rate hotels for nearly a decade, was brutally murdered in a hotel room at the Astha. The man who killed her and later turned himself in for the crime, Jerry, had also been a resident of daily-rate hotels for countless years. Hotel residents and we outreach workers were always well aware of his presence, but many avoided him. He was a regular stimulant user and could be confrontational in the hallways. The first time I met him on an outreach shift, he was walking through the halls of the Thomas Hotel, carrying a mop bucket and various cleaning supplies. As he approached the group of us outreach workers huddled in a corner, filling bags for women,

he got close to my face and shouted: “You know me, I’m the BBD!...Big black dick!” And he walked down the hall chuckling, seeing that we were all visibly uncomfortable by his performance of hyper-masculinity. I had met Julie and her partner, Benjie, only a few times. They were both sweet and soft spoken and struggled every day to meet their most basic needs of food and shelter. As I later heard, on the night of her death Julie could not get enough money together to pay for a room and Jerry offered, as he occasionally did, for her to stay with him at the Astha.

A woman who I saw regularly on outreach named Stella was also staying at the Astha Hotel that night, a few doors down from Room 46, where Julie was killed. She knew them both well and also admitted to being afraid of Jerry’s violent tendencies. Stella typically kept to herself, seeking to avoid hotel drama as much as possible. But after that night, she isolated even more and her drug use escalated. Though none of us ever wanted to push Stella into reliving the details, she told us on the street one day that the evening of the murder, she had heard piercing screams coming from Room 46. Chillingly, she told us (and later verbatim to one of the local neighborhood newspapers that reported on the murder) that yes, she had heard the screams and was aware that Jerry was probably beating up Julie. But, that if she had known he was *actually killing* her, she might have tried to do something. She had contemplated going to that room—she did not say she contemplated calling the police—but feared that Jerry would likely turn on her and attack her. The gravity of her rationale weighed heavily. Violence against women was so routinized in this context that Stella was making differentiations about whether someone was “just” getting beaten versus “actually” getting killed.

The next day the SFPD got an anonymous call that there was a dead body in Room 46 of the Astha. Later, Jerry turned himself in to authorities. People in the hotels were devastated, as Julie was well loved and very close to many. The shock of the event was intensified as both rumors circulated about what had happened and the District Attorney filed charges against Jerry. When word got around weeks later that he had been charged with murder, rape, and sodomy and that Julie had been killed "during the commission of sexual assault," it was clear that the scenario was as unimaginably brutal as it could possibly have been. Stella told us with a protective detachment on the street that day that the cops, after they taped off the door, had left Julie's body in Room 46 for two days. She had not wanted to get too involved in the investigation, despite the fact that the cops were in the hotel continuously. People were already claiming that Julie's ghost was wreaking havoc in the hotel.

People planned a memorial for Julie at a resource center around the corner. Several articles ran in local online papers expressing shock, disgust, sympathy, and sadness in dozens of comments to the articles. My friend Emilia, who runs the overdose prevention program for the City of San Francisco, posted an open invitation to the memorial in the comment section of one article. Several months later, much to our total astonishment, an Assistant District Attorney (ADA) contacted Emilia, saying he saw her post and wondered if she might be able to connect him with informants as the ADA built their case against Jerry. The ADA was desperate for help because the file he had received on Julie's murder, which should have had statements from police and witnesses, was empty.

Emilia and Timo, who were very close with Julie, did the best they could to connect this ADA with Stella and other people with information about that night. But, not surprisingly, many did not want to reawaken that trauma and preferred just to try to move on. It was not lost on the ADA that the lack of evidence in the file was an atrocity. For those of us who work frequently with this population in both a direct service and research capacity, we were saddened by the confirmation that these people's lives were undervalued, even after an exceptionally brutal death. At this time too, the level of violence in the neighborhood had escalated and there was a real sense of burnout among the social service providers who worked with this population. In an attempt to express the level of injustice he recognized in the mishandling of Julie's case, the ADA made several symbolic appearances at vigils held soon after for victims of violence in the Mission, sticking out like a sore thumb in his neatly pressed grey suits amidst all the harm reduction social service providers covered in tattoos and dressed in all black and the hotel residents congregated in local plaza.

Julie's murder represents my first navigation of an extremely challenging situation ethically and methodologically as an ethnographer. In fact, even as I write this, I am disgusted that while so many people were suffering the trauma of her loss, I was contemplating how I would go on with data collection and whether it would be naïve to "miss out" on key information regarding this event. Given that many people in my life were intimately intertwined with her murder and trying to make sense of the brutality that had been acted upon her, I opted to document the situation from a distance, rather than pursue the gritty details in the aftermath. Admittedly, this was also a protective mechanism for myself. Would I be able to go on with field work at this early stage, if I

dove into the ruthlessness of Julie's murder, when I had cultivated some necessary distance from the pervasive threat of danger I put myself in during field work? Also, the situation triggered my more general sense of potential for violence against women. As far as the details of Julie's murder, I knew that it happened and I knew it was as ruthless as it possibly could have been. Requiring more simply for analytic purposes at that time from the people around me simply seemed pornographic. Two close friends and direct service providers later went to bear witness at the murder trial. They said that hearing the details of what happened that night was incredibly traumatic and something they would never forget.

In the months after Julie's death, violence in the neighborhood had escalated. A man had been shot in the face and killed in front of a bodega at six o'clock in the evening, while the streets were still bustling. We began to see fewer and fewer women in the evenings during outreach shifts. And the streets were eerily empty. SFPD suggested that it was gang-related and that the *Norteño* and *Sureños* were battling turf. On my work commute, which sometimes included travelling by bus through the Tenderloin, I began to occasionally see women from the Mission in the Tenderloin. Alya, a former SRO hotel resident who was now volunteering with us, confirmed what I had seen—more women from the Mission in the Tenderloin. She suspected it was actually a mass migration to the Tenderloin due to the escalating violence around the corridor.

Besides the threat of getting shot, women were also fleeing the intensified police presence since the SFPD was now under increased pressure to take action to curb the alleged surge in gang violence. The intensified violence continued for several months, with a high profile murder of a 24-year old Latino man, a retaliation shooting, and then a

stabbing at the vigil for the slain man. There was a shooting that police reported had happened on the street, but as we later found out from women, actually took place inside the Prachi Hotel. The victim was the boyfriend of a woman we knew from outreach. He was shot inside the hotel, but then crawled out onto the street, as rumor had it, so as not bring the cops into the Prachi, where many of his associates were staying that night. This long stretch of exceptional cases of violence in or around the daily-rate hotels was extremely traumatic for women and all took place in the context of their management of existing mental health issues, addiction, and chronic illness. While it was sometimes possible to distance oneself from the mundane and exceptional violence by socially isolating, as the next section demonstrates, at times the social dynamics of specific hotels undermined this strategy.

Gendered Violence: The Making of a Brothel

Because women have few options to ensure their basic survival and hotels are their only option before the streets, women can quickly become enmeshed in the social dynamic of a specific hotel that is predatory. In the daily rate hotels, the illicit drug and sex trade was omnipresent, despite the routine and sometimes drastic ebbs and flows in activity because of broader police presence, crackdowns and sweeps of particular hotels, people getting incarcerated, or moving on for other reasons. Doing long-term fieldwork in this context characterized by transience afforded me the opportunity to witness these changes and the factors that contributed to them.

I took a hiatus from field work after an appendicitis and immediately upon my return noticed a strange transformation of the Yash Hotel. The Yash has long held the reputation of being one the most chaotic hotels on the block in terms of drug trafficking

and sex trade. Many people attributed this to the fact that it was the only hotel on the block that was zoned as a tourist hotel, meaning that no one could ever be given residency there under San Francisco's tenant rights laws. So turnover was by nature always high and the hotel was frequently used as a space critical to the neighborhood's sex trade. As I mentioned, the Yash is part of a network of three hotels—the others are the Prachi and Diamond—that are under the same ownership. Women are frequently "musically roomed" within this network. At the start of my field work, the Prachi was managed by the Latino family and the Yash and Diamond were managed by two South Asian families.

In the Spring of 2011 when I started going in to the hotels again, I noticed slight cosmetic changes happening in the Yash. First, there used to be a small little nook at the top of the stairs where a lone, young south Asian man sat, demanding to know the purpose of each person's visit if they were not paying customers. He was the only representative of the hotel management that was visible to tenants. The living quarters of the management were hidden behind locked wooden doors. On this day, I noticed that a large, dusty fake plastic plant that had hung at the top of the stairs had been replaced with two large mirrors. They were positioned strategically, so that if someone were to stand at the doorway to the manager's quarters, he or she would have a direct line down the stairs to the gate at the street. We ran into Lorena, who gave me the lowdown on what was happening. Lorena's daughter, who had previously helped to run the Prachi, was now taking over at the Yash. Another family member who had been involved at the Prachi would also be taking over the Diamond Hotel.

Lorena unlocked what had, until then, been the mysterious and inaccessible wooden door to the manager's quarters. She wanted to show me around and demonstrate what an improvement it was over the conditions at the Prachi. The door from the hallway opened right into a cramped bedroom, about 9 x 9 feet, with a large outdated television, an old wooden dresser, and a queen-size bed. She pointed through another doorway and I could see a kitchen and large living room with windows facing the street. Lorena would be sleeping in one of the regular hotel rooms near the manager's quarters, but since she was family, she had free access to the larger space during the day. Despite the fact that she was happy about this relative improvement, she told me that she was eager to get back to Mexico as soon as possible. Her husband was about to cross the border with a coyote and they planned to work for just a few months to earn money before heading back.

As Lorena was showing me the new space, several tenants came down from upstairs. One was Claudia, a Latina woman in her early twenties who was about five months pregnant. We had not seen her in months and we heard that she had gone into drug treatment. She immediately assured us she would not be using drugs while she stayed at the Yash that night, and that she was only there while she tried to secure a slot in the family shelter with her baby's father. A drunk and belligerent man stumbled into our outreach bags that were lined up on the floor and started swearing at us about how it was bullshit that we only gave supplies to women. He lingered around us, getting more and more agitated before finally losing interest in us and meandering back up the stairs. Lorena pulled me to the side and went on a tirade. She was disgusted by how lazy Americans are and how they expect people to give them handouts. She said "In Mexico

people appreciate the handouts they get, even though it's mostly crap. But here, people get nice things and don't appreciate them and are just hungry for more." She said, with tremendous disgust, that she would only be able to handle the hotels for a short time longer.

I continued to notice other changes at the Yash. A second metal gate was added at the top of the stairs for additional security. A glass window was added to the wall alongside the manager's quarters. More women started to stay there on a regular basis. There seemed to be friendlier relationships between the young Latino couple that now managed the hotel (Lorena's daughter and her husband) and the men that stayed at the Yash. One evening, I witnessed two African-American men residents excitedly carrying pink plastic bags full of meat from the butcher a few doors down. The new managers had coordinated a barbeque on the roof later that night and had invited all the tenants to join. This was truly perplexing, since it stood in such sharp contrast to the relationships between the prior management and tenants I had witnessed before. As I began to inquire about what was happening at the Yash, it became clear that there was an intensification of the drug and sex trade there, initiated by the change in management.

Management in these hotels had long been complicit in profiting from the sex trade. Besides the fact that they knowingly rented rooms to women who paid their rent solely through sex work conducted in the hotels, there was also a ubiquitous, though illegal, practice of charging "visiting fees" to anyone who entered the hotel that was not a paying tenant. In fact, the first time I went into the Yash on my own outside of the outreach shift, the man at the desk told me that if I stayed for longer than five minutes, I would need to pay a $5 visiting fee. These fees function to ensure that hotel management

can command their own profit margin from the sex trade beyond the rent, since multiple men visit the hotel in punctuated times throughout the day and night to connect with women. This practice was a source of much anger and frustration for women because the practice often complicated their relationships with incoming clients and, at times, jeopardized their ability to make money.

One woman Cecilia, who was staying at the Northpoint Hotel, told us that she was used to the $5 visiting fees expected by the hotel management. But recently, if a client tried to pay with a $20 bill, the management would say they did not have change and take the whole twenty for the visiting fee. Clients, expecting compensation from somewhere, would then refuse to pay the woman the full amount that she was charging to meet with them. Cecilia also later told me that the visiting fee mechanism provided a means by which the management could collect on the rental debt that they had allowed her to accrue. At this point, when a client came to see her, the manager would say that the visiting fee to see Cecilia was $40. The manager told Cecilia that this money was being collected to put directly toward her accrued debt. That day Cecilia was forced to comply because she needed the money. However, her date refused to pay her anything additional and she was left with nothing.

As women who cycled through the daily rate hotels noticed the changes at the Yash, they began strategizing about how to avoid what soon became mounting chaos at the hotel. Natasha, a 35-year old woman with light skin and dirty blonde hair, had just purposefully moved out and was lucky to have secured a room at a highly coveted hotel on the block, the Parth. She uses crack, but her primary drug is heroin. She also works as a drug runner for her partner, who brings in heroin from the East Bay to sell in the

surrounding corridor. She had to get out of the Yash because it was becoming too much of a risk for encounters with the police, since it was now such a concentrated site for drug and sex trafficking. She told me:

> It's pretty quiet [in the new hotel]. That's why I stay there, because it's quiet. It's a lot quieter than that other motel [the Yash]. Yeah, it's kinda crazy over there, you know. I kind of want to keep the heat off me, you know, so I go where it's quiet because being where everybody else is at, it puts heat on me with the police and stuff like that. It's crazy over there. Because all the dope sellers are over there, you know. Mostly everybody's selling dope or prostituting. [The new arrangement is] more convenient. [It's] for everybody's convenience. They try to make it convenient. You know, they don't gotta go far for their dope. It's crazy over there. I would not stay there again. I would sleep in the street before I would stay there.

Lilah, who was a ten year veteran of the daily-rate hotels also echoed that the Yash had undergone radical transformation. Interestingly, she appealed to a romanticized past, when both the drugs were better and the hotels were safer. She attributed the changing Yash to the shift in management, which meant more raids on the one hand and also that the management was less likely to call the police in moments of real crisis. She reflected on past eras she had experienced in the hotels, between the 1990s and now, activating a racialized interpretation of the shift:

> Lilah: Actually, you know, to me the hotels was safer back then. And a little more—like I said—it was nicer. People wadn't getting robbed and jacked. You didn't hear too much of tricks getting fucked with or nothin. Now, man, it's off the hook! And it's like, you know, since they changed, like the Yash. See, that's another thing too. In [my old] hotel, [the manager] never—he would never put nobody in—he's picky in other words. Not everybody can go up in them hotels, okay? You know what I'm saying? Once you do some dirt, you not going back in. I don't care how much money you got. Them other hotels, they don't care as longs as they get the money and rent paid, you can come back. That shit ain't cool. Yeah. The Prachi and the Yash—ever since they changed too. See they [the South Asian family] don't work there no more. So they let the Mexicans take over. And it's crazy now! Man, it's off the hook! Yeah, that's one of the worst things that ever happened, you know, that change, okay? It's to the dogs, you know what I'm saying? And at first, you know,

> I liked it. But those Mexicans, they started out at the Prachi. The Prachi was the first hotel that did that, right? Those Mexicans was down there running it. Now those Mexicans from the Prachi, they got their relatives. And once they do that, then they let whoever they want in. It's just to the dogs. You got more police coming up in there now, raiding the motherfucking place. Excuse my language. But it's been real bad, you know. I'm so glad I don't stay in there man. It's off the—I don't feel safe up in there. It's crazy, I mean. And you know, most of them ain't even legal. The one's that's running it, they's not legal. So they not gonna call the police nine times out of ten and you can get away with a lot of shit up there. It's like my kidneys failed at the right time because I do not want to stay up there."
>
> Andrea: So you haven't stayed at those hotels recently then?
>
> Lilah: No! And I don't plan to. I've been by them. I've been up the stairs and shit [to cop drugs]. See the Yash, the Prachi, and the Diamond's run by the same people, so. Oh shit, they be robbing tricks, they be beating people up, they be—they done hurt some people pretty bad up in there. And it's all hush hush. They got nothing but dope dealers up in there and these dope dealers want—that's another thing I don't understand—how could you sit up there and sell dope, be on probation, and be up in them hotels?! Cause as long as [the managers] pay them [the dope dealers] for protection or whatever, they [the dope dealers] pay [the managers] for anonymity. They got all kinda shit going. It's bad. It's really bad. That's another reason why I'm kinda very glad that I don't have to be up in here because of that. Because it's gotten really out of hand and it don't look like they gonna be able to do nothing about it. These are dangerous days. To me [SROs] is the worst places for women. I really believe that. Because you're vulnerable. You know what I'm saying? And nine times out of 10 your room management, they're not legal in the first place. You know, it's always some illegal dealings going on around here or something shady. And you made to be—to me you stand out as a potential victim. So you definitely are not safe. Every woman. To me, that's my opinon. You're not out of the line of danger. Especially in the SROs down here. Because these places are—well, I don't consider these no SROs. These ain't nothing but brothels. That's how I feel.

During further fieldwork the theories about the transformation of the Yash into a brothel were confirmed. Several women had started to approach our outreach team in the back hallways of the hotel to let us know that the management, the dealers, and the pimps had essentially united under one operation in the hotel. The reason why more women

were staying there was because once they came in, they became so ensnarled in the hotel's illicit economies, that it became impossible to leave. Women were doing sex work to pay for their rooms and sustain their drug habits, but now, no money ever went through their hands directly. All transactions were controlled directly by the management, dealers, and pimps. The women said that there were positive and negative aspects of the arrangement for them thus far, and so did not yet want formal advocacy or intervention. But the women worried whether things would become increasingly violent and wanted us to be aware of the escalating situation. There had been a robbery at the hotel just a few days previously by a few masked men who came in, robbed, and rough-housed the women. The women suspected that the management and pimps had arranged for the raid because they thought that the women were pocketing some money from sex work clients. The women said there would have been no way for the assailants to make it through the security gates without being in cahoots with the manager on duty, they suspected, who would have witnessed the whole thing.

Natasha, glad to be in a relatively less chaotic, but still unstable housing environment for the time being, reflected:

> Natasha: The Yash's off the chain. I would rather buy me a tent and sleep out on the sidewalk than to stay at the Yash.
>
> Andrea: What do you think is going to happen over there? Do you think the girls are going to come forward or leave?
>
> Natasha: I don't know. It's hard to say. It's really hard to say.
>
> Andrea: Do you think they're stuck?
>
> Natasha: Pretty much. Pretty much.

Summary Analysis

The daily-rate hotels represent some of the lowest threshold housing for the urban poor in San Francisco. That is, if one has the money and there are available rooms, one can walk off the streets and into a room without having to navigate complicated social service bureaucracies. In this way, even given their deplorable conditions, violence, and instability, they nonetheless fulfill a critical role in a context of crushing poverty, where few options exist before the street. The widespread drug use and sex work in the daily-rate SROs are treated as "public secrets"—they are concentrated sites where known illicit economies flourish. These illicit economies are the only potential source of income for this population and therefore also play a critical role in helping people to eek-out the minimal resources for survival that the state does not provide. Further, they house those who may have barriers to engaging with the social service institutions that are the gatekeepers for more sustainable housing options, which I discuss in Chapter 4.

They have a quality of lawless, deregulated zones where illicit activities and related violence are allowed to flourish, even in spite of the fact that the police are routinely called or that the vice squad raids them on narcotics operations. As quasi-institutional spaces where the syndemics of the urban poor are left to play out, they are intimately intertwined with the broader political economic processes which leave this population socially marginalized. Yet, as the ethnographic case material demonstrates, the fulfillment of their function as low-threshold housing is mediated by routinized, exceptional, and gendered violence. These hotels are thus paradoxical spaces—without them more people would endure street homelessness and inside them, people endure violence and deplorable conditions. This violence is often rendered invisible in these hotels because it happens out of the purview of "the streets." That is, their spatial

isolation and the violence that takes place within them, therefore, does not provoke the widespread panic and rally action the way that street-based violence can.

The daily rate hotels provide a poignant example of the extreme edges of contemporary poverty, the conditions that people face, and the strategies they use to mitigate them. These privately-run, daily rate hotels are critical notes in the geography of poverty and hypermarginality in San Francisco and demonstrate a striking level of exclusion from state intervention, except for by directly punitive apparatuses such as policing. I described these hotels in such detail because they are a critical part of the overall defacto housing system of hotels in San Francisco. Further, the conditions within the daily-rate hotels and the level at which the poor lived there in social abandonment (Biehl 2013), were the specific problems that the city sought to address by institutionalizing SROs and converting them into various degrees of supportive housing. Thus, one would expect that people's experiences in the institutionalized SROs that I describe in the following chapter to be radically improved. However, as I will demonstrate in the following chapter, similar problems are found there and new problems arise so that help and harm are blurred and care comes with punishment.

Chapter 4

INSTITUTIONALIZED SROs

The daily-rate SROs are both zones of relegation characterized by violence, yet critical components of a system that provides housing to the urban poor. Acknowledging this simultaneously critical and problematic function, there has been significant momentum in San Francisco to formally integrate SROs into the city's broader plan to combat homelessness and its associated social problems. In this chapter I examine how local advocates, policy makers, and the Department of Public Health (DPH) enacted San Francisco's own version of "Housing First," drawing from a national "evidence-based practice" to intervene locally among the most vulnerable and chronically homeless. In the local model, the DPH collaborated with non-profit agencies to convert and *institutionalize* SROs into more stable and supportive housing environments.

In this chapter, I first examine the rationale and political force behind the Housing First model of intervention. Then, using ethnographic data, I examine the real-world implementation of this model and the ways in which, despite the best intentions in the local context, the institutionalized SROs can function too to reproduce and reinforce hypermarginality. Despite the critical differences between these hotels and their daily-rate counterparts, I find that many of the same issues of regarding violence and instability still plague these spaces. Most importantly, I find that even in these institutionalized and supposedly health promoting spaces, "ontological security," one of the fundamental benefits Housing First interventions claim to confer, is tenuous in spaces where people

with widespread addiction and mental health issues are strategically concentrated and where social services to address these issues are still deficient.

In this chapter, I first outline momentum behind the implementation of Housing First as evidence-based practice on a national level. Then, I examine San Francisco's own version of Housing First, which adds a component logic of compassion to the national model. Finally, I look at the experiences of women living in these supportive housing hotel environments and both the practical and subjective ramifications of these interventions on their lives. I demonstrate how women who live in institutionalized SROs become caught, both materially and subjectively, in a paradoxical state of being, between "encompassment and abandonment" and between the full enactment of "life and death" (Biehl 2013: 4).

From "Housing First" to "Evidence-Based Practice"

In 2004, the conservative Bush Administration paradoxically endorsed a socially progressive national response to the mounting crisis of homelessness in U.S. cities —the "evidence-based practice" known as "Housing First." Housing First is a model that was initially tested in New York City's Pathways to Housing Program founded in 1992. The leaders of this program posited that in order to provide sustainable solutions to the most chronically homeless, people should be immediately housed with access to supportive services, regardless of whether they are still actively using drugs or have unmanaged mental health issues. This model was viewed as a critical intervention into the dominant "continuum of care" or "residential continuum" model (Stanhope and Dunn 2011), which held that in order to move away from homelessness, people needed to be guided through essential steps en route to permanent housing— e.g., from the streets to city shelters to

transitional housing, and then, only if they can demonstrate capability in those realms, finally into permanent housing. The federal government poured money into this continuum model via the Stewart B. McZachary Homeless Assistance Act of 1987, in an effort to address the growing rates of homelessness in US cities and local social service providers integrated this model into their practice. However, a series of quantitative studies of service utilization and the associated costs of the "chronically homeless" significantly reframed the debate in the US and created a key opportunity to usher in the ideology of "Housing First" in mainstream policy interventions into homelessness.

In the late 1990s, researchers and as well as federal agencies identified the "chronically homeless" as a critical subcategory of people who had either been homeless for at least a continuous year or who had been homeless at least four times in the previous three years (U.S. Department of Housing and Urban Development 2007; Stanhope and Dunn 2011). Researchers sought to measure the service utilization patterns and associated costs among this subcategory, since due to everyday acute crises, the chronically homeless were subject to repeated shelter stays, hospitalizations, and incarceration. They found that in this subcategory approximately $40,000 worth of services were used per person per year, while if the same subcategory of people were placed in supportive housing, this resulted in an over $16,000 per housing unit per year reduction in service use (Culhane, Metraux, and Hadley 2002). These findings, alongside some national media coverage that suggested it cost exponentially more to *not* target efforts for the chronically homeless (Gladwell 2006), caught the attention of policy makers.

The Bush Administration rallied efforts and created the U.S. Interagency Council on Homelessness. Soon after, they spearheaded the Collaborative Initiative to Help End

Chronic Homelessness over the next ten years, with funds funneled through the Department of Housing and Urban Development, the Health Resources Administration, the Substance Abuse and Mental Health Services Administration (SAMHSA), and Veterans Health Administration (Stanhope and Dunn 2011). In order to capitalize on newly created federal funding pipelines, US cities, including San Francisco, established their own ten-year plans to end homelessness. On a federal level, this was a critical re-orientation of the debate about homelessness. Not only was homelessness defined as a major social problem, but the driving rationale in the national call for action now shifted to the potential strategies that would result in cost savings—reasoning that was palatable to a conservative administration. This was, interestingly, a choice opportunity for the implementation of extremely progressive housing policy on a national level (Stanhope and Dunn 2011).

With the promise of new federal funds, advocates sought to flip the model of the "continuum of care" on its head and demonstrate through rigorous implementation and program evaluation that the Housing First model was a more efficient and more productive approach to targeting the chronically homeless. They argued that one of the deficiencies of the continuum of care models is that the chronically homeless confront insurmountable obstacles as they try to move through the steps in the continuum. Therefore, Housing First advocates argued instead for immediate placement in permanent housing irrespective of one's addiction or mental health issues or whether they first went through preparatory transitional housing environments. Since the terms of the debate about chronic homelessness had already been reframed in the national imaginary, policymakers were by and large "on board" with Housing First, and this allowed initial

implementation to incorporate, without intense ideological scrutiny, fairly radical harm reduction principles on a wide scale.

Programs initiated Housing First models and program evaluation took place across the US in New York, Seattle, San Diego, Chicago, and Denver, among other cities (Bendixen 2008; U.S. Department of Housing and Urban Development 2007; Greenwood, Stefancic, and Tsemberis 2013; Mares and Rosenheck 2010; Stanhope and Dunn 2011; Tsemberis and Eisenberg 2000). Findings of over 20 evaluation studies largely demonstrated improved housing retention rates and reductions in service use for the chronically homeless, which translated into cost savings (Culhane et al. 2008; Gulcur et al. 2003; Larimer et al. 2009; Stanhope and Dunn 2011). Because this proliferation of studies included the gold standard for positivist science—the randomized controlled trial—the Housing First model was officially endorsed by the federal government (Stanhope and Dunn 2011), conferred the status of "evidence based practice," and added to the SAMHSA's National Registry of Evidence-Based Practices and Programs. To be on this list, an intervention has to meet a certain "Quality of Research" and "Readiness for Dissemination" score. The "Quality of Research" score is based on "reliability of measures, validity of measures, intervention fidelity, missing data and attrition, potential confounding variables, and appropriateness of analysis" (Substance Abuse and Mental Health Services Administration 2014). The "Readiness for Dissemination" score is based on "availability of implementation materials, availability of training and support resources, and availability of quality assurance procedures" (Substance Abuse and Mental Health Services Administration 2014). In 2014, Housing First was given an

overall score of 3.5 out of 4 for "Readiness for Dissemination." The weakness cited in this category was:

> No information is provided on the specific clinical, interpersonal, and problem-solving skills required for staff to implement the intervention effectively. There is no observation tool for supervisors to use in assessing staff skill in delivering the program. No written instruction is provided on using the quality assurance tools or interpreting data in an effort to improve program delivery. (Substance Abuse and Mental Health Services Administration 2014)

San Francisco's "Compassionate" Version of Housing First

In line with the national trend, in 2004 the newly elected and controversial Mayor Gavin Newsom appointed a committee which released San Francisco's own version of a ten year "Plan to Abolish Chronic Homelessness." In the report, the committee's fundamental recommendation was that it was time to "change directions" and make the widespread implementation of the Housing First model a top priority. While the authors of the report appealed to the cost savings rationale and quality of life issues of the broader national homeless debate, they also included a rationale unique to the legacy of San Francisco, an appeal to a logic of compassion and humanitarian intervention. The report opens:

> The "Housing First" model is a radical departure from the Continuum model in use for almost two decades in San Francisco. San Francisco is Everyone's Favorite City. But San Francisco also has the dubious distinction of being the homeless capital of the United States. There are estimated 15,000 people who are homeless in the city and county of San Francisco and 3,000 of them meet the definition of chronically homeless. New York, a city many times our size, has 2,700. This plan is directed at the 3000 chronically homeless. It is a crisis that must be addressed immediately. We need change now. San Francisco spends approximately $200 million annually on homeless direct and related services, yet the numbers of homeless continue to rise alarmingly. San Franciscans consistently identify homelessness as the number one problem in San Francisco. San Francisco voters have repeatedly sent a clear and overwhelming message to City Hall that they want change, and are willing

> to try any and all new approaches that look promising and do not perpetuate the status quo…
>
> Our mandate is clear. Our task begins with the admission that the city's focus to date -- based on Continuum of Care strategies, i.e. separating the provision of services from the provision of housing -- has not worked, as evidenced by the highest per capita number of homeless people in the United States. We must have the courage to set aside our failed policies and change direction. *We must have the courage to say that we will no longer tolerate, as the compassionate City of St. Francis, human beings living in abject misery and sleeping in our streets.* (San Francisco Ten Year Planning Council 2004 emphasis added)

The plan sought to "Close the Front Door to Homelessness" by implementating the following principles, which takes Housing First as the premise, but also focuses on the coordination of services between programs, case management, and carceral institutions:

- **Housing First:** People must be stably housed before they can effectively deal with the other issues in their lives.
- **No Exit to Nowhere:** No one should be discharged from programs, hospitals, prisons, or other systems to the streets.
- **No Wrong Door:** No matter how people enter the system, they should not be prevented from getting the housing and services they need.
- **Continuity of Care:** There should be no gaps in services; toward that end, clients should retain the same primary case manager over time.
- **Integration of Services:** Housing, mental health, substance abuse, and SSI advocacy services must be integrated through the Dept. of Human Services, Dept. of Public Health, and Dept. of Children, Youth and Families. (San Francisco Ten Year Planning Council 2004)

The crux of San Francisco's ten year plan was the goal to create 3,000 units of permanent supportive housing over the next decade, through both new construction and the conversion of existing SRO housing stock. Impressively, by 2014, the city's Homeless Czar, Bevan Dufty, reported that 2800 of these supportive housing units had been created. Interestingly, however, the homeless population in San Francisco has remained the same since 2005, hovering between 6,200 and 6,400 according to data from

the San Francisco Homeless Count and Survey (Sabatini 2014). The discrepancies between the homeless population estimates reported in the Ten Year Plan and those from the San Francisco Homeless Count and Survey are reflective of the difficulty in tallying a population defined by instability and transience. I attended the official 2011 "Homeless Count" and was amazed that the process involved assembling a mass of volunteers, assigning them strategically mapped out areas of the city, and then having them literally walk the streets with a pencil and paper and record the number of homeless people they saw. The forms are turned in by the end of the night and tallied by the city. Thus, I witnessed first-hand how problematic and subjective reported estimates may be. Regardless of imprecision of estimating the homeless population, the city is now impressively close to their numerical target of new supportive housing units outlined in the Ten Year Plan.

At the time that Housing First gained traction nationally and the city released its Ten Year Plan, San Francisco had, in fact, already started to institutionalize its own supportive housing initiatives in the late 1990s and early 2000s. Community-based housing advocacy organizations, in collaboration with the San Francisco Board of Supervisors, sought to officially incorporate dilapidated tenement buildings into the city's social safety net by implementing a Master Lease Program of numerous SROs. Under master lease arrangements, owners are responsible for renovating SRO buildings, but the administration and management of previously privately owned and operated SROs is transferred to a "master tenant" (e.g., the San Francisco Human Services Agency and San Francisco Department of Public Health). That master tenant takes over responsibility for screening sub-tenants and the overall management of the building. The master tenant

provides full rental payment to the building's owners regardless of whether all the hotel rooms are filled with occupants and also determines the terms of the lease agreement with the occupants. The master lease program was conceived as a way to provide potential housing stabilization to poor tenants with high physical and mental health needs, who would otherwise have no chance of being accepted as a leased tenant because of their lack of income, credit, and housing references. Through the master lease arrangement, the master-leasing agencies collaborate with non-profit organizations who manage the properties and provide a range of supportive services to the tenants. Some provide on-site case management and therapy, some have an in-house medical clinic, and many organize social events and community building initiatives for tenants.

The Direct Access to Housing Program (DAH), established in 1998, is supported largely by the city's General Fund and operated through the Housing and Urban Health Division of the San Francisco Department of Public Health (SFDPH) in collaboration with non-profit organizations. In line with Housing First principles, its mission is to provide a low-threshold permanent supportive housing pool for the most marginalized urban poor. To be eligible for the DAH program, one must be: homeless; have a mental health or addiction diagnosis and/or complex medical needs; be a San Francisco resident; be extremely low-income; be willing to pay 50% of one's monthly income towards rent and utilize a payee; and be referred by a social service provider who manages the application (San Francisco Department of Public Health). The DAH program is one of the major gateways into permanent supportive housing in an SRO in San Francisco. There are currently approximately 20 DAH hotels in San Francisco, with a combined total of approximately 1,000 SRO units.

Access to rooms in master-leased hotels is administratively filtered through either: 1) DAH, which owns and manages several hotels and city-wide Homeless Outreach Team (HOT) stabilization rooms and 2) the San Francisco Human Services Agency, which runs the Single Adult Supportive Housing Program, which manages what are known as Care Not Cash units. In addition, SFDPH also has some "stabilization" rooms that they reserve in privately-owned SROs throughout the city, which are housing slots for people in need of temporary respite after hospitalization or after transition from jail or drug treatment programs. Referrals into all supportive SRO units are made through a complicated network of social service organizations and institutional channels, which includes: 1) the city shelter system, 2) the County Adult Assistance Program, the city's welfare system known as "General Assistance" (GA), which is linked administratively to Care Not Cash, and 3) Human Service Agency-selected social service programs. The rooms in buildings managed under master leases are paid for largely through city-funds, such as the San Francisco General Fund and the Care Not Cash arm of the city's GA program. The exception is for adults with disabilities. People diagnosed with disabling addiction, mental health, and chronic illnesses such at HIV/AIDS are eligible for the Shelter Plus Care program, which is a federal funding stream managed by the U.S. Department of Housing and Urban Development. For individuals who are recipients of Shelter Plus Care, rooms in city-run supportive SRO hotels are paid for with federal funds. Given the incredibly complicated institutional network of access to city-run supportive housing SROs, one must be connected with a case manager who acts as a gatekeeper into the administrative determination of eligibility, files paperwork, and manages follow-up appointments before one is potentially placed in an available unit. In

addition to the bureaucratic timetable for processing applications, there is often a waiting list for available rooms.

The other major gateway to a city-run SRO is through the "Care Not Cash" system. Care Not Cash is a referendum approved by voters in 2002 and implemented in 2004 after a highly contested ideological and political struggle over how to continue to address the "homeless problem" in San Francisco. Gavin Newsom, who was a young city supervisor at the time, largely forged his subsequent mayoral candidacy by being a staunch advocate of Care Not Cash. Essentially, the measure was a radical reform of the local system of welfare provision. Previously, those enrolled in GA, would receive the totality of their monthly dispersement and were able to manage the money as they saw fit, regardless of whether this included paying partially for housing for the month or not. Under the Care Not Cash initiative, GA cash payments were reduced by 86% and money was instead filtered back into the city funds to pay directly for the maintenance of SRO hotel room housing stock. Thus, after the implementation of Care Not Cash, people received welfare checks of just $59 per month (plus food stamps) and in order to gain access to the rest of their entitlement, must, through the assistance of a case manager in a partnering non-profit organization, secure a Care Not Cash master leased hotel unit.

This proposition was billed as a compassionate, yet firm solution to the city's homeless problem because in this system, it would be impossible for people to squander their GA checks on drugs and alcohol and would provide a chance at housing stabilization. The measure was also sold as a deterrent to homeless people who were seen as flocking to San Francisco because of the appealingly high GA checks. The Care Not Cash issue was extremely divisive, as some homeless advocates saw the initiative as a

municipal form of total abandonment of the most marginalized and difficult to serve homeless populations, who may have trouble engaging with social services to garner referrals to secure housing. As Murphy (2009) argues, the initiative was uniquely San Francisco in its delicate blend of progressive, yet punitive undertones. Given the progressive political landscape it would have been unacceptable to implement policy that plainly attempted to eradicate or ignore the plight of the poor, but the specific form of intervention nonetheless came alongside a punitive element to reduce perceived abuse of the system. This is a plain example of the intersection of care and punishment within the context of contemporary poverty.

Regardless of one's political position regarding whether Care Not Cash was ethical or functional, it effectively folded a significant portion of the SRO housing stock into the official repertoire of social service provision for the hypermarginalized urban poor at the same time that the city committed to the Housing First model. It required that the city continue to master lease properties to keep up with the increasing demand of people who would now be eligible for SRO housing. As Murphy (2009) aptly argues, however, the activation of Care Not Cash and resultant increases in the number of master leased properties institutionalized two violences against the urban poor. First, it effectively uses city money to place people in new institutional and *concentrated* geographies of substandard housing (Murphy 2009: 12 emphasis added)—that is, in networks of hotels have unique socio-spatial issues, which contribute to continued hardships that I will elucidate shortly. Second, filtering of GA through the Care Not Cash system delineates two categories of "homeless" people—those who are "deserving and dutiful" and thus able to navigate the social service system to take advantage of the

supposedly compassionate housing opportunities and, in contrast, those who become marked as “service resistant” because they do not desire or are incapable of doing so (Murphy 2009). Also, the initiative imposes a rule that if there are no available Care Not Cash rooms when an individual is seeking to be placed, then he or she is referred to the local city shelters and must stay there for the entirety of the wait. This requirement is a huge barrier for people who would otherwise access Care Not Cash because many, especially women, find the city shelters to be undesirable, violent, and that they trigger precariously managed mental health issues, so they simply refuse to stay there.

Through the collaboration of local policy makers and housing advocates and because of the unusually large existing SRO housing stock, a local version of the Housing First model has been institutionalized in San Francisco in the last two decades in a way incomparable to most other US cities. However, as I will show, while this model does provide opportunities to house the chronically homeless, in this particular implementation it also institutionalizes a socio-spatial phenomenon: concentrated sites where people manage long-standing addiction, acute mental health issues, and disabling chronic illnesses in spaces which can be the antithesis of therapeutic and where the level of accessibility to supportive services such as medical and mental health professionals is inconsistent. Thus, these publically-run, supportive housing hotels are, similar to the daily-rate hotels, simultaneously sites of chaos and control, respite and harm and stand in as the imperfect institutions of last resort to address the crises of poverty in the absence of total institutions that may be more equipped to do so.

The ethnographic data in the following sections is used to illustrate the two key issues I identified in the supportive housing hotels: 1) because these hotels are sites of

concentration of people with addition and mental health issues, they may not be capable of conferring "ontological security" and, instead, create unique hardships for women and 2) these hotels are extremely bureaucratically complicated to secure and nonetheless do not guarantee material or subjective stability.

The Institutionalized SRO Hotels as "Corrals" for the Urban Poor

In this section, I examine the experiences of living in a hotel where mental health crises, violence, and punitive police intervention are routine. In the absence of comprehensive mental health interventions to serve this population both within and outside of the hotel, the penal state takes over in the primary, yet problematic, management of these spaces and in the management of people with complex psycho-social and clinical needs. One morning, I went to meet Jenai at the massive, 200-room Anza Hotel, just a block from the active drug copping spot and public social space for people living in the SROs in concentrated in a four-block radius. When I walked up to the building at about 10 am, there was already a group of about five men standing in front socializing on the busy four lane avenue. Even though it's only two blocks off the busy subway corner, it feels more isolated, as the only reason one would turn down the street as a pedestrian at that corner is to get to the Anza Hotel. The Hotel is run by a non-profit agency and tenants pay through SSI or GA.

I suspected that Jenai would have forgotten that we agreed to meet. At the time we saw each other to coordinate, she did have a phone, but when I tried to call to confirm a few days later, the phone was already turned off. This is a common occurrence for this population—they obtain their cell phones through punctuated, non-contracted accounts that do not require a credit check. When someone runs out of money, their phone is

turned off. But, when they are finally able to turn their phone back on (i.e., at the first of the month when their SSI or GA check is dispersed), their original number has already been given to someone else. This inability to maintain a consistent line of communication is extremely disruptive for continuity of medical care, social services, and maintaining support networks.

With Jenai's phone turned off, I was lucky that when I approached the booth at the entrance of the hotel and I was greeted by a couple of young Latino men manning the desk, behind the glass wall. A quick flash of my ID badge from county hospital immediately legitimated my presence there, as it was assumed by how I dressed and acted, that I was a case manager scheduled to meet a client. The Anza Hotel has an expansive, dingy lobby. There are a few couches and a big old television sits in the corner. People were crowded around to watch on the blurry screen. I knew that Jenai's room was on second floor. As I approached the stairs, I was surprised how institutional the building felt, with its fluorescent pipe lighting, linoleum tile like that found in schools built in the 1950s, and rows of rooms down the corridor as far as they eye can see. It is very different from the daily-rate hotels. This place is vast and starkly institutional. It did not immediately trigger my bed bug paranoia as other hotels sometimes did. Since it was my first time here, I recalled some of the rumors I had heard about it while doing outreach in other hotels—that it is so massive and dangerous, that women get attacked in the dark, hidden corners of the building. As I made my way up the stairs, I turned the corner to find Jenai's room and I snapped a picture of a sign that hung in the hallway.

Jenai's room was near the stairs on the front side of the building. When we first met, she told me about how she actively pursued certain room locations in the various

hotels she had stayed at that she imagined would be safer for a woman. She had developed spatial strategies within each hotel: she consciously sought to get a room in a particular location, whether it be near the manager's office or near a surveillance camera, as some measure of protection, however marginal, against violence. I did not see a surveillance camera despite the sign, but imagined she must be pleased that her room in located near the stairs and elevator and not far down the long hallway away from the street. I walked over to Jenai's room and tapped lightly on the door. No response. 10 am in the hotels is early, since many stay up all night, so I was consciously aware of making too much noise that would disrupt others. Then I called out "Jenai? It's Andrea from the study!" Shortly thereafter I heard some movement in the room and Jenai opened the door in a baggy white t-shirt, shorts, and flip flops, groggy from having just woken up, but also frazzled that she had forgotten our appointment. She kept the door ajar, open only about a foot wide, and did not invite me in, saying that her room was a mess because she had been sorting through her clothes and had them spread all over the place.

From what I saw, the room was tiny and dark, about 6 feet by 6 feet. Jenai had the window covered with a blanket and there were piles of clothes and other things lining the walls of the room. Jenai is a 55 year-old woman who identifies as mixed race, whose drugs of choice had previously been crack and methamphetamine, though, since becoming more stably housed at the Anza Hotel, she had started to taper her drug use. She and I met while I was working on another study at a research center in the Tenderloin. Jenai self-describes as bipolar and is open about the difficulty of managing her rage episodes in the context of her chaotic living environment. Jenai has a long-term abusive partner who also lives in the building and he is always a source of stress and

anxiety, but she feels that it is simply easier to keep him closer, because otherwise he stalks her. Having gotten to know her a bit in the context of the other study, she is very adept at the self-narration of her diagnosed mental illness and struggles related to poverty and addiction. This is not to say I ever felt that she was embellishing her story, only I recognized that she had likely recited her story many times and was very perceptive in terms of identifying the particular topics that might be of interest in her conversations with clinicians, case managers, and researchers like myself.

Jenai was very apologetic about forgetting we had set up a meeting and asked if I would not mind waiting downstairs in the lobby for a few minutes while she got dressed. She assured me that the condition of her room was out of the ordinary, that it was not usually this messy. I did not mind waiting downstairs and was eager to have a reason to sit in the lobby and observe the steady stream of people coming in and out of the hotel as well as the small group of people that had gathered in front of the old television. I went downstairs and sat on the edge of a concrete fireplace. No one really seemed to notice me or question my presence. Again, I am sure people just assumed that I was a social worker waiting for my client. About ten minutes later Jenai joined me downstairs, just as some case managers were starting to set up a weekly offering of free coffee and donuts.

Jenai suggested that it would be more interesting for us to just sit down here in the lobby to talk because then I could get a better sense of the everyday activity in this hotel. I agreed and we stayed sitting on this small brick edge of the fireplace, near the mailboxes. I was surprised too that this hotel had mailboxes. For people living at SROs, something as mundane as receiving mail can be a huge headache. People cannot usually receive mail at SROs and so have to set up general delivery at the main post office on the

edge of the Tenderloin. Because of the coffee and donuts, people started pouring into the lobby and forming a line.

In many ways, despite the different institutional feel of the space, it was a typical SRO population—there were many people with visible markers of long-term drug use, others emaciated from chronic illness, and several people with evident mental health issues pacing the lobby. I took stock of how much this moment referenced my own visual images of an asylum, with the people and their behavior, their bodily movements, the staff behind glass encasement, the dingy vinyl tile, and the intense fluorescent lighting. To my surprise, Jenai immediately launched into an analysis of the complex hybrid penal/medical management of this institutional space and how she navigates this space as a perceived addict and person with serious mental illness. "They tend to dismiss us and our complaints," she said. I asked, "Who does?" surprised with how she dove into the conversation.

> Jenai: The police. Now the fire department and the paramedics and stuff, they come out here and they come out here really fast, but some of them have attitudes and stuff like that. Like one time they came out. I fell or something like that. They came out and said 'Well, your blood pressure's high. How much dope did you smoke?' And I said 'How about I didn't take my blood pressure pills in two days?' …For the most part they're pretty good, but you know they do come out here on a lot of false alarm calls…Somebody's always doing something, you know and they come in here like stormtroopers ready to handle whatever is going on…
>
> Andrea: How often do the paramedics get called here?
>
> Jenai: Oh man, a couple times a day! Consistently. Consistently. I mean, it's consistent.

Jenai stood up to grab us both a cup of coffee from the large industrial pot. She introduced me to the social worker manning the pot as her "worker" and asked if it was okay if I got some coffee and a donut too. Every institutional space I ever entered with a

woman (e.g., various publicly run hotels where ID was required to get in, doctor's appointments, clinic visits), the woman would, without my prompting, introduce me as her "worker." They knew this would get me in, without too many questions. Of course the actual social worker agreed and said I could help myself to as much as I wanted. We poured our coffee into small styrafoam cups and sat back on the ledge. Then, within a matter of minutes, before I could really grasp what was happening, the lobby erupted into a chaotic scene, and the police stormed the building. My recorder was on, stashed in the pocket of my vest. When transcribing this audio file, I was struck by the hectic soundscape around us—the sounds of what I later saw were five police cars, two police motorcycles, and one undercover cruiser screeching to a halt in front of the building and the policeman's boots stomping in as at least ten cops, menacingly stormed the lobby.

Though we had attempted to carve out a little corner for ourselves in the lobby for some privacy to talk, when the situation escalated our distance seemed insignificant, since we were only about ten feet away from where the cops had swarmed. This incident involved a man who had been arguing with the front desk clerk, alleging that his room had been broken into and his belongings stolen. Because of the baseline level of noise and the echoing effect of the lobby area, Jenai and I had not even been aware that an altercation was taking place. The man, after reporting the burglary, was unhappy with the manager's dismissive response to his complaint, the conversation escalated into a shouting argument and the cops were called, not in response to the original allegation of the break-in, but in response to the man who had started screaming, stomping, and waving his arms in frustration near the front door. After a few minutes the police, who were clustered at the entrance so no tenants could or wanted to pass in or out, shuttled the

man outside to the sidewalk out of our earshot. Coincidentally, an unrelated woman then also approached the manager's booth and started screaming loudly about how she refused to pay rent. The police approached her and shuttled her out onto the busy street.

We sat back, reflecting on how the incident seemed to spring out of nowhere. Then, a few minutes later, the police stormed the building again, this time coming closer to where we were sitting and surrounding a woman in a wheelchair near the elevator. The previous cops re-entered the building and clustered around the clerk's booth, where the man and the woman screaming before had reposted themselves. For a moment, it felt like shouting was coming from all directions and it was hard to focus in on any one thing. Jenai laughed out loud when I asked if this level of police presence was common, saying that the cops, like the paramedics, come "Daily. And on a real bad day, several times." Jenai had recently decided to "cut back" on calling the cops herself. She had been calling them constantly during a period of intense harassment from male tenants in the building and sought protection from the cops as a last resort. She said:

> The men here seem to think that any woman that's here is an available whore to them…And it's like—I'm almost 60 and it's just so confusing to me because, um, where did this stuff come from? The last thing I'm thinking about is sex with one of these clowns in here, trust and believe that!...I just wanna be left the fuck alone! Truly. Just wanna be left the fuck alone. I'm trying to work on Jenai…And so now I'm, you know, I try to keep it on the up and up and everything else. I don't imply anything of a sexual nature or anything like that. Nothing! No provocative clothing, no provocative language. I do not talk about stuff like that, I'm just totally, just—if there's anybody, I am the most non-fuckable person in here. Trust and believe that!...So I mean, I'm just now realizing yesterday, well, it's been going on for the last couple of days that I gotta stay mean now. Get mean all over again 'cause I'm bipolar and I have a hard time with boundaries. The only way I can enforce my boundaries is just to be angry. Yeah, just be angry! Just open that door and get ready to go off! You know, which is not—it's not fair, it's not right. But I mean people do not take no for an answer around here! And there's not a whole lot you can do about it.

This management of her subject position as a woman in her hotel was extremely burdensome and tiring, but she had developed hypervigilance as a protective strategy. A man, whose advances she had rejected got upset and he began spreading a rumor in the building that Jenai was a "crack whore" which brought more harassing prompts from men in the building. Multiple men were repeatedly knocking on her door asking if she wanted to trade sex for crack. She goes on:

> Jenai: So I had to call the police at least five times a day! But see, [the men] don't understand. I was a paralegal for 28 years and you might be fucking with me honey, but I'm not sitting taking nothing lying down! And that's the bad part about the [other] females here because they do! I don't! I'm in constant *war mode*! I got him off me that day by the evening time 'cause the police said 'If you even look at her, you're going to jail.'
>
> Andrea: So what had he done to you?
>
> Jenai: Call me a ho and crack ho and yelling outside my door and everything, you know…They came out and they talked to him. I wasn't ready for the guy to go to jail, but I needed him to stop what he was doing! He was drunk, abusively drunk. I mean a real mean drunk. I can't stand those. The thing is that I wrote him up, right down here. The office said nothing. Because unless the office gets stirred on it—the way I got them—you see, I know how to get them riled up though, you know. To get them involved I actually stood and helped the manager do her paperwork so she could come and talk to dude. And when dude told her to fuck herself, she called the police!
>
> Andrea: Do you feel like cops have been helpful or are there situations…
>
> Jenai: For me they have been helpful because I know how to talk to them. I know to be waiting at the desk because they're gonna believe the first person they see who's calmly speaking. And then I'm rational and I'm logical [in my] way of speaking and stuff like that. I'm obviously no fool! You know, so their response to me? They're willing to act on anything that I ask them to act on.
>
> Andrea: So you feel like they've been pretty cooperative…
>
> Jenai: I think that the police have been very cooperative with *me*. I think that they're not very cooperative with a lot of the other females.

Andrea: Why's that?

Jenai: Because the females are very ashamed.

Andrea: What do you think they're ashamed of?

Jenai: It's the concept of feeling like you're worthless. Feeling like you don't count like everybody else counts. It's something that I have to force myself to remember everyday as a homeless woman. And we're still homeless, in this temporary situation here. Women still feel like they're less than and everything else. They don't have jobs, you know GA or SSI doesn't make you feel a whole lot better. You know so when people of authority come out here and everything else, you feel like you don't count, your voice doesn't count. Nobody wants to hear you, you know. And most of the females are beaten down…You know what I mean and it's like they dismiss a lot of the things that they wouldn't necessarily do in a day when they were functioning. You feel like you're—like before when I was a functioning *human*. You know you feel less than *human*. And it's really hard [she starts crying]. You know some people just accept that. Accept that as their lot in life [crying more, voice is quivering]. But it's real hard for me because I see it around me. And I see the females around me and they don't wanna fight.
So anyway, it's just—it's painful! It is painful. And I had a job! [voice quivering]. I was somebody who had a right to speak to the police in a way, you know any way it's like, 'Hey look at me! I'm a taxpaying, functioning person and I have a right to your services' and stuff like that.

Here, Jenai is describing the affective, symbolic complexity of her everyday engagement with police, which, because of the social context in which she lives, she is forced to confront frequently. Even though she has developed practical strategies based on past experiences about how to get what she needs from the cops, the encounters are still intertwined with her own conceptions of worthiness and the exclusions she has faced as a perceived homeless drug addict. The interactions, even when prompted by situations where she is undeniably entitled to police protection (e.g., being incessantly harassed by her neighbor), still incite intensely emotional responses about her very *humanness*. So, the burden in Jenai's case becomes two-fold: she must deal with the repeated situations at

hand that necessitate police intervention and she must contend with the symbolism of her engagement with the penal state and medical establishment as filtered through her experiences of addiction and poverty and as an SRO hotel resident.

Jenai's experiences of living in an institutionalized SRO reveal the nuanced ways in which she resides in a position of relegation. Neither of the two institutions she interfaces with regularly at the hotels (law enforcement or emergency medical care) serves her "well" or serves her fully. Their responses to her needs are not only impartial, but are also stigmatizing and force her to confront the perceived moral significance of her relegation. In grappling with this, she is both critical of the injustice and deeply pained by the denigration. She sits—literally, in this socio-spatial context—at the nexus of a particular paradoxical form of simultaneous state control and abandonment. At once the penal arm of the state via the police enact a particular stringent form of control over these institutional spaces. However, this control does little to alleviate the problems in the hotels that impact women's lives on a daily basis. In these spaces, the police do not function to maintain order, they are sources of disruption and frustration. The police demonstrate an obsession with policing the drug trade through pre-planned narcotics operations, which may yield little or no results or merely the discovery of petty possession. Yet, hotel residents are abandoned to fend for themselves in critical situations when police are summoned, which might warrant sustained forms of state intervention, whether it be punitive or other forms.

Due to the frequency of Jenai's encounters with police in her hotel, she was able to draw clear distinctions between the types of police that entered the hotel—those that came on 911 calls and those who came as part of narcotics operations.

> Jenai: And the vice cops have a lot of attitude. But the regular cops don't. The vice cops come swooping through here. Like, you know, you'll come out of your room at about seven in the morning and everything and they're down there reading the register to see who is in here.
>
> Andrea: Are they?
>
> Jenai: Yeah, girl! They come through here! Then they go trop-tropping like tens of 'em. They're beating on people's doors talking about they're looking for somebody.
>
> Andrea: How often does that happen?
>
> Jenai: Once a month.
>
> Andrea: So you think they have a schedule, like, 'allright, we gotta go in?'
>
> Jenai: Yeah! Do the sweep and everything. Try to catch all the little drug dealers and everything else. They already know who everybody is! They need to quit that, you know!
>
> Andrea: Yeah, I've heard rumors about the vice stuff.
>
> Jenai: Yeah, they do! Are you kidding me? In the regular hotels, the ones that you go and pay by the night? Girl, they go in there and they got this much space under the doors [she hold her fingers about a quarter of an inch apart] and the holes is this big [she demonstrates the size of a pea] and all they have to do is stick that thing in there and look in there. You know, stick that mirror under [the door]!

This level of obsessiveness in policing the drug trade in combination with the dismissiveness seen in both the daily-rate hotels and in Jenai's account reveals a certain absurdity to the penal management of the population relegated to these spaces. This paradoxical mode of intervention does little beyond the reproduction of a particular form of social exclusion. It is more than merely ceremonial display of the "war on drugs," rather, it illuminates the structural mechanisms related to the unmet needs and abandonment of this population, even in settings which are purportedly supposed to provide stability.

Jenai directed my attention towards the three police officers who were surrounding the woman in a wheelchair. It was a strange sight because the cops were addressing the woman with familiarity and were scolding her in a very juvenalizing tone. One police officer was shaking his index finger at the woman as he spoke. Seeing my puzzlement, Jenai offered some interpretation:

> Jenai: That woman has the worst voice in the world. Now she used to go and run around and run over people with her wheelchair. They ended up taking her back to the cops. Some [other] guy in a wheelchair broke a guy's nose! The police waited a long time. They weren't gonna take him, they weren't gonna take him! Where that's obviously an assault. They didn't want to take him because he's crazy! They didn't wanna deal with him! He's in a wheelchair and he stinks! They did not wanna take him even though he broke dude's nose! They [eventually] took him, but man, that sucker was [back] here before I woke up in the morning. That's the part I can't deal with, with the cops! They don't keep the people! These people run around with knives and things like that, do all kinda shit! And they take them. And the crazier they are, the faster you see them at home!"
>
> Andrea: What's going on there?
>
> Jenai: Are you kidding me? Don't you know? [The cops] take them to the hospital for a little while, let them get shot up with Thorazine, or whatever the hell they give them, and they send their ass right back here! That's why they kind of keep us corralled here! That's my true opinion of this place!
>
> Andrea: That's what's going on?
>
> Jenai: Hell yeah! They ain't got no place. The jails are full! They ain't got a place for all these people and they don't need to deal with them! They don't like to arrest criminals because that stinky little son of a gun, they didn't want him and then he stink and everything. It would take about five to six officers to get him in the car. So here's a violent crime. Breaks the guy's nose, the guy's nose is broken and bleeding all over the place! That guy was supposed to go away for at least 18 months! Now they just left him here for us!...We're being subjected to people that *know* they can do whatever they want! They can hurt you if they want to and there is no repercussions! Because the police will take them, maybe a day, but let them go *right* back. Next thing you know, they getting a ticket, you know what I'm saying? Something like that. And the people ain't did shit with that ticket! And these are people that should be in jail…

This dynamic that Jenai describes so aptly captures the paradoxical and concurrent neoliberal penal management and social abandonment (Biehl 2013) of the urban poor. Further, she shows how SROs function as unique socio-spatial sites for the enactment of impartial penal and medical management. In this configuration, residents are left responsible for the fallout of historical marginality and exclusion—the palpable manifestations which are the addiction, mental health crises, and violence which become routinized in these spaces. In the absence of more therapeutic management of mental illness and disabling chronic illness or addition, these institutionalized SROs become the sites where the syndemics of the urban poor are, as Jenai says, "corralled." But contemptibly, the agents relegated to the frontline management of what manifests as the "everyday emergencies" of the poor are the police, who do so through their punitive repertoire, and the hotel residents who themselves are in various states of crisis. Police, therefore, operate in an unsettling gray area of responsibility regarding the nexus of punishment and supposed protection. Their mandate is to punitively intervene, but in the neoliberal structural context, their role is grossly more complex.

At this point Jenai had become agitated watching the scenes unfold and interpreting them for me, so she told me that she was "near her limit" and might not be able to take much more of the chaos before retreating to her room for respite. She told me she was barely managing her own crack use, bipolar disorder, and violent relationship with her partner, who she whispered had been circling around us the whole time we were talking to keep abreast of her activity. There were so many people around, that I had not noticed. In her frustration, Jenai started to narrate the social scene around us loudly. Admittedly, Jenai's vocal commentary produced some anxiety for me, since she was

bluntly remarking about several people in the lobby who were engaging with the cops. Given the intense energy level in the room, I wondered if this would invite confrontation. She said loudly amidst all the shouting around us:

> You see, they didn't take dude nowhere! And he was assaulting that woman in the chair, talkin' crazy to the police, messing around. But see that, they *know* him. They know he gonna fall down on the ground and they gonna end up in the hospital. They *know* this shit!...Some people are too 5150 for them to take!...And they should have took him and everything because he was like ready to fight everyone. But they didn't take him.

Jenai's analysis of this scene is illustrative of a specific site of failure on the part of state institutions to address the mental health needs of the poor. In the absence of widespread community-based services, the 5150 mechanism comes to represent the lowest threshold neoliberal state intervention in these socially produced spaces of extreme mental health burden. The term "5150" references a section in the California Welfare and Institutions Code which allows either a police officer or a clinician to place an involuntary psychiatric hold on a person believed to be a harm to him or herself or others or "gravely disabled due to a mental disorder." When someone gets "5150'd" they are taken into custody by police, but instead of being arrested and going to jail, they are taken to Psychiatric Emergency Services (PES) at the county hospital and placed on 72-hour treatment and evaluation. During this detainment, although people are not under arrest, they are assigned a more explicitly hybrid classification somewhere on the continuum between "criminal" and "patient." Women told me that when people are 5150'd, they are often administered psychiatric drugs such as Thorazine, a medication used to treat schizophrenia.

As I will discuss more from the perspective of the police, the 5150 mechanism is considered an important resource officers have at their disposal to engage with those living at the locus of poverty, addiction, and mental illness. Its use is quite routinized in this context, indicative of the degree of penal state dominance in these contexts. Most everyone that I spoke to during the course of research had been 5150'd at some point in recent history and many had multiple times. Often times the symptoms prompting a 5150 can be ambiguous. For instance, it can be hard to disentangle whether someone is presenting psychosis related to too much stimulant use, thus having a drug induced psychotic episode or a "mental health crisis." Further, in the context of such persistent housing instability, getting 5150'd may provide 72 hours of much needed respite from hustling for money to pay for a hotel room, seeking a partner to share a room with, or sleeping on the street. It can also provide someone who has been on a methamphetamine or crack cocaine "run"—that is, using stimulants constantly for several days in a row without sleeping—an opportunity to level out their physical and mental state in a safer environment than the hotels or the streets. The 5150 circulates in these contexts as an intensely rich socio-structural symbol. Though it is supposed to be a clear cut mechanism based on a set of safety and clinical assessments, how the act of 5150 circulates among people and police officers in this context reveals a productive discursive terrain about what constitutes "crazy" in the community, how one accesses resources for basic survival, and the realities of negotiating routine mental health crisis in these spatial contexts.

Jenai is succinctly offering insight into how the act of a 5150, something that is supposed to be based on a set of clinical criteria regarding an individual's mental state, is

negotiated by police officers, but also intersects the realities of their routine encounters with extreme bodily suffering (e.g., detaining and transporting a man in a wheel chair whose clothing is always soaked in urine). In addition, Jenai points to the structural realities of a mechanism like the 5150 in a context where mental health crisis coupled with police involvement are commonplace. A 72-hour hold is just that—72 hours. Though a person can be given a 5250, extending their involuntary detention for up to 14 days, it is rare in the case of these routinized calls and people end up at back in the same hotel environment battling the same crises. Further, as some police officers told me, from a bureaucratic standpoint a 5150 or trip to the hospital for a medical issue while in police custody requires a lot more paperwork for the officers involved than a regular arrest and booking in the County jail. This may also explain, as Jenai describes, the moment of rumination that she saw the police engaging in while interacting with the man who had indeed committed a crime but was maybe "too 5150" for them to take.

From Jenai's perspective the mechanism that is supposed to relieve the risk posed by a violent, mentally unstable individual, is ineffective because police transfer the burden onto residents in spaces where these types of incidents are recurrent. This is the contradictory nature of the neoliberal penality and service provision (Wacquant 2009), concepts which I discuss further in Chapter 5. At once, the police enact an intimidating and repressive demonstration of their control through sweeps of the spaces inhabited by the urban poor, but they also do not provide a level of assistance in moments of crises that palpably reduce the risk for violence and trauma for people living in the social environment. The link here between the penal arm and the medical/social service arm of the state is evident. The police's negotiation of deploying the 5150 reveals the frontline

manifestation of a structural reality where cycles of addiction and mental health crises for the urban poor are left to transpire repeatedly on the streets and in the housing environments of last resort, rather than sustainably addressed by the mental health care system. Then, the police operate in a socio-spatial field where they negotiate a murky terrain regarding how to intervene to simultaneously protect and contain the categories of people historically managed by total institutions—those Goffman (2007) referred to as the "diseased," the "mad," and the "criminal." Thus, even in environments such as institutionalized SROs, created for people to have a chance at attaining some stability, people must paradoxically negotiate the reality that these spaces bring new palpable risks.

Displacement and Addiction in the Supportive Housing Hotels

While Jenai's narrative demonstrates how the social scene in a supportive housing hotel can be incredibly chaotic for women, the following story demonstrates the intersection of instability even in supportive housing environments and the relationship to one's management of drug use and chronic disease. When I first met Sheryl she was "clean and sober." Her overall demeanor is tough and detached and I was actually quite intimidated by her the first few times we met in the Tenderloin. Sheryl's history of incarceration had inserted her into the complicated bureaucratic trajectory of supportive housing in San Francisco. While she was still incarcerated at the county jail just a few blocks south of the Tenderloin, she realized that if she participated in certain programs, she would be given the opportunity for an early release. Sheryl seemed to value her experiences of these programs while in jail, but also admitted that her motivation to participate was really driven by the promise of an expedited release through San

Francisco's system of sentence diversion. As she told me, "I got hooked up with them in jail and I wanted to get out of there. Plain and simple. I wanted to get out of jail."

Sheryl is HIV positive, making her eligible for the Housing for People Living with AIDS (HOPWA) program, a federal program which allocates funding to house HIV positive people. Certain local programs receive the funds and then oversee HOPWA housing slots at various hotels. The case managers in the jail programs were able to advocate for her to be placed in a designated HOPWA hotel room upon release and so she secured a temporary, transitional room at the Zachary Hotel in the heart of the Tenderloin. When I asked Sheryl how long she would be able to stay there, she said "I have no idea. It's not permanent." There are case managers on site, as well as a program manager that Sheryl recognized was strict, though she respected him. The architecture of the building is similar to that of the daily-rate hotels, with steep stairways, and narrow deep hallways. However, the Zachary was significantly cleaner, the halls were brightly lit, and, in general had a more clinical feel with the hallways painted white and pastel blue. The rules at the Zachary were firm—any visitor had to be cleared ahead of time by the tenant's case managers and all tenants were expected to obey designated curfews.

Nonetheless, Sheryl told me that the drug economy in the Zachary was thriving. She was a long time heroin and crack user, but after release from jail, got on the methadone program at the county hospital and was committed to staying clean and staying out of trouble. Her primary strategy to do so was social isolation from the rest of the tenants in the hotel. "I'm in my room all the time," she said, "I don't come out. I don't go room to room." I know there's a whole bunch of shit happening in that motherfucker, for sure!" Though people in the building knew she was not using drugs

and did not bother her about that, she expressed disgust that people still occasionally broke into each other's rooms and robbed each other. Upon release from jail, Sheryl had secured a 30-day emergency bed slot, then transitioned to a slot for 90 days during which the program helps to secure permanent housing. After her time had expired, having not yet secured a permanent housing slot, the program manager had pulled some strings and Sheryl had been able to stay at the hotel for six months, while she waited on the various waiting lists for hotels in the Tenderloin. But she always knew that her time was limited so lived with the constant stress of seeking permanent housing.

At this point, Sheryl did not have Supplemental Security Income (SSI) and was surviving by going to the various free food programs in the neighborhood. "I'm hoping to get it [SSI]," she said. "No, I'm hoping to get it. I—fuck—my back always fucking hurts and I just get fucking major headaches and shit." The previous week she had filled out paperwork assessing her current health status. "I remember what they said on the piece of paper—'do you know what your fucking temperature is?' NO! Because I don't have a fucking thermometer!" Sheryl was nonetheless feeling a little optimistic that some relative stability was in her reach. Her SSI application was under review and she would be receiving word soon from a HOPWA case manager about an application for a permanent hotel room a few blocks down at the Frontside. She was not too clear on all the details and had not even seen the potential building, but had been told "when housing comes up, go for it." She was hopeful because at this point had been homeless for 23 years and she said "I can't take more of this shit. My body can't take it anymore, you know?'

Less than two weeks later, I got a call from Sheryl with the good news that she had been approved for the room in the Frontside. We made plans to meet up at the Zachary mid-morning one day, so that I could help her finish packing up and we could move her few belongings—a small, chipped dresser, a lamp, and small plastic container. I borrowed a steel cart from my office a few blocks away, thinking it would be no problem to wheel it a few blocks to the Zachary and then the one and a half blocks to the Frontside from there. When I arrived and Sheryl realized that I did not have a car, she was extremely irritated. Though we had since become friends, her anger towards me that day reminded me of the first few times that I met her. It also became clear a few minutes into this interaction, that Sheryl had been smoking crack. She had gotten a stipend from the AIDS Emergency fund to move to the new hotel and had a big wad of cash stuffed into her jean pocket.

Sheryl's energy, exceptionally heightened by stimulants, was actually practically useful that day, as we loaded her things and carried the heavy cart down the steep steps and onto the busy street. Sheryl pushed this metal cart with such force through the crowded and bumpy sidewalks of the Tenderloin and I laughably had to lightly jog to keep up. To my surprise she jaywalked and haphazardly pushed the metal cart clanking loudly into the middle of the street, right in front of the Tenderloin Police Station, without care. We arrived at the Frontside, wheeled in the cart, and were stopped at the clerk's desk. Sheryl introduced me as her "counselor" and I was immediately granted access. The desk clerk came around the counter and promptly initiated an inspection into Sheryl's furniture, looking for bed bugs and other vermin. Sheryl proclaimed to the clerk "I don't do the scratchy-itchy thing, boy! I been through all that shit!"

We made it upstairs on the elevator and the hallways were similarly clinical. Sheryl unlocked the door and opened to a shockingly tiny room. The entire place could not have been more than 6' x 6'. It did indeed have a bathroom, a kitchen, and closet, but the living space was so small that she would only be able to have a twin bed and it would effectively be in the kitchen, with just a couple of feet between the bed and the stove as the only walking space. I struggled to find words of encouragement amidst my shock at how depressingly small the apartment was. A shelf against one of the walls was filled with packages of adult diapers, which she needed recently due to side effects from her HIV medications. Sheryl opened the window to light up a cigarette and immediately the tiny space filled with the sounds of the street—incessant shouts and honking— from one of the most loud and lively blocks in the neighborhood.

> Sheryl: This is was like the only place that I really wanted to move. Out of all the places I applied for. But it's just not affordable to me.
>
> Andrea: How much is it?
>
> Sheryl: $550 a month. Yeah, it's not affordable. But, so, I have to take a few classes now, so I can get $250 taken off of it.

Sheryl's SSI had still not been approved, which would make her eligible to pay only two-thirds of her total income to rent the room. Until then she would have to figure out how to pay the rent herself and had worked to patch together what she needed in the meantime, capitalizing on mini-stipends from various agencies. Her rent now was $550 and with SSI would be around $370, leaving her approximately $580 to live on for the month from the approximately $950 SSI payment. This would be a tremendous help, but it would still be a struggle. Her bus fare to the methadone clinic five days a week would alone take about

$80 per month. Further, getting SSI was going to be helpful, but it was also deeply symbolic and signaled that her health was rapidly deteriorating.

"I'm not well, okay?" she told me. "Did you go to the clinic today?" I asked, thinking she was referencing her chronic pain and wondering if she had been to the Thursday morning clinic dedicated to women at the HIV/AIDS ward at the county hospital, where she got her primary care. "No, I didn't go today," she responded. "But overall, it's depressing." I responded with some complimentary words about her new place. And she agreed, but put it all into perspective for me. "Yes," she said, "It doesn't feel like the other hotel at all does it? It's like night and day…Peace of mind, man. I can't even—how do you dream in a place like that!" she exclaimed, referencing the dilapidated Zachary. "Where's the hope? Give me a fucking break!...I mean, it's like—this isn't the kind of shit that was my dream," she said, gesturing to the tiny shoebox of a room around us—"to have HIV and be living in places like this, with 30 percent of your income."

For the couple of months after she moved into the Frontside, I saw Sheryl infrequently. She did tell me she had gotten approved for SSI, but the emotional weight of what it symbolized had deepened. When I offered congratulations on being approved, she told me woefully "Yeah. But that's depressing too…you only get it because you're sick…" Then she burst into tears. "I'm getting depressed," she said, "I don't want to talk. Yeah. But I will talk to you later" and she abruptly turned and walked the opposite direction from me one day in the Tenderloin. I worried after I lost track of her, especially since I knew she had started to smoke crack again. Then, I heard the news that there had been a serious fire at the Frontside and that all of the people in the building had been temporarily displaced. I tried calling Sheryl's phone. A woman who I had never met

named Diamond picked up. Sheryl and Diamond knew each other from a drug treatment program they had been in together. She had helped Sheryl by temporarily trading the phone as collateral for money. But Diamond did not know where Sheryl was either.

Then, early one morning I ran in to Sheryl on Market Street while she was extremely high. She was holding a gloppy cup of milk and cereal, spilling it onto the sidewalk as she swayed back and forth struggling to stand upright. I ran up to my office to put down my bag and when I came back I found her in the check cashing place a few doors down, trying to sell a yellow dog jacket she had found on the street to the people inside. Sheryl looked emaciated. She had been skinny before, but now she was so skinny that her pants would not stay up around her hips and with each step they would slip down. Her struggle to keep them up with each step added to her overall look of dishevelment. She almost stumbled into traffic twice as we were trying to cross the busy Market Street. I suggested we go to the donut shop nearby so she could sit down for a bit.

She told me that she had started using again, had not slept in two days, and because she could not find any heroin to fix that morning, she had taken several Temazepam pills. Temazepam is a benzodiazepine used to treat severe cases of insomnia. Clincal guidelines suggest that one should get into bed immediately after taking the drug and stay there for at least seven to eight hours. Yet, Sheryl had been all over the Tenderloin that morning trying to hustle some money for heroin. Temazepam can also cause side effects which can be hard to discern from psychosis, including hallucinations, intensified depression, suicidal ideation, and feeling as though you are outside of your body, among other things. As we waited in line, it became clear to me that she was too high to stay in the café. We were already enduring harsh gazes from the Philipina woman

at the register. I doubt that Sheryl would have been allowed inside looking like she did, if we had not been together. I also doubted that Sheryl could make it back through the neighborhood to where she was now staying. I suggested we go and sit in my office across the street, hoping that the coffee and donuts would help.

Sheryl told me that she had recently taken up petty drug dealing, selling "chiva" (heroin) and vicodins in the neighborhood to supplement her income. She was not going to the methadone clinic regularly and had been buying heroin instead. When she could not get heroin, she was buying the Temazepam for fifty cents apiece and would occasionally sell them for between $1 or $1.50. She was taking these pills three to four times a week. She was also sometimes injecting methamphetamine, but was reminded that she did not like the social circle of speed users in the Tenderloin. Since the Frontside burned down, the Red Cross had intervened and Sheryl was forced to bounce around staying in cots in the lobbies of other Tenderloin hotels run by the same non-profit until the HOPWA case managers could secure her a permanent room in another hotel. She had been back in the Zachary and also spent a few nights at the West Hotel on Turk Street. For her, this mirrored the experience of city shelter stays, with people lined up in rows of cots in one large room. She finally did get placed in a room at the Diplomat Hotel, but was feeling emotionally overwraught because the room she had been assigned previously belonged to a good friend who had died in that room. Sheryl was sure her dead friend's spirit was living in that room.

As we sat and talked that day, Sheryl's mood was erratic and it was not clear if it was because of her lack of sleep, the Temazepams, her overall depression, or frustration from the last few weeks of chaos. One moment she aggressively snapped at me and the

next she was weeping. Again the symbolism of her swift SSI approval was deeply troubling and felt a sense of impending doom, certain that her clinicians were withholding information about the seriousness of her health.

> Sheryl: I wish I could get clean, girl.
>
> Andrea: What do you think brought you back to using regularly right now?
>
> Sheryl: Phew… [she starts crying intensely]
>
> Andrea: Sorry, I didn't mean to…
>
> Sheryl: You know, I thought it was going to take a while, but they, um, they approved my SSI immediately.
>
> Andrea: I know that's been a rough thing for you to have to go through.
>
> Sheryl: That just tells me that there's more going on than what—that what's being said.
>
> Andrea: What do you know so far?
>
> Sheryl: Nothing.
>
> Andrea: Do you feel like they're not telling you?
>
> Sheryl: They're not going to because it's too much money and my insurance won't cover it.
>
> Andrea: Like a procedure you need?
>
> Sheryl: I don't even know... [SSI] it's a good thing, but it's a bad thing.
>
> Andrea: You never know, it might be a good way to get some good care going and get yourself kind of stabilized.
>
> Sheryl: If my body was breaking down, they wouldn't even tell me because they couldn't afford to take care of me.

Sheryl started to weep more intensely. We sat for a few moments in complete silence as she cried. She had disengaged from care at the HIV clinic at the county hospital in the

last few weeks, since she had gotten SSI and started using drugs again. Her primary care physician, a progressive HIV doctor with years of experience working with active drug users, had been out of town for several weeks, unfortunately. Being that I was also employed in the HIV/AIDS division at the county hospital, I knew that her doctor had a replacement clinician that was keeping all the patients' appointments should they choose to come to the clinic. Nonetheless, she was experiencing a sense of abandonment. She had access to clinicians, but did not trust she was being cared for fully and honestly. She felt devalued by the medical establishment, perceiving that there would be limits to what she, as a differentially categorized citizen with only public insurance, would be deemed worthy of receiving. She felt a terror that her body would be permitted to degrade to the point of no return. She told me the following while crying intensely.

> Sheryl: Those guys are contracted to say that this person doesn't have insurance, or if they don't have this, they don't get treatment. I mean, they wait until it's too late, until your body's breaking down. And then they try to give you treatment for the last end so that they don't have to give it to you the *whole* time. Because it costs *too* much money!...
>
> Andrea: Did they tell you that they want you back on [HIV] meds?
>
> Sheryl: Hopefully when she comes back, she'll be changing my meds…
>
> Andrea: If you want to see someone, you know, she has replacement people. So, you could see someone, you know.

Sheryl started to nod off. I could see the cup of coffee teetering in her hands and as I reached to grab it, she jolted awake, spilling hot coffee on her hands and all over the carpet. This brought her some additional lucidity and again we sat in silence for some time while she let out big sighs and wept. The clock in the office was ticking loudly.

> Sheryl: Sometimes I think if I go to sleep, I'm not gonna wake up. Because I'm on so much medication.

> Andrea: The meds that the doctor gave you, or that you're getting on the streets?
>
> Sheryl: Both…my addiction won't let me stop…if I don't ever see you again—thank you.

At this point, I was really worried about her and did my laymen's suicidal ideation assessment: Was she thinking about hurting herself or overdosing? Did she have a specific plan to do so? She did not seem too, but of course, I was still worried. Then she perked up a little bit and said, "I need crack to get me to the heroin, then I'm gonna go straight home." She was starting to feel opiate withdrawal set in and she was motivated to leave to locate drugs. But finding heroin might take a little while longer and she was already feeling the nausea and clamminess of dopesickness, so she would need the momentary physical boost from crack to endure finding the heroin. "I don't think I'm going to get any better," she said. "I've stayed clean for a year and a half, and it didn't get any better so…" she said, referencing her HIV. Sheryl started crying again. "Now that I'm using," she told me, "I'm not skipping [HIV medication doses]—not on purpose, you know. It's just—addiction is a motherfucker." She got up to leave the room and repeated a kind of mantra: "I wanna fix. I wanna fix. I don't really wanna fix. But, I need to fix," she said, as she abruptly left. I watched out my office window as she walked up the block to find crack. Despite the heavy foot traffic on that block at that time of day, I saw her crouch between two cars to urinate, then rush up the street.

A couple of weeks later, Sheryl invited me to visit her new room at the Diplomat. I was excited to have an excuse to visit this hotel because it is a significant landmark in the history of HIV/AIDS in San Francisco. A non-profit acquired and renovated the Diplomat in 2003. Prior to that, the building and its rooms were in dilapidated condition,

however, the hotel had served as an informal respite facility during the height of the AIDS crisis in San Francisco in the late 1980s and early 1990s. Before the supportive housing movement became institutionalized in the city, the Diplomat was transformed through a truly community-based effort and an activist manager into some of the very first harm reduction housing of San Francisco. A 1994 short documentary done by a local news station took viewers inside the Diplomat, which demonstrated how the hotel was the "last stop" for many before premature death related to addiction and AIDS-related infection.

In 1994, it cost $82 per week to rent a room and $97.50 for a room with a personal bathroom. The manager had of his own volition coordinated with community-based health care and social service providers to provide low-threshold support services for the most marginalized people impacted by the HIV epidemic at this time, within their hotel rooms. The images of people living in intense physical conditions in the early years of the HIV epidemic were striking. While conditions at the hotel were significantly improved, I reflected upon how Sheryl looked just as sick as those who were battling HIV before widespread access to HIV medications and who suffered severe wasting. She could have been inserted into the documentary seamlessly. The Diplomat is one of the hotels that received a commemorative plaque when the neighborhood was rebranded and christened by Mayor Newsom as the Uptown Tenderloin Historic District.

Sheryl was now smoking crack consistently and when we met, she immediately launched into an account of her most recent bed bug paranoia. She was happy that the inspectors were scheduled to pass through her floor today because she had been getting bites all over her body. She recounted a narrative that I had heard before in the daily rate

hotels among women who smoke crack—that occasionally she would see bugs that had a human face. She told me the ones she had been seeing lately since moving into the Diplomat had the face of an old man. We rushed down the block to her hotel.

The lobby area of the Diplomat was much like that of the Frontside. It was clean and clinical, but by no means fancy. There was a large reception area where every guest must check in with a receptionist and present an ID. We rode the slow elevators up to her floor and she took me to her room. I was relieved to see it was much bigger than her room at the Frontside. In fact, the room size was probably about the size of my own city living space, about 9 feet by 9 feet, plus a separate kitchenette and bathroom. "I haven't fixed since yesterday," she said. "You didn't take any pills or anything?" I asked. "Nothing," she said. "Wow, you feeling awful right now?" I asked. "Yeah," she answered. "Before you start recording and shit, do you mind if I get something?" she asked. Sheryl left me sitting in her room for about 15 minutes, while she stepped out to buy heroin. Before she left, she turned on the television, which had a staticy picture, and left it at high volume on the Maury Povich Show.

The inspectors knocked on the door while she was still out and I let them in to inspect the bed. They did not find anything and left within less than a minute. When Sheryl returned, I let her know they said there was no risk for her bed because the hotel management had put the mattress into a plastic slip cover that would prevent an infestation. Sheryl exclaimed, "Oh hell no! Fuck that!" And she opened the door and screamed down the hallway to the inspectors:

"My cover is really ripped all over the place and I'm getting bit everywhere! It's gotta be covered again, man, for real. 'Cause I mean look at this shit. If you look at it real good,

you can see the bedbugs." The inspector told her that he did not handle requests for new hotel property and that Sheryl would need to contact the manager downstairs. I was simultaneously impressed by how she was advocating for herself, even while so dopesick, and also processing my own discomfort, since I had just been sitting in that bed for the last 15 minutes while Sheryl went to buy drugs.

Sheryl dug around in a drawer of her dresser, looking for a cooker, and recounted that she had missed a vein while injecting the night before, which is painful and also can result in an abscess. She was regretful that her drug use had escalated again so quickly and she was trying to figure out a plan to get back on methadone maintenance.

> Sheryl: It's so motherfucking bad right now. Yeah. I'm off the *hook* bad. But I really want to get on the [methadone] clinic. I talked to my doctor before I left right? I told her. She said that she'd help me get methadone pills, but I know she can't give me methadone unless I get on the fucking clinic!
>
> Andrea: At the hospital, over there?
>
> Sheryl: Yeah! Or else she can't do anything for me!
>
> Andrea: You don't wanna go out there, or?
>
> Sheryl: Everyday?!
>
> Andrea: But if you got the pills, wouldn't you get take home pills?
>
> Sheryl: That's what I mean. It would be take home pills. I wouldn't have to go out there every day. I wouldn't have to go there unless to see my doctor.

Sheryl was technically enrolled in the methadone maintenance program at the county hospital. But since her drug use had escalated, the long trek on the busy bus line to the hospital and back had become impossible and she had missed several days. She was not sure if she had missed twelve days consecutively or not, which would mean she would

have to go through a re-enrollment process. I asked why she was not enrolled at the methadone clinic walking distance from her hotel, only six blocks away. I knew from personal experience that riding the bus between the Tenderloin and the hospital could be tiring and also overwhelming, since at certain times of day, people from the area go en masse to dose at the clinic. She said that she and her doctor had talked about it, but since her drug use escalated, she had been going to the clinic much less frequently to follow up.

> Sheryl: With the SSI thing…and stressing out about the Frontside and all that shit. That's when. A week before [moving out of] the Zachary I started smoking.
>
> Andrea: Smoking crack?
>
> Sheryl: And even then I wasn't smoking that much. But, I could just put it down, you know, after a while. And then when I went to the Frontside—got to the point where I was smoking nonstop.
>
> Andrea: You were smoking tons of crack then?
>
> Sheryl: And I was all by myself too. So I bought a lot and it's just me! I wasn't sharing it with nobody, so.
>
> Andrea: And then when did you start shooting again?
>
> Sheryl: I think I shot twice. Four times in like three months, something like that. 3, 4 months. And then all of a sudden, man [she lights her crack pipe]. Yeah. It was so easy—so much easier just to get some chiva than to go all the way to the clinic. It's fucking crazy, man! It is!...And I don't have no veins or nothing. I'm fucking—aw man I wish it was never a bloodbath! And then my blood is so thick from the HIV. [she starts crying]…See, I left the Frontside because it caught on fire, right…

Sheryl frequently described the intense sensorial experience of HIV circulating through her body. These experiences manifested more intensely when she was using drugs, but in general, she could be obsessive about imagining the actual virus taking over her body and manifesting in grotesque forms. No amount of counseling about HIV being a chronic disease akin to diabetes had helped. She still harbored stigmatizing feelings about the

disease and felt that her body was rapidly decaying and being consumed by the virus. After being displaced by the fire at the Frontside, these feelings intensified as she was forced to sleep in a room with other people also displaced. All the while, she had started using drugs frequently again and was experiencing what seemed like intensified paranoia as a result of crack use or the very real agitation of mental health issues related to previous trauma and the distress of her displacement.

> Sheryl: This dude that was next door to me, he was pulling shit out of his nose and putting them in his arms…It was bugs!...And you know what? I think because he does a lot of speed and he doesn't take his medication often, that instead of HIV [affecting him] from the inside, it starts coming out and eating the outside too. And they're actual bugs. They're actual bugs. So I think because I have twelve strands, I have twelve types of bugs. That's why I see all those different kinds of bugs. Because I have twelve strands…with my HIV. But they're actual bugs! That come out of your body! You don't believe me, huh?

It was, of course, not that I did not believe that she experienced the bugs in a very real way. It was that for me, the bugs represented the intense affective way she experienced being HIV positive. It was akin to an infestation upon her body, agitated by her stimulant use.

> Sheryl: I can show you, look! It's all on my hands! You have to look real good. It's under my nails on the top. It's eating my skin!...Okay, it's under my nails. It's under my nails. It's eating my skin under my nails. And on my skin. So now it's coming out and eating me on the outside!
>
> Andrea: Have you talked to anybody about that?
>
> Sheryl: Yeah! I'm talking to you right now!
>
> Andrea: No, I mean, what do I know? I'm not a doctor, you know what I mean.
>
> Sheryl: I haven't seen my doctor. She's still on vacation, so…the weird thing is that when I started smoking a little more crack… it works better than the vicodins did.

Sheryl's primary care physician did routinely prescribe her Vicodins for pain management, but she quickly realized that she would have to take far more than the indicated dosage to effectively manage her chronic pain. Smoking crack-cocaine worked much better at controlling her pain, though she admitted the major drawback was that because of the pharmacological nature of crack and its punctuated high, she would have to perpetually smoke it to keep her pain under control. But, it was easy to get crack in the surrounding blocks of the Tenderloin, thus making it preferable to trekking out to the hospital to get a prescription that may not be all together effective. As she said, "I mean, it even works afterwards like hours later until I'm like really coming down. Then it starts hurting. All over again. I'd be like fuck, I need some crack! You know?"

Sheryl did not conceptualize her heroin use as part of her pain management strategies necessarily—it was her physical addiction that kept her using heroin now. As I sat on her bed, Sheryl prepared her shot: first scrounging for a syringe with a sharp needle in her dresser drawer, then mixing the heroin with water and heating it up, then soaking the heroin into a small cotton ball, from which she drew up the liquid into her syringe. She started looking for a vein in her arm. Despite saying that all her veins were "blown out" from years of injecting, she found one relatively quickly and the barrel of the syringe filled with blood, indicating that she had managed to insert the needle tip into a vein. Nonetheless, she said, injecting always took a long time because the drugs took a while to pass through the now restricted pathways, damaged from years of injecting. She sat there calmly, with the syringe hanging out of her arm, waiting for the heroin to enter her bloodstream. In the meantime, perhaps because she was reflecting upon me sitting there and observing her inject, she said:

> Sheryl: Yeah, when I was on the bus yesterday, this dude was taking pictures of this other dude and I was thinking, man, I gotta get a camera while I'm still using. Because it's the only thing that I always never end up doing—is getting [pictures]. 'Cause I wanna make a story, you know? About my life. And I don't have no pictures of me…And, you know, it's important that I like get them, so that when I make my collage. Like, you know, my probation officer would give me mug shots. Like the last time she gave me one of every single time I fucking got arrested. Yeah. I must have had like fucking thirty of them, you know?

Sheryl desired to be her own self-documentarian and three things about this were particularly striking to me. I told Sheryl I usually always had a digital camera on me and we could take pictures and make prints whenever she wanted. At times she played with the notion that I was, essentially, a type of documentarian. When she was in a bad mood, she would tersely say "Don't you want to take pictures of me *now*?" Sheryl recognized that images of her at her worst likely carried the most capital in terms of communicating the daily severity of the suffering of street-based drug users. But she also felt a sense of urgency to produce some lasting account of her life because she feared, and as her interpretation of having been granted SSI confirmed, that death was near. Further, I was struck that in the absence of having "normal" pictures of herself to construct her life history, she had at her disposal over two dozen mugshots. The only existing material manifestations of her life history were all mediated by her interactions with the penal state.

A couple of weeks later when I saw Sheryl, she had lost even more weight and had been very sick. She said that she had had diarrhea for the last eight days and had barely been able to eat. Rather than going to the hospital to see her regular primary care doctor or to urgent care, Sheryl had been buying antibiotics on the streets and self-treating. She had been taking one or two Amoxicillan a day. It had now been two and a

half months since she had been to her primary care HIV doctor. In the meantime, she had run out of her anti-retroviral HIV medication. She had been completely off of them for two weeks now.

> Sheryl: Yeah, we roll by and I forget to take them. And then when I did remember to take them I thought, 'Well, it's too late to take them now.' And I just didn't take them. Yeah, you know, one day rolled in to the next day and the next day and pretty soon I didn't even know how many days had passed by!

She had been taking anti-retroviral therapy for about two years, but said that she had never missed doses as frequently as she had been doing lately. When I asked her what was different about this time in her life, she said "It's probably just depression." Despite the immediate impact on managing her HIV, starting and stopping her HIV medication regimen could lead to future drug resistance. Her disconnection with regular care, including going daily to the methadone clinic, meant that she was relying totally on street-based hustling to self-medicate her chronic pain and addiction. This was wearing on her physically and emotionally.

> Sheryl: I'm just tired. Hustle hustle hustle—I just can't do! Somedays it's okay, but most times, I'd be like fuck that shit, man. You just get tired.
>
> Andrea: What do you think's keeping you in it right now?
>
> Sheryl: I don't know. I just need to get on methadone with my doctor and get a new regimen and start clearing my mind up again. And I don't want to go back to the [methadone] clinic. Any clinic! I don't want a clinic! I just want to self-administrate my own stuff, so I don't have to go there!
>
> Andrea: What is it about the clinic?
>
> Sheryl: I just don't like all the doctor stuff. That's depressing.
>
> Andrea: How so?
>
> Sheryl: I don't like the questions. I don't wanna be fucking UA'd [given a urine analysis] all the time. All that shit. Even if I was clean! I get stopped

> and they wanna know what's going on. I don't wanna tell you what's going on all the time! Fuck!
>
> Andrea: You mean you get stopped by...
>
> Sheryl: Counselors or something like that. I just don't wanna do all that no more! It's intrusion.
>
> Andrea: So it that what's basically keeping you from going back on methadone?
>
> Sheryl: Yeah! Basically.
>
> Andrea: If you could dream up the ideal way for you to get your methadone, what would it...
>
> Sheryl: I'd just administrate it myself. I'd do the pill thing. Because even when I was on it and I was clean, you know, some days I'd be like, I don't wanna do the whole hundred [milligrams], maybe I just want to do sixty. Just enough to, you know what I mean, just enough to be ok! And then some days, I might want to do a hundred because I've been feeling bad! And, you got syrup—how do you fucking decide how much to spit out? You know? Fuck!

The politics of control around methadone were a source of great frustration for Sheryl and could keep her from engaging altogether with her opiate replacement program The Diplomat does have in-house case management, but according to Sheryl "[I] only see them randomly in the hallway" and there was no on-site methadone program or medication distribution. At the moment, Sheryl's relationship with her case manager was largely consumed by the continued bureaucratic process to secure permanent housing. Even though she had been placed at the Diplomat after the fire, the type of hotel slot she had been placed in via the HOPWA program meant that she would have to reenter a lottery to secure a permanent room. This ongoing process was incredibly frustrating for Sheryl, given that she was simultaneously managing her addiction and chronic health

issues. The Diplomat, where she was currently housed, was her first choice, but she was not guaranteed to be allowed to stay there.

Sheryl told me, “I don’t wanna move again, man. I just don’t. I’d rather just die here. I’m tired.” Meanwhile, despite the fact that she had started to get SSI, Sheryl was still having to engage in petty drug selling to make it through the month because her SSI check of a little over $900 did not sustain her, especially while self-medicating. At this point, she had accrued a small debt with the dealer—around $400—and was stressed about having to “duck” around the neighborhood to avoid being spotted by the dealer. “What is today?” she asked. “Today’s barely the 16th, ho!...it came and went!...[the first of the month, when she will get her SSI check] is a ways off—so fuck it. There’s nothing I can do about it [the drug debt] now. Just stress and wait. I mean what else can you do?”

Sheryl’s narrative demonstrates the paradox of one having a kind of intense institutional engagement (e.g., her HIV primary care clinic, the criminal justice system, diversion programs, the methadone clinic), yet also a simultaneous subjective sense of abandonment and feeling of being near death in her hotel. Despite having been inserted into the complicated bureaucratic terrain that would grant her access to stable housing, she had experienced great instability and her drug use had intensified. She was constrained by the fact that she was not able to secure take-home methadone doses, and once her heroin use increased, it became insurmountable to travel all the way to the county hospital to dose on methadone daily. Although she had help in securing placement at these various hotels and also in processing her SSI application, she needed further support to process the displacement, her increased drug use, and the depression related to the symbolism of being granted SSI. Her case illustrates the deficiencies in supportive

services (e.g., transitional mental health support; no methadone distribution on site) and the intense affective dimensions of being housed within the supportive housing context while managing addiction, mental health, and chronic illness. Sheryl was deeply reflective about her own marginalization and how life itself was intertwined with the politics of care and control.

On paper, Sheryl might be classified as a "success story"—that is, she had been granted SSI and a permanent supportive housing unit. She had been able to interface successfully with the complicated bureaucracies that would facilitate access to welfare entitlements and permanent supportive housing. In many ways, she was the perfect candidate with exactly the characteristics that advocates of San Francisco's version of Housing First sought to intervene upon. She was an active drug user and had been chronically homeless over several years. But following her ethnographically reveals critical nuances. Her SSI, though admittedly helpful, impacted her mental health and she spiraled into depression since for her it signaled chronic illness. In this context, her housing was not a place of security where she imagined that she would finally have a chance to *thrive*. Instead, she was relegated to the interpretation that now, at least, she had some place to *die*.

Summary Analysis

I am consciously cautious of being overly critical of the supportive housing hotels because they represent a progressive, well-intentioned intervention into the crisis of homelessness and housing instability in San Francisco and are often far superior alternatives to the daily-rate hotels or sleeping on the streets. The city's master lease program and formal institutionalization of SROs into the city social service provision has

attempted to address two of the primary issues within the daily rate hotels: the uninhabitable conditions and the routine forced transience (i.e., musical rooming and daily payment structure) that I discussed earlier. Yet, as Jenai's narrative demonstrates, women are still exposed to everyday violence within them. Further, these are the sites where the "triply diagnosed"—those with addiction, mental health issues, and chronic illnesses such as HIV—are strategically placed en masse as a matter of municipal policy. This results in a social environment with unremitting daily crises as people do their best to manage these circumstances. Further, the resources allotted to help manage these crises (e.g., 24-hour conflict intervention, wraparound mental health services) are deficient. While this is a preferable option to street homelessness, the city's supportive housing plan has also created concentrated living environments that may in fact contribute to the reproduction of social suffering, stigmatization, and marginalization among this population.

As both Jenai and Sheryl's narratives demonstrates, there are also powerful affective dimensions to living in the publicly run hotels. Both women describe a sense of perpetual transience, despite both having secured permanent supportive housing slots. Jenai still identifies as a homeless woman and recognizes that she must forever navigate engagement with penal and medical institutions as a perceived homeless drug addict. Sheryl is deeply saddened by the fact that her qualification for SSI and the opportunity to be housed stably because of it, symbolizes her march toward an untimely death. The fire at her initial SRO hotel was beyond control, however, the resultant destabilization sent her into a tailspin and coincided with depression related to the symbolic meaning of SSI. Despite her placement at a supportive housing hotel and assigned case managers, she

nonetheless disengaged from her methadone clinic, her HIV primary care, and became totally re-immersed in her addiction and social isolation.

Though there are practical differences between them, the daily rate SROs and the institutionalized supportive housing hotels are part of a continuum of the same socio-cultural phenomenon: the relegation of the urban poor to states of transience and liminality, where women must negotiate tensions between care and punishment and make sense of their stigmatization and marginalization. Despite their differences, daily-rate and supportive housing hotels both constitute different points in a continuum of housing for the urban poor that are at once sites of respite and harm, control and chaos, stability and placelessness, and where circumstances coalesce so that violence and crises are daily occurrences, without the social support to process them.

Ethnographic examination of the supportive housing SROs brings up a critical question regarding one of the implicit premises of the Housing First approach—that housing is one of the fundamental building blocks of stability and ushers in more potential for the actualization of some measure of quality of life. However, as I demonstrate in this chapter, in San Francisco's version of an attempt to implement these principles, securing one of the highly coveted permanent SRO rooms does not necessarily guarantee a fulfillment of "ontological security," a concept defined by Padgett (2007) as "the feeling of well-being that arises from a sense of constancy in one's social and material environment which, in turn, provides a secure platform for identity development and self-actualization." For women, these environments can be chaotic and traumatic—people enact predatory control over women, there is routine violence and crises, and police surveillance and raids are anxiety-producing and destabilizing.

Further, despite the fact that women may recognize that these hotels are indeed preferable to enduring the harsh conditions and dangers of street homeless, the weight of relegation to these spaces is palpable. Women express a sense of being "corralled" or sent to the hotels to wait for impending death. The hotels are spaces of state relegation through different mechanisms: the daily rate hotels house the most socially excluded who are forced to attempt to meet basic survival via the illicit drug and sex economies, while the supportive housing hotels house the addicted and mentally ill, but at the lowest threshold of basic human survival and with great senses of social isolation and purposeful exclusion. Further, in these spaces, women must navigate the daily challenges of their bifurcated subject positions, which categorize them both as criminals and victims simultaneously worthy of punishment and salvation.

As Biehl (Biehl 2013) demonstrates, the nature of these sorts of institutions of social abandonment is such that while they function as the catchment zones for the hypermarginalized, they also produce and maintain the conditions which force the people who live there to exist in a state of perpetual exclusion (Biehl 2013: 3). Further, it is a palatable tragedy that, as Biehl shows, the supposed "life-enhancing mobilizations" that are enacted to address the malaises of the urban poor are intertwined with "the public act of allowing death." That is, while the spectrum of SROs in San Francisco provides sites of relative respite from the wretchedness of homelessness, their existence institutionalizes forms of suffering that are produced, both materially and subjectively, through supposedly compassionate state interventions.

In the following two chapters, I focus on the dynamic between law enforcement and the hypermarginalized and how, in the face of deficiencies of the social services

needed to mitigate the impact of housing instability, drug use, mental health crises, and chronic illness, the police are forced to take a much more active role in the management of these populations.

Chapter 5

PROBLEM-SOLVING PENALITY

As I showed in the last two chapters, within the housing system of last resort, police become imperfect and problematic first responders to violence and mental health crises and play a critical and complex role. In the absence of a flourishing welfare state, street-based law enforcement is especially implicated in the management of the everyday crises of the poor, typically through punitive dominance. Police officers are the primary "face of the state" that actively confronts this population, often accomplished through various forms of surveillance, intimidation, and potentially brute force, citation, and arrest.

In Wacquant's (2009) adaptation of Bourdieu's left and right hand metaphor that I introduced in Chapter 1, he argues that the penal system is increasingly a dominant right hand function of the state. Undoubtedly, police enact oppressive punitive control over the socio-spatial contexts where poverty is concentrated, especially in their unremitting policing of the illicit drug economy. However, within the structural reality of an ever-diminishing social safety net, law enforcement is also paradoxically called upon to fulfill left-hand functions of the state through the frontline management of the crises of the urban poor. In this chapter, I examine this phenomenon from the perspective of police tasked with fulfilling this role.

In San Francisco, this has been formally institutionalized through the implementation of a hybrid model of policing, which mandates that at each station, specific officers are designated to respond to dispatches regarding "homeless" issues.

This model rewrites certain officers' roles by mandating three simultaneous rationales for engagement with the hypermarginalized poor: 1) punitive repression—what might be considered police officers' "normal" function, yet which serves a deeper both moral and practical interventionist purpose; 2) the practice of "care" for both the individual and social bodies through public health and social service provision; and 3) attempts at compassionate redemption and even salvation, through officers' gendered moral adjudication of women. I situate my findings within Wacquant's (2009) analysis to argue that through the model enacted in San Francisco it becomes evident how within the context of contemporary US poverty, street-based police can simultaneously embody the left and right hand functions of the state. What is unique in the context of San Francisco is this arrangement is not merely an inadvertent, consequence of a diminished social safety net; rather, it is a model the city has institutionalized strategically as part of the logic of compassion that guides the overall governance of the urban poor. In San Francisco, the blurring of punishment and care is a matter of city policy and a reflection of the contemporary reality of policing neoliberal poverty.

Through this configuration, women's particular gendered engagement with the typical "helping hands" of the state (housing and other social services) is mediated by the penal state, as street-based police officers act as not only front-line responders, but also as gatekeepers of social services and moral adjudicators of women. Ethnographic examination of these interactions illuminates an extremely productive symbolic terrain where conceptions of criminality and its corollary sentiment, worthiness, are negotiated in the context of material deprivation, limited resources, and ever-increasing instability and suffering among the urban poor. Street-based police officers too must negotiate

bifurcated subject positions as both adjudicator *and* savior for the women, while women are cast simultaneously as criminals, moral transgressors, *and* victims potentially worthy of salvation.

In this chapter, I first trace the historical and discursive threads which frame the enactment of San Francisco's style of penality, both in the context of the broader US ideology and in the eventual policies implemented locally, where there already existed a legacy of liberal "problem-solving policing" (Wacquant 2009). Next, I will demonstrate how this enactment of penality plays out from the perspective of the police in the urban spaces where they are tasked with intervening through these hybrid modalities and must grapple with an inherent tension between the deployment of punitive oppression and humanitarian intervention in their everyday responses to the perceived criminality and suffering of the urban poor. Finally, I will discuss the structural deficiencies that are revealed through an examination of this model.

This chapter engages in theoretical conversation with Wacquant's notion of "neoliberal penality" to examine the nuances of how street-based "addicts," the "mentally ill," and those with stigmatized chronic diseases like HIV are conceived of and managed through penal institutions. The penal system is often theorized as a colossal, oppressive force analyzed from a distance—defined by its institutional endpoint for the accumulated social inequality of the urban poor—the jail or prison. Wacquant (2009) urges us instead to examine the historical assemblage of "neoliberal penality," a concept which refers to the policy-driven radical expansion of institutions of enforcement such as the police, jails/prison, and community supervision like probation/parole alongside the accompanying ideological negotiations that implicitly associate poverty with criminality.

Neoliberal penality examined through everyday encounters between the police and the urban poor reveal that at times interactions are overtly oppressive and disruptive, but at times also tempered by familiarity and affect that is a result of the repeated interaction between the agents of the penal state and the urban poor. The fact that long term social relationships are inevitably forged powerfully demonstrates the scope of penality in the US urban context which, as Wacquant (2009) argues, is the crux revealing the magnitude of the neoliberal transformation of the state. The following two chapters examine how the penal state steps in to manage the problems of poverty within an ethnographic context where hybrid modalities are mandated by local policy.

Wacquant posits that in the broader context of neoliberalism, three state strategies are routinely deployed to confront the "conditions and conducts" deemed problems that necessitate some form of state intervention—in this case "addiction," "mental illness," and the street-based suffering associated with extreme poverty. The first two have long been theorized by urban and medical anthropologists working in US cities. These strategies are: 1) the socialization of the socially marginal, 2) the medicalization of their afflictions and individualized modalities of "treatment," and 3) the penalization of these conditions (Wacquant 2009: xx-xxii). In the context of San Francisco, the enactment of penality takes on a unique character reflective of the city's historic progressive political spirit. This research adds to Wacquant's conception of the nature of contemporary management of the poor by arguing that in this context, a fourth critical component reveals itself ethnographically—the circulation of a discourse of gendered neoliberal salvation.

I find that police act as rudimentary frontline service providers—a form of the "helping hand" of the state, albeit deficient. My ethnographic data supports Wacquant's (2009) assertion that in the context of neoliberal penality, welfare provision and penal sanction become enmeshed. In Bourdieu's configuration, the metaphoric left and right hand functions of the state operate through distinct institutions. While Wacquant, drawing from Bourdieu, suggests that there is a currently a double regulation of the poor administered by these two separate hands of the state, I find that the left and right hand functions of the state have merged and operate as a singular deployment via hybrid policing. Examination of this phenomenon reveals the sites of structural failings in the state's interventionist chain of response to addiction, mental illness, and the suffering of the poor. Further, the gendered moral discourse plants a seed of promise of salvation for hypermarginalized women. This discourse is problematic in its assignment of gendered neoliberal subjectivity, but, the structural reality is such that few women can or will ever be "saved." Nonetheless, women must navigate these paradoxical discursive and moral terrains as they try to secure minimal resources for basic survival.

"Broken Windows" in the City by the Bay

In this section, I will illustrate San Francisco's ethno-historical legacy of policing amidst broader discourses about policing in the US that proliferated in the late 20th century. In April of 2010, just after I started fieldwork, there was a flurry of national media attention towards the city's Tenderloin District. First, the Wall Street Journal reported on how the new police chief, George Gascón, a silver-haired, Cuban-born outsider was brought in to the San Francisco Police Department (SFPD) because of his reputation as a tough tactics reformer while chief of an Arizona police department. It is

rare for a department to not promote from within its ranks, so this political gesture was received by the public and SFPD as a bold statement about the need to shake up the department and usher in a new era of San Francisco policing. Swiftly upon his arrival in the city and amid media buzz, he implemented a two-pronged tactical plan "aggressively targeting crime" in the Tenderloin (White 2010), the city's supposed disgrace of public disorder, crime, and vice. First, Gascón oversaw an unprecedented upsurge in concentrated police sweeps in the neighborhood's approximately sixty square blocks, including zero tolerance for even petty infractions in this urban space that he alleged had been overlooked for too long by the SFPD and was allowed to function as San Francisco's lawless containment zone for the open-air illicit drug/sex market.

But, the undercurrent message of this aggressive approach against crime was, that in addition to focusing on "the bad guys" (e.g., those involved in larger scale drug/sex trafficking, gangs, violence, and other more serious crime), SFPD would also be more forcefully policing the street-based expressions of poverty and homelessness—those behaviors dubbed "quality of life" infractions, such as public urination, public intoxication, and camping on the sidewalks. SFPD demanded the right to ambiguity about the exact details of their strategic plans to police the Tenderloin, suggesting that they needed to maintain an element of surprise to maximize the success of the operations. But this opacity did not sit well with many citizens of San Francisco, a city known not only for its active police watchdog groups, but also a place with an ever growing movement towards the decriminalization of "quality of life" infractions associated with poverty, in addition to prostitution and minor drug possession associated with drug addiction.

Coming up against skepticism of the SFPD's desire for carte blanche tactical policing in the Tenderloin, department officials employed the argument that similar strategies infamously implemented in New York City in the 1980s and 1990s under the supervision of ex-police chief William Bratton, had proved successful. Bratton was Rudolf Guiliani's co-conspirator in the transformation of policing in New York, which, rallied the "Broken Windows Theory" generated by a conservative think tank that called for implementing a harsh "zero tolerance" policy for all crimes great and small (Wacquant 2009). The theory posited that when even small crimes go too lightly punished, a climate is created where people are more motivated to commit further and intensified crime. The solution was to police aggressively and New York City was flooded with an additional 7,000 police officers who were tasked with rolling out a massively amped up punitive machine of police presence and unremitting citations and arrests for crimes that spanned the gamut of severity.

During the same time period that New York was undergoing this penal transformation and receiving widespread media attention about supposed resultant crime reduction, San Francisco resisted this model and instead developed alternative programs to address crime in the urban core, such as the San Francisco Pretrial Diversion Project. Established by a group of activists in the late 1970s who contended that citations and jail time were not beneficial nor rehabilitative for individuals or the community, the project established a tradition in San Francisco where individuals could have their cases dismissed if they agreed to participate in a relevant community program. This project is still in existence and now has many related sub-initiatives of which the women who

participated in this study have frequently engaged with after getting a citation or after serving time in San Francisco County Jail.

In an analysis by the Center on Juvenile and Criminal Justice (see Wacquant 2009), it is argued that during the time period when "zero tolerance" ideology was propagated in other US cities, San Francisco represented the *antithesis* to New York City's broken windows experiment. Crime statistics compared between cities showed that even though San Francisco was being labeled as "soft on crime" in its rejection of zero tolerance policy, violent crime rates in the city not only declined, but declined more than New York City's. But this fact was lost in the national discursive casting of San Francisco as an almost freakishly leftist liberal haven, something that happens regularly to this day by mainstream right wing media. Bill O'Reilly, in particular, enjoys lambasting San Francisco, citing its "radical leftist government" and lax policing practices as the reason why New York City is so much more "under control" and San Francisco is a mess of vice at every corner. He sent a reporter to San Francisco in 2008 who pronounced that because of this radical leftism, mothers were forced to roll their "strollers next to hypodermic needles" and that "every neighborhood has this dark underbelly that seeps into the regular society" (see http://www.youtube.com/watch?v=og5-FSbLYP4). These sensationalized accounts of San Francisco's liberal political climate on a national discursive level inhibits a broader national dialogue about the functionality of San Francisco's historic orientation to policing in contrast to the Guiliani/Bratton model of the 1980s and 1990s.

So, it was indeed bewildering, yet perhaps indicative of an ideological shift, that when Gascón was appointed police chief in 2010 when I started fieldwork, he was given

unlimited resources to aggressively police the Tenderloin in the style of Bratton. The early implementation resulted in flooding of the county jail and clogging the county courts with petty offenses, when paradoxically San Francisco had more momentum for decriminalization of offenses that were seen as intertwined with poverty and inequality. In 2008, the city nearly passed Proposition K: Changing the Enforcement of Laws Related to Prostitution and Sex Workers, which would have essentially decriminalized prostitution. The measure failed by a somewhat slim margin, with almost 41% voting yes on K. So it seemed that there was some hidden political agenda at work for the penal logic in the vein of Bratton to gain a foothold in San Francisco. When Gascón was instated as chief, he was painted as a sort of maverick, who despite his controversy, sought to radically reform SFPD and the city's streets. Indeed, even more mystifying was that all this was happening in the context of the most severe state and local budget crises on record. Social service programs were being radically cut and those that remained were forced to defend themselves continually in the face of further cuts and even program closures.

In San Francisco's typically paradoxical fashion, a major story in the Wall Street Journal at the time described these political and policy changes at SFPD, yet presented conflicting sentiments. In the article, Gascón dramatically proclaimed that it was an urgent time for the open air illicit drug market and its associated crime in the Tenderloin to be squashed: "There's no way I could let it continue," he said, "Don't ask me to not do my job because of budget cuts or a city agency [that] is short-staffed. The department has an obligation to stop criminal activity" (White 2010).

Attached to the article were two evocative photos that conveyed sentiments that were incongruous with Gascon's desire for a no-holds-barred approach to policing the Tenderloin. In the first photo, two cops stand on either side of a faceless, genderless person who is slumped over, in prostration, while the cops each grip the person's black rain jacket tightly. The cops' bodies form the frame for the photograph in such a way that the viewer's eyes are directed to the center of the image. It is clear the person is not standing on his or her own legs, rather, that in this moment, the cops are literally supporting this person's weight by the grip of their gloved hands on the slick fabric. The officers, each tall and muscular, with tightly cropped hair, are both gazing intensely downward at the slumped body. The framing of the image inserts the viewer into a scene which evokes the feeling of an intensely intimate moment for all parties involved—this person seems injured, unable to support his or her own weight. Though the image is cropped, one can still make out their location. They are standing in the Tenderloin in front of a large, modern residential building with over 100 units of low-income family housing. Directly across the street is a well-known food kitchen in San Francisco, in the heart of the Tenderloin. Hundreds of poor people stand on this corner daily waiting to get a hot meal—often their only meal of the day—bringing along the shopping carts, bedding, and suitcases that are their only belongings. Behind the figures in the photo is the sprawling, dirty Tenderloin sidewalk, which stretches out on the horizon.

The image does not read as *criminal*, but instead it reads as a moment of intense *sickness* or *suffering*, and the officer's faces, even in their apparent detainment of the slumped figure, are showing compassion. The other photo, though less dramatic, is similarly evocative. A homeless man is shown quickly gathering things he has displayed

on the sidewalk to sell, while his shopping cart is perched against a building and an officer writes him a citation. These images hardly communicated criminality or rallied an urgent need for oppressive policing; in fact, they conjured sympathy and concern. This level of intimacy between police officers and those they police is strangely inconsistent with the description of the second prong of Gascón's plan which would usher in a new era of reliance on statistical data rather than officers' intimate knowledge of the Tenderloin.

The second prong was the initiation of COMPSTAT (short for Computer Statistics) citywide, a form of technocratic surveillance and intervention first piloted in the Tenderloin. COMPSTAT is both a philosophical orientation to policing and a method of tracking crime using geographic information systems (GIS) and statistical analysis of crime trends. Bratton had formalized this system in New York City during his tenure there and it has since been implemented in many major US cities. The idea was that policing practices should to be reoriented from relying on community-based police officers' knowledge of needed priorities to tracking clusters of crime statistically generated by the GIS data. Then, departments could more "reliably" predict the urban areas where "preventative" policing was needed and deploy aggressive police force in those specific locations. The goal was to shift from responding to crimes after they happen, or "reactionary" policing, to data-driven predictive, "proactive" policing, where potentially crime-ridden pockets of the inner-city could be identified and targeted preemtively. "Trust in the numbers" gave the department the statistically-driven sanction to forcefully flood certain urban areas with zero tolerance policing practices because the predictive numbers mandated intense intervention. Further, "the numbers" get cast as

inarguable, neutral statistical evidence of how policing should be deployed in these urban spaces.

The SFPD adopted the following four elements of COMPSTAT: 1) accurate and timely intelligence, 2) effective tactics, 3) rapid deployment, and 4) relentless follow up and assessment (San Francisco Police Department). In order to operate at their highest level of efficiency to preemptively intervene to keep crime low, the police department needs resources to capitalize on the "*intelligence*" generated by COMPSTAT, SFPD's own language of combat to reference the statistical evidence the program produces. This includes: technological innovations for rapid GIS data analysis and intelligence sharing to coordinate their operations; authority and personnel resources to intervene offensively while the data are still fresh and before the crime trend moves to another location; and finally, a weekly dramaturgical display of accountability for the department's performance in the form of regular public meetings where police captains stand up to the firing range of scrutiny from their superiors if the crime reports show tactical failures. Note, it is not the reliability of the statistical prediction that is held at fault for any discrepancies (e.g., elevated crimes committed), but rather, the officers in a precinct must respond to why they were unable to harness the predictive power to lower crime in the targeted area. These COMPSTAT accountability meetings were featured in the HBO urban crime drama *The Wire*[1], after a rebel Baltimore Police officer effectively decriminalized drugs in his district by rounding up street-level dealers and designating areas where drug trafficking would not be policed. He is exposed to his superiors because he has to account for the radically lower crime statistics at the weekly COMPSTAT

[1] For a clip of this moment, see http://www.youtube.com/watch?v=n4j_oSeWZyU

meeting. Though the San Francisco version held weekly at the Hall of Justice is much less dramatic, the depiction of the format is accurate—each police precinct captain takes a turn standing up in front of department officials to explain either the rise or fall of crime in their districts—all relative to the previous week's "valid" statistical predictions. This is what the department references as the necessary "relentless follow-up and assessment" to bring down crime. Their rationale for this element of COMPSTAT is revelatory of a market-oriented ideology of expected returns for citizen-consumers from the police department. The department says:

> One of the main differences between private enterprise and the public sector is the bottom line of positive returns. The public sector and police departments have rarely been evaluated on their results. On the other hand, if a business implements an unsuccessful strategy or provides an unacceptable level of customer service, it isn't long before bankruptcy is filed. The bottom line with CompStat is results. Everything the police department does no matter whether administrative, operational, or investigative in nature, is evaluated by the results achieved. Static operations that do not provide for successful results are immediately assessed for their value and necessity to the overall operation of the department. (San Francisco Police Department)

COMPSTAT is an attempt to clean up the "messiness" of real-world policing in favor of managing crime through the use of tightly packaged statistical assessments which are designed to promote efficiency and provide precise assessment measures. But, as the over six foot tall, weathered Tenderloin Police Captain told me from behind his big wooden desk as he sifted through piles of COMPSTAT statistical reports, "There's lies, damn lies, and there's statistics," quoting Mark Twain. "So numbers sometimes can give you false perceptions. I know the ones that are important" he said. "…The violent crimes: homicide, rape, robbery, aggravated assault. Our rape went up 200%, but it was the same woman two or three times. That throws them off…" he said, pointing to a yellow,

crumpled paper, with the Tenderloin's crime statistics printed in blotchy black ink. The captain was resigned to the fact that since COMPSTAT started, his job was now partially consumed by explaining the statistics to his superiors, which required deconstructing the numbers themselves and also situating them within the real world context of crime in the district. Yet this was a bureaucratic irritation that did not diminish what he ultimately relied on to command the police force in the Tenderloin—the wisdom he had accrued over his 25 years of being in the neighborhood.

Admitting that there is of course persistent petty and serious crime related to the drug economy, in his quarter century of policing the Tenderloin he had come to see important distinctions between the two primary groups involved. First, there are the drug traffickers who come in to San Francisco each day from the East Bay to push drugs, but then go home. Second, there are the people driven to addiction because of poverty and mental health that live out their entire lives enmeshed in the illicit economies of the Tenderloin out of desperation. On paper, both of these groups are defined as criminals and COMPSTAT requires the officers to be accountable for the "crimes" of both groups, big and small. But for cops with years of work in the neighborhood, their savviness in the grey areas of the illicit economies forced them to be conscious about how they define, interpret, and respond to these two types of "criminality,"—one committed by perceived outsiders (e.g., "real bad guys") and the other type committed by residents of the Tenderloin, who deserve a little more compassion. The captain goes on:

> Oh yeah, oh yeah. We know the players. [Outsiders] they come through here, it's very difficult. And we are concerned. Sometimes these guys come through and they assault [a homeless person] just for laughs…Years ago, probably when you were younger, they lit that one guy on fire. They threw lighter fluid on his blanket, you know. So we don't tolerate that. They go right to the bucket. The crook does.

But the distinction between the two types of criminality presented a conflict for police officers in the neighborhood, who were nonetheless mandated to police both groups, despite this notion of their differential criminality. Then, they were expected to be accountable for the range of crimes committed as they appeared in the weekly statistical reports. The captain was on board with the notion that this population is not being provided the mental health services that they need and police officers are routinely the first responders to crisis. In the neighborhoods with concentrated pockets of co-occurring addiction and mental health issues, officers have frequent interaction with this population. But, according to the captain, the street-based urban poor of the Tenderloin are not those who the department ultimately desires to "really" punish. Expressing concern for my safety doing research with this population, Captain Cassidy told me:

> Just be careful. That's all I ask you is to be very careful. Because like I said [there are] mental health issues. It's because they're off their meds. They're not being regulated by what program they should be in. And we understand that. The officers are pretty good at doing that. Our guys. We don't have that many problems with people dying in custody that are mental health. While other police departments do. You know, because they're not used to that. We are. We have problems with the other guys. You know, the crooks. That's our main focus. We're trying, you know. We're trying to help the community get to these problems.

As the captain describes, repeatedly dealing with street-based mental health crises as first responders was a frequent occurrence and a source of frustration for officers.

> There's a guy down on 7th and Market. Cojo, he's an African American guy…he had a nervous breakdown. And we moved him and had to get a stay away order each time on mental health cases. And he's probably away now at some mental health place, I haven't seen him. And he'll come back. And the process starts all over again. And it's a very tedious thing for the officers to do…I mean people don't realize. It's not that the person's evil or anything, it's just that they're off their medications.

The captain lamented that may people face barriers to continued mental health treatment. Further, those that do have prescriptions for medications were often so poor, they were forced to divert their medication, selling their mood stabilizers or opioid analgesics prescribed for chronic pain in order to meet their basic needs. Or, the opioid analgesics prescribed to them do not treat their chronic pain and anxiety disorder as well as smoking crack cocaine does, so they trade their prescription pills directly for crack or money to buy crack. The "diversion" of prescription pain pills from prescribed patients to small scale sales on the streets of the Tenderloin and in the Mission is a huge concern for the clinicians who work with chronic drug users and impacts treatment for chronic and acute conditions. This is likely one of the reasons why Sheryl in Chapter 4 was never granted methadone take-home doses. Captain Cassidy was sympathetic to this reality, but was nonetheless responsible for policing this activity as criminal. As he artfully told me before shuttling me out of his office:

> Captain Cassidy: This person is really, really chronically [homeless] and it's a mental health issue for people that you see out in the street out here in this area. I mean you get the low of the lowest down here. It's unfortunately really hit rock bottom. And it's kind of a shame. But this pill thing, you probably notice it—these guys bum rush the people for pills. And what are you gonna do? This guy's sixty-something years old, he's got medical problems, he's trying to sell come pills to buy food, cigarettes, or alcohol. It's kind of tough, re-arresting this guy, but what do you do with him? When you were down in El Paso, did you go fishing with your dad or your aunts and uncles?
>
> Andrea: Yeah, a little bit.
>
> Captain Cassidy: What do you do with the little fish? What do you do with the little ones? Throw them back, right? Uh-huh. We can't. We don't have that option."

The captain demonstrates the challenges of having a mandate to punitively intervene in crimes related to drug use, mental health crises, and quality of life issues related to

poverty, alongside a critical lens regarding the definition of "criminal" in these contexts. Thus, their subsequent actions are characterized by rumination and negotiation of the socio-structural context in the communities that they police. In this section I laid the foreground for the complicated socio-cultural context of policing in a place like the Tenderloin. In next section I examine the discursive context for this negotiation, which draws on a gendered moralistic trope, to shape the interactions between police and unstably-housed women.

Transforming the "Addict" and "Hooker" into a "Soiled Dove"

I gained access to police officers by attending monthly community meetings and subscribing to the captain's email blasts, which eventually led to one-on-one interviews. One day I opened one captain's weekly report, which usually began with a short overview message about activity in the neighborhood. On this day, the "captain's message" opened with a singular quote:

> *Soiled dove* is defined as 'perhaps the tenderest and most sympathetic term used to refer to a prostitute, evocating a sense of outrageously tainted innocence.

The list of arrests and incidents for the week were pasted below, with a slight modification to the usual text. For each narcotics or prostitution incident or arrest that involved a woman, the captain had replaced the word "woman" with the term "soiled dove." For instance, one entry read: "6:45am—Officers Lucero, Peterson, and Tanaka arrested a *soiled dove* and her wannabe *paramour* for loitering for the purposes of prostitution" (emphasis added). In the late 19th century, an attorney in Oklahoma, Temple Lea Houston, agreed to defend a poor woman who was charged with prostitution and had no representation up until moments before she was due to appear in front of the judge.

The lawyer became famous by delivering a dramatic, unscripted closing argument in her defense that came to be known as “the soiled dove plea” or “plea for a fallen woman.” The speech was so powerful and so convincing, that the all-male jury immediately and unanimously acquitted the women of her charges. In the speech, Houston appealed to the juror’s sentiments by arguing that the woman was not inherently bad, but rather a victim of her social positioning. Further, that the woman had a deeply buried worthiness and, ultimately, a soul that not only *could* be redeemed, but was *worth* saving. Here is an excerpted version of the plea:

> Gentlemen of the jury: You heard with what cold cruelty the prosecution referred to the sins of this woman, as if her condition were of her own preference. The evidence has painted you a picture of her life and surroundings. Do you think that they were embraced of her own choosing? Do you think that she willingly embraced a life so revolting and horrible? Ah, no!...Then let us judge her gently. What could be more pathetic than the spectacle she presents? An immortal soul in ruin! Where the star of purity once glittered on her girlish brow, burning shame has set its seal and forever. And only a moment ago, they reproached her for the depths to which she had sunk, the company she kept, the life she led. Now, what else is left her? Where can she go and her sin not pursue her? …Society has reared its relentless walls against her, and only in the friendly shelter of the grave can her betrayed and broken heart ever find the Redeemer's promised rest…Were she with her wasted form and bleeding feet to drag herself back to home, she, the fallen and the lost, which would be her welcome? Oh, consider this when you come to decide her guilt, for she is before us and we must judge her. They (the prosecution) sneer and scoff at her. One should respect her grief, and I tell you that there reigns over her penitent and chastened spirit a desolation now that none, no, none but the Searcher of all hearts can ever know.
>
> She, like those the Lord forgave, was a sinner, and yet I believe that in the days of reckoning her judgment will be lighter than those who would prosecute and seek to drive off the earth such poor unfortunates as her whom you are to judge…They wish to fine this woman and make her leave. They wish to wring from the wages of her shame the price of this meditated injustice; to take from her the little money she might have — and God knows, gentlemen, it came hard enough.
>
> …And now looking upon this friendless outcast, if any of you can say to her, 'I am holier than thou' in the respect which she is charged with sinning, who is he? ...A man who will yield to the reproaches of his

> conscience as they did has the element of good in him, but the modern hypocrite has no such compunctions. If the prosecutors of the woman whom you are trying had brought her before the Savior, they would have accepted His challenge and each one gathered a rock and stoned her, in the twinkling of an eye. No, Gentlemen, do as your Master did twice under the same circumstances that surround you. Tell her to go in peace. (Shirley 2010)

By invoking the soiled dove narrative to describe women who were cited or arrested for prostitution or drug possession, the captain had characterized the women the police encountered as simultaneous moral transgressors and worthy victims. But in doing so, as the soiled dove plea does, he had also positioned the intervening police officers as central to a moral equation. If street-based women are "soiled doves," then the intervening police officers, like the prosecutors in the original case, function as both sympathetic adjudicator and a form of perceived savior in relation to their gendered subjects, even in the most seemingly mundane street-based interactions that the police reports described. This small institutional text signals the circulation of a gendered moralistic trope of the soiled dove, which I will situate within local policy and specific officers' hybrid policing mandates.

"We are the front line:" Institutionalizing a Sympathetic Cop

Gavin Newsom, the slick young city council member from the upscale Marina District, was elected Mayor of San Francisco in 2003 on the platform of many grandiose plans to tackle "the homeless problem" in San Francisco. Despite the fact that in the broader scheme of US politics, Newsom might be classified as a socially progressive democrat, in the context of San Francisco's socially progressive political climate, he was often seen as a business-centric moderate at best and a pro-development conservative who did not believe in giving "hand outs" to the poor at worst. But he often tempered his proposed initiatives regarding "cleaning up" San Francisco with the counterpoint that

they were essentially obligatory humanitarian interventions. At the time he came in to office, the "quality of life" issues associated with homelessness (e.g., public urination and defecation, public inebriation, and open-air drug use) were a constant urgent topic of debate. Newsom introduced a series of controversial policies in San Francisco during his political tenure. The one with particular historical significance was the Care Not Cash initiative described in Chapter 4.

When Care Not Cash launched in Spring of 2004, Newsom was also credited with pushing through an accompanying program, the Homeless Outreach Team, designed to facilitate homeless people's access to the "care" component of his larger initiative. Newsom said the program would centralize efforts of existing weak and uncoordinated outreach teams by designating approximately 15 street-based outreach workers to roam the streets seven days a week and have the ability to make housing, drug treatment, and health care referrals. The goal was to maintain a street presence and target the most chronically homeless by building long-term relationships of trust and provide social service referrals that eventually result in their placement in drug treatment programs and sustainable housing. The Tenderloin's sixty blocks would be the experimental pilot site for their concentrated efforts. The mayor's office premiered the program with a big media splash, which included a publicity event in a neighborhood park, a site previously known for its open illicit drug use. Newsom strolled the park with three members of his outreach team, reporters, and a camera crew and talked to homeless congregants about municipal social services that would be made available to them. Newsom dramatically pronounced in the press: "I cannot in good conscience walk around the streets and see people

suffering. We have outreach now, but it's not coordinated…and there's not enough of it. This effort is going to save lives" (Lelchuk 2004).

For many, Newsom's real political motives were thinly veiled in the media spectacle. Homeless advocates long charged Newsom with being anti-homeless and anti-poor, seeking to transform San Francisco by riding the gentrification wave ushered in by the dot-com boom and continuing to make San Francisco into an urban playland for the rich. Many considered these policies, which had been successfully reframed in the media as charitable interventions into the lives of the suffering, to really be part of a continued effort to control, contain, and displace the street-based urban poor. As I will show, these policies and practices, regardless of the political rhetoric and accompanying skepticism, did function to enact a model that deploys simultaneous care and punishment.

The Homeless Outreach Team, since its inception, was to involve direct collaboration with law enforcement. Many homeless advocates, however, urged caution in collaborations with law enforcement in homeless outreach initiatives because they feared it would minimize people's trust in the team's overall activities. But eventually, the SFPD designated that at least two officers at each police station should serve as Homeless Outreach Team cops, tasked with responding to all dispatches regarding homeless people or quality of life issues in their precincts. Within the department, the initiative was called Operation Outreach, and officers assigned to this duty were under direction, like the city-wide trained outreach workers, to first attempt to link people with social services to address the minor offense that had mandated police intervention. For instance, if the police were called because a homeless person was openly using drugs on the streets, the homeless outreach officers would respond to the call, assess the situation,

and first offer referrals to drug treatment programs and city homeless shelters before citing or arresting the individual.

This effort was an attempt to institutionalize the "problem solving policing" ideology in contrast to the zero-tolerance model discussed earlier. But the officers, unlike social service providers, have a second line tactic of intervention—if an individual is not responsive to being linked with social services, the officers can at their discretion, as had been their primary directive before this program was initiated, punitively intervene through a citation or an arrest. The mandate to have designated police officers on duty at all times who would specialize in handling the large volume of calls related to homeless and/or "quality of life" issues is particularly revelatory of the neoliberal penal state mode of engagement with the poor: a hybrid cop on the frontlines who simultaneously embodies both the left and right hand functions of the state. This configuration incites the following questions: How do officers enact their mandates to police using this hybrid model in the everyday contexts of high need and limited resources? If these hybrid roles are being enacted by the police, what is their relationship to the traditional "helping hands" of the state?

One veteran woman police officer, Officer Davila, who worked on the Homeless Outreach Team when it was first started, described the impetus for initiating the program and its secondary function in reframing the police as more than solely oppressors of the urban poor in liberal San Francisco. She said:

> I think somebody realized that there are homeless people in San Francisco, they are never going away, and there needs to be more outreach. You know, like depending on what district you work in, like I worked in the Southern District, which includes Market Street and 4th, 5th, 6th, and 7th [streets]. So, I worked there prior to going to the outreach [team]. And, like 90% of our calls were homeless calls. Even if it was a robbery, when

> you got there it was a robbery of one homeless person stealing the other person's blanket. If you went to the theft of a store, you went there and it was a homeless person that was stealing coffee from Starbuck's. You know what I mean? It was just a lot of our calls are homeless related…But depending on what district you work in, it really needed more addressing than your officer coming up in a car and dealing with this. It needed some kind of outreach. It needed some kind of us connecting with other agencies to try and—because Gavin Newsom at the time really wanted everybody housed and wanted more than just the police being the bad guy and shooing people away. So it really developed over several years of us being in contact with the street team that goes out and does things. And we and those smaller [social service] agencies at lots of points have not had a good working relationship with police officers. So we are the bad guy. And so it became where it is sort of important to have specific officers that these people knew that they could go to.

When the SFPD attempted this formal collaboration with the large network of social service agencies in the area it became clear that the police knew little about what the agencies offered. Officers sought clarity and insight into the resources they were to have at their disposal and the potential outcomes of their referrals. In the early days of attempting to forge collaboration, those involved in the initiative instituted informal case conferencing to pool resources for individuals they targeted. Ironically, Officer Davila describes a similar phenomenon that Jenai outlines regarding the SROs, where "problem" individuals that the police referred to social service organizations might disappear for a few days, but then end up back in the same areas shortly. It was not clear that the linkage to the social services was delivering results:

> Sometimes [an officer] would go out of their way and call one of these agencies and these people would come help. And we know they would disappear from the street that day, like they took them somewhere, but we didn't really know what exactly happened to them. And then they would be back, let's say ten days later. And so it's like, that worked last time, should we call them again? But we didn't quite understand what each little agency did. And so what we did is we formed this outreach and on Wednesdays we met. And all of these other agencies also came. And so we wouldn't share information about a specific person or sometimes we did, but they didn't give us [confidential] medical information. But we

> would say 'You know, we have this family that is on the corner. Can anyone in the group do something else other than offering them the shelters every night?' And someone might step in and say, 'I have a contact that houses families.' And so we would work in our department agencies, you know. And we build up a relationship, rather than just no relationship.

That intense level of case conferencing eventually stopped because the city did not formally institutionalize it nor allocate specific resources for this coordination between agencies. But, as I came to find out, the homeless outreach efforts by SFPD in the Tenderloin had remained strong under the guardianship of two veteran Tenderloin cops, Sanchez and Donahue.

Becoming a Sympathetic Cop

The captain of the Tenderloin Police Station connected me to Sanchez and Donahue, the two primary Tenderloin Homeless Outreach Team officers. Officer Sanchez was immediately responsive and even included his personal cell phone number, so we could coordinate as needed. Sanchez and Donahue, largely through their own savviness as veteran cops, had come to embody the social experiment that sought to blend two seemingly distinct elements of state intervention. While this model was instituted by policy, it was allocated minimal resources and implementation and assessment were left primarily up to the street-based police officers who were given these responsibilities. Sanchez and Donahue, largely at their discretion, were responsible for enacting the program in the Tenderloin. Through this process they sought to establish a new mode of engagement between cops and people of the Tenderloin. At the time that I met them, nearly a decade after the initiative was established, they perceived themselves as having been transformed from solely punitive oppressors into *sympathetic*

adjudicators and even *compassionate documentarians* driven by their own version of humanitarian principles. In their hybrid positions, they draw on a unique repertoire of resources—beyond what the average social service provider can leverage—and become capable of simultaneous punitive repression, social service intervention, and compassionate redemption. In this configuration, it becomes clear that in addition to socializing, medicalizing, and penalizing the street-based urban poor as Wacquant (2009: xxi) outlines, there is an important gendered category—that of redemption/salvation.

The Tenderloin Police Station is a very barren, cold, institutional space. The front waiting area is small, about nine by nine feet. There are no seats and the front desk is walled off behind thick glass. On the wall, there is an old red telephone that one must pick up to communicate with the receptionist, much like those they have at jails or prisons to talk to inmates "through the glass." As I walked towards the red phone I gave pause, as I thought about putting the phone, which was caked with dirt, up to my face to talk to the receptionist. Perhaps sensing my hesitance as I reached for the phone slowly, the young officer sitting behind the glass stood up from his desk and came around to open the door near the window, so we could talk face to face. Sanchez and Donahue were still on patrol, so my fellow researcher and I waited for a few minutes, but shortly a battered SFPD pick-up truck pulled into a parking space in front of the station. I had seen this 4-door pick-up truck around the Tenderloin many times before, actually, since it is the only vehicle of its kind that patrols the neighborhood. For many months, from my Tenderloin office overlooking one of the most active blocks in the neighborhood in terms of drug and police activity, this truck passed daily, often with shopping carts full of people's belonging loaded into the back. Only at this moment was I able to put it together that this

truck was often used to transport homeless peoples' possessions around the city, after they were either abandoned or confiscated by police.

Donahue and Sanchez greeted us warmly and we went back into the cramped administrative area of the Tenderloin Police Station. The space was dotted with small cubicles filled with stacks of paper. Since officers do not have a designated office space for administrative duties, we sat in a small room that had a few plastic chairs set up in it, as well as piles of boxes and papers around the perimeter. Sanchez immediately launched into what he considered to be a more accurate version of the history of the initiative—that is was not Newsom, but instead police officers that had started the collaborative homeless services, including Homeless Connect. Homeless Connect is a bi-monthly event held at the Bill Graham Civic Auditorium in Downtown San Francisco. This event brings multiple agencies together under one roof to provide a "one-stop-shopping" type of access to homeless services such as: health care, dental, mental health, social services, assistance with welfare entitlements, legal advice, California ID applications, access to glasses, employment services, and drug treatment referrals. It was allegedly too part of the whirlwind of activity to address homeless issues in San Francisco during Gavin Newsom's tenure, in response to the fragmentation of homeless services. This was the first time I had ever heard the assertion that cops had played a part in its inception.

Neither Donahue nor Sanchez had specifically wanted to work with the homeless in the Tenderloin. They said it was initially the draw of the good schedule (every other weekend off) that made the positions appealing. Sanchez, however, later revealed his background in drug treatment. When he was in the Marine Corps, he was designated a "substance abuse officer" and had received special training and eventually coordinated a

program that dealt with Marines who tested positive for illicit drugs in the routine urine analyses. He had even written a Master's thesis on drug treatment and worked at an agency that facilitated support groups for addicted service members. Nevertheless he did not come to SFPD with the intentions of being directly involved in addressing addiction issues. He said:

> But then I kind of put it to the side, became a cop. Come to the Tenderloin and we're doing our thing. So it was a chance to kind of maybe use some of that, but not that I was looking for it. It was the schedule. I liked the schedule—but then as I got into it and then worked out to me and Donahue becoming partners.

Despite the splash that Newsom's homeless outreach efforts had made in the media, in the early months of the homeless outreach initiative Donahue and Sanchez were navigating the significant challenges of being the first generation of hybrid cops. They were using trial-and-error to distinguish their duties from the "regular" police and forging the path for what constitutes an institutionalized "hybrid cop" in San Francisco. This included what they perceived as a general transformation of policing in the Tenderloin.

> Sanchez: Luckily at the Tenderloin [Station], our supervisors are 100%...They know we're working and what we're doing. We get outstanding support from the captain and Lieutenants. If you walked out here before—I have some old photographs of how the sidewalk used to look out here—wall to wall campers. This looks immaculate compared to 6th Street.

Sixth Street is a notorious few blocks in San Francisco, just south of Market Street with many SROs and a concentrated drug economy. It is what many think about when they imagine a quintessential inner-city skid row. It is only a few blocks from the Tenderloin Station, but not in the Tenderloin precinct, so provides a site for comparison regarding the policing strategies implemented between the Tenderloin and Southern Stations. Both the Tenderloin and the 6th Street corridor are the geographical focus of concentrated

policing efforts by SFPD. Occasionally, the SFPD will set up a 24-hour kiosk on the first block of Sixth Street in the hope that their constant presence will minimize drug activity and crime.

When Sanchez and Donahue took on the role of hybrid cops, many in the department had initially cast them as "softies" who were basically doing "social work," rather than "real" strong arm policing. Sanchez recounts:

> There was no manual. There was no training program for us in terms of how to do things. So we just kind of stumbled through it and found what worked…Then there's a lot of stumbling blocks, both from a lack of support from the district attorney at times [and] fellow officers—but that's not a big deal. That's just the guys, because they don't understand. I would've been one of the first ones in line to make fun of me. It's nothing harmful about it. There's nothing bad meant by it.

Sanchez and Donahue were unique cases, however, because they had already had established reputations before becoming hybrid cops. However, it was known that the other, more junior outreach cops, were typically treated differently by the rest of the squad:

> Sanchez: Well, these other guys, the outreach guys, they get detailed for every little—the terminology is 'shitty little job.' Every 'shitty little job' that comes up, those guys are getting jammed up because [the other cops] think 'they get every other weekend off, so to hell with them.'
>
> Donahue: What they're doing is not really important.
>
> Sanchez: That's an old way of thinking, old school policing, right? The homeless wasn't really an issue. We're here to enforce penal codes. We're not here to be social workers. The captains and the lieutenants at the other station would say 'No,' [to prioritizing the hybrid model] but the captains and lieutenants here [in the Tenderloin] saw what it does. They saw how quick it cleans up the streets and how many people get help.

The hybrid model was simply more sensible in the Tenderloin because of the concentration of homeless people and active street scene. Donahue and Sanchez were

aware that they would have to exercise caution on the streets of San Francisco, a city with a long legacy of active police monitoring and critique. Before Newsom's election, the SFPD had taken a purposeful "hands off the homeless" approach in response to pressure from advocacy groups that charged that homeless people were unfairly harassed by the police on the streets. This points to the fundamental and ongoing ideological battle over what constitutes criminality in the inner-city urban context: Is it criminal to not have a home, and be in public spaces conducting behavior that typically takes place in private spaces? The broader political sentiment before Newsom's election was that the homeless should not be made criminals simply because of their lack of stable housing.[2] Sanchez said:

> "The department kind of had this view of just—because they're homeless—don't approach them. Don't ask them to move on. Everybody took that as, 'Don't harass the homeless.' It's supposed to be a liberal city."

While Sanchez and Donahue reported on the complexity of policing within San Francisco's unique political landscape in a matter of fact tone, two junior outreach police officers who I interviewed, Officers Archuleta and O'Rourke (in their late 20s and early 30s), still seemed to be coming to grips with realities of how this political climate drastically shaped their everyday experiences of patrolling the streets of San Francisco.

> Officer O'Rourke: It always seems like we are the center—everybody is out to get us.
>
> Officer Archuleta: Eyes on us.
>
> Officer O'Rourke: …The littlest thing they want to hang you out to dry, you know? So I don't think it is like that as much in other departments. Just the way, because everybody [here] is so liberal. People will get in

[2] In 2010, the city of San Francisco officially made it a crime to "sit" or "lie" on a sidewalk in the city between the hours of 10pm and 7am through a city ordinance called "Sit/Lie" or "Civil Sidewalks."

your face and start making comments, even though they don't know what is going on…

Officer Archuleta: Yeah. Because definitely, it is funny because I guess [it's] the only perspective I have, because I didn't have a lot of contact with law enforcement growing up. I guess that is why I was able to get this job. But from my perspective, the way other places do it is watching things like Cops or other shows, and definitely I don't see the same kind of encounters where people will outwardly criticize what you are doing actively.

Andrea: Like to your face?

Officer Archuleta: Right to your face. In the middle of…

Officer O'Rourke: You are trying to do something. And they want to let you know their two cents.

Officer Archuleta: You are trying to control somebody who is fighting with you.

Officer O'Rourke: Give me a break! Come on!

Officer Archuleta: And I know that phone cameras are popular everywhere, but just the amount, anything that we do is something somebody wants to see and post on YouTube. It is definitely hard because no matter what people's attitudes about us or the city or the politics are, we are in charge of keeping everyone safe and handling, going to all of these things that people have no idea are happening when they are asleep, or before they are even awake in the morning, or what happened on the bus that day they are riding now. And they have no idea…it is a thankless thing. And I think in a city like this it is hard because it feels more thankless sometimes because you get a lot of negative and unappreciative feedback from people because they don't like who you are, but they have absolute freedom to say it. And in other places that they have been to or come from, they know they can't.

Andrea: So you have people in your faces when let's say you are arresting someone or you are trying to deescalate some situation?

Officer Archuleta: Yeah, sometimes making things more difficult…just different things where people are trying to criticize what we are doing actively when they have no idea that we are this close to being hurt until we can get the situation under control.

> Officer O'Rourke: People out there with note pads and pens, writing stuff down.
>
> Officer Archuleta: And cameras, and saying, 'You are going to pay for what you are doing.' …Saying things like 'Rodney King,' and it is obviously not a situation like that.
>
> Officer O'Rourke: I ignore a lot of it.
>
> Officer Archuleta: You have to.
>
> Officer O'Rourke: It's almost laughable sometimes. You are just like, 'You have to be joking me.'
>
> Officer Archuleta: The City and County of San Francisco…There are its positives though, too. And there are positive feedback that a lot people say that as officers, their general experience is that San Francisco police officers are easier to talk to than anywhere else they have been.
>
> Andrea: That's interesting.
>
> Officer Archuleta: And I guess they mention that we are a little more laid back. But, I think part of the atmosphere in San Francisco is, I mean there are protests about some of the most wild things that you can ever imagine. We don't really shut down a lot of protests here. In other places they would.

In contrast, Officers Sanchez and Donahue, the veteran cops, had been working in this context their entire careers. The political climate was not necessarily a source of personal conflict in their everyday policing practices. Further, the veteran hybrid cops had historical perspective on the role of the police in neighborhoods like the Tenderloin, as untrusted oppressors. From Sanchez's perspective, the general perception of the police on the part of people living in the Tenderloin has shifted significantly, in part due to the policing style that they had put into place over the years. He says:

> We've come a long way. [In the past] in the Tenderloin, for anybody to approach a patrol car, they might get beat up. 'You're a snitch, you're talking to the person.' Yeah, the person would get beat up. So [now] we drive around in this big pickup truck and people wave us down like we're the ice cream van.

Despite the changing picture he painted in the neighborhood, Officer Sanchez also described the ongoing uphill battle of negotiating their image as cops in a political environment where distrust of the police remains normalized, especially by harm reduction social service providers who specifically serve drug users (e.g., syringe exchange), the subset of the unstably housed population who experiences the most potentially hostile police interaction. This intensely contentious dynamic between "injection drug users" (IDUs) and police has its legacy in the emergence of the HIV/AIDS epidemic. "IDUs" references the public health risk category of people who inject drugs. Police utilized this risk category to assess who posed a particular risk for a needlestick while officers searched their pockets during detainment.

Sanchez was once stationed at a Project Homeless Connect event, where there had been a series of altercations at the booth where people could obtain their state-issued ID cards. Like cell phones, IDs are something that unstably housed people lose frequently, which is a huge barrier to accessing social services and establishing SSI or General Assistance. At an event like this, people can get their IDs reissued at a reduced fee of $7. Sanchez said he posted near the line to help keep the peace, noting that he knew many of the people involved in the altercation personally because of his many years patrolling the Tenderloin. A young woman working one of the booths approached him and bluntly told him that his mere presence as a cop was offensive and that he was intimidating the individuals there to access services. This was a slap in the face to Sanchez, who not only saw cops as integral to the launch of the Homeless Connect event altogether, but also felt that he had trusting relationships with some of the people the woman charged him with intimidating. This situation caused Sanchez to reflect on his function in relation to street-

based urban poor, in contrast to the social service providers who he said were supposed to be their real advocates:

> Sanchez: I'm just standing there in uniform. We know all these homeless by their names! I said 'first of all young lady,' I wasn't being rude, but I said 'First of all, young lady, I'm here because I'm *supposed* to be here. I was *told* to be here and I don't tell you how to do your job so don't tell me how to do mine'…I'll take my orders from a senior officer, but not from a 27-year-old girl…We're changing the whole thing! We have this one individual that's accusing us of being offensive and stuff and not realizing that *we're the front line!* We get up at six o'clock in the morning before the sun comes up and we seek out the homeless. We find these people laying on the ground. They're still asleep. We find out if they need medical attention. We find out if they got needs or if they're just there because of their drug addiction or are just there to fight it.
>
> Donahue: We bring clothing from home. Shoes…
>
> Sanchez: Socks. We got a big bag of socks in there.

Sanchez, without hesitation, equates his function as a hybrid cop with the social service organizations' role in ensuring basic survival and access to critical social welfare. He cites a key temporal factor impacting the street-based urban poor—the fact that they must suffer through nights on the streets—and most social services organizations are only open during daytime hours. But further, Sanchez suggests that police deploy a particular kind of public health and humanitarian *care* for the street-based urban poor as one of their *primary* functions. His statements poignantly capture the neoliberal penal state reality, where it is true that a person is suffering from acute illness, addiction, or mental illness on the streets is much more likely to open their eyes to find a police officer standing over them than a social service or medical provider. This reality nonetheless still invites criticism from social service organizations who see the dual function of cops as plainly irreconcilable. But nonetheless, this does not disrupt the hybrid cops' notion that they operate as the front line interventionists into the problems of the urban poor.

> Officer Sanchez: The Homeless Coalition—they've set up on us and they've *filmed* us. 'Why are you harassing the homeless?' The thing is they do what they do, but then they go home somewhere else. We're *invested* here. We don't live here…I don't even live in the city anymore, but I'm *invested* here. We've both had plenty of opportunities to leave, but we're invested. We believe in what we're doing. Not only that, I mean—[we're] helping folks. But there's so many good people here. There are people of color, they don't speak the English language very well. So it's almost like they're thrown to the dogs. It's almost like it's contained here. God forbid—some of the things we see—God forbid if they happen up in Seacliff or Russian Hill, I guarantee something would be done. If Angela [a city supervisor] had to step over some guy who had feces and bugs on him like the one we pick up off the ground, there would be something done…There's nobody advocating. *We're* advocating for the guy on the ground—'Look, you deserve better than this. We can't allow you to do this!' …The Homeless Coalition, I've gone and talked to a couple of the attorneys there and they just absolutely will not—
>
> Officer Donahue: Instead of working with us, they work against us! I walked in there and asked, 'What services do you have for the homeless? I mean *you're* the Homeless Coalition. How can *you* help *us*? What do you have for us that we can *bring* to people on the street?
>
> Officer Sanchez: They won't have anything to do with us…The atmosphere of the police and the media, the news, saying police are always picking on the homeless type thing. It goes way back. That's the problem.

Sanchez is adopting the containment metaphor of the Tenderloin District discussed in Chapter 2, which is assumed to be a sinister and purposive policing strategy by homeless advocates. He also introduces the puzzling notion that even in the context of the relatively rich network of safety net social service and advocacy organizations for the poor that *"there's nobody advocating"* in the way the police seemingly do, within the critical socio-spatial domain that only they can effectively dominate—the mythical inner-city "streets." Here, the most unfailing point of interaction between the state and the urban poor has become the citation or arrest administered by police.

Sanchez and Donahue are particularly reflective about the historically contentious relationship between the SFPD and the San Francisco Coalition on Homelessness. The Coalition provides, among a range of other resources, very widely used legal advocacy for people who are cited by the police for petty infractions and "quality of life" offenses, including sleeping on the sidewalks and public intoxication. The Coalition's pro-bono lawyers frequently get these citations dismissed, which for many SFPD officers, including Sanchez and Donahue, is infuriating. The officers view the program's primary objective as specifically to counteract the work that cops do on a daily basis in the streets of the Tenderloin. This also minimizes the impact of their valued first line of hybrid intervention into the lives of the street-based urban poor—the citation for petty infractions. They too express frustration regarding the revolving door phenomenon that both Jenai in Chapter 4 and Officer Davila described wherein state intervention, whether it be from the traditional arm of welfare provision or penal state intervention seems to have no significant consequences or lasting effect on the problems of inner-city neighborhoods.

To make the citations that police give "stick" in the relatively liberal courts of San Francisco, police strategize about questions posed while citing someone and the language used in the police reports. The Coalition and the SFPD engage in a constant dance of technicalities around each other as they each try to leverage their power with regard to these citations, which take on symbolic importance revealing two distinct, yet interrelated ideologies of intervention that each side defends passionately—one which relies on penal state intervention and the other which actively combats it.

> Sanchez: One of the charges is sleeping without permission on the sidewalk. They [the Coalition advocated and] made it very vague now.

> [The law is now] anybody who sleeps in a private or public space *without permission* [can be cited]. So they came up with the defenses. Well, how do you know they don't have permission? So now we had to go out and we had to get the building owner [and ask] if they're sleeping with permission…So, that was their defense, so we had to change our reports and we have to go out and now we have to ask them: 'Did anybody give you permission to sleep on the sidewalk there?'

This dynamic produces frustration among police officers as they sometimes feel like they are engaging in fruitless policing activities, where "criminality" goes unpunished. Yet, for the hybrid cops, the citation had taken on increased significance—they envision it as their most essential front-line tactic for intervention, which was continually rendered null and void by the Coalition's legal advocacy. Thus, their perceived failed attempts to connect with social service agencies and the phenomenon of citation dismissal had left the hybrid cops soured on collaboration. This fueled their commitment to their repertoire of punitive mechanisms.

Sanchez and Donahue recalled the story of a heroin addict and alcoholic who they encountered on the sidewalks for fifteen years and who they described as suffering from debilitating "wet brain." Wet brain is the colloquial term for a condition brought about by intense, prolonged alcohol consumption that results in a distressing presentation of symptoms such as severe disorientation and memory loss and sometimes, a stumbling gait. Sanchez and Donahue interacted with this man repeatedly on the streets of the Tenderloin and in an attempt to facilitate his enrollment in treatment, they cited him approximately twenty times for quality of life offenses.

> Sanchez: Citations. The game plan was to violate his probation. Get him in [to jail] for six months. Get him over his wet brain so he could function at least at minimum. So he doesn't die on the sidewalk…as soon as he gets out the [city outreach workers] were going to get him on methadone and they had a room for him. He got out. Probation didn't contact us. Fell right through the cracks. Went right back into the gutter. All that work for

> nothing…He's doing good at this point. Keeping our fingers crossed…We become social workers and we're handling these individuals person by person.

Here, the citation is meant to function as both punitive mechanism and helping hand, drawing on both the rationality of criminality and humanitarian intervention. The police also implicitly use the citation as part of their moral adjudication of the homeless because it is within their power to determine whether a person is "worth saving" through the compassionate/punitive citation or deserving of punishment through pure strong arm of the law. Sanchez demonstrates through his description of the citation mechanism the indistinct line between advocating for basic human rights (i.e., housing to mitigate the effects of addiction-related health issues) and categorizing the street-based poor as an imposition on even more worthy citizens who reside in the neighborhood, but are not part of the street scene. The criteria demarcating people's criminality and worthiness can be a moving target because the categories are constructed based on his discretion.

> Sanchez: What the citation allows us to do—first of all the real tough ones—they won't go to court, so now we got a warrant. It might only be a $200 or $300 warrant, but that allows us to at least first of all remove them from wherever they're making a mess, but that's when we start wearing them down. It's not vicitimizing them. The purpose is to get them off the street. Nobody should be on the street. They shouldn't be allowed anyway because it's a neighborhood. People live here. They got to get to and from work and it's not right.

The officers' perceived failure of the safety net social services strengthened their resolve to practice hybrid policing. Here, the police point to the overarching structural deficiency: the fragmented social safety net, which reduces effective intervention.

> Sanchez: The biggest problem that we have with all these programs that are giving help: no one touches bases with the other. The left hand doesn't know what the right hand is doing with all these services. Getting them under one roof and having them work together. Even if they've got cubicles right next to each other, no one knows what the other person's

> doing. That's one of the biggest downfalls, I think, of this whole thing. Everybody's got to be communicating, interacting with one another, seeing this one individual all the way.

This fragmentation further enhanced their perception that the social service organizations were inefficient and the hybrid cops had developed an oppositional discourse about social service providers. From his subject position within the penal state, Sanchez had also taken on the role of moral adjudicator relative to the perceived inefficient social service organizations:

> Sanchez: …We're not trained as social workers. This is something we had to learn. We flew by the seat of our pants and day by day we learn, getting a hold of different social service providers. We found out which ones are BS [bullshit]. Some of them are just a storefront. They're stealing federal funded money. Let's be honest. They don't do anything. They don't offer services. They're worthless.

With their unique frontline positioning among the crises of the urban poor, the hybrid cops also expressed a moral imperative to document the suffering on the streets of the Tenderloin. In their hybrid subject positions, they see themselves as having been effectively transformed from punitive oppressors into compassionate documentarians. Since 2008, Donahue had become impassioned carrying a camera around on his patrol of the neighborhood. He desired to produce images of the grittiness and suffering in the neighborhood from his distinct perspective, for a dual purpose: because he believed the suffering needed to be communicated on the basis of humanitarian principles and also because the images functioned as a sort of capital to validate their policing practices to city officials and the judges who oversee the cases for which they produced the citation or arrest.

Donahue was fully committed to the power of images of street-based suffering in the Tenderloin. Over the last several years he and Sanchez had taken countless photos

and filled a tattered 3-ring binder with pictures chronicalling the plight of the homeless and "addicted" in the Tenderloin. In the absence of formal data collection or evaluation on the part of the SFPD this binder acted as Sanchez and Donahue's low-tech version of a "database" of case files of people who they encountered frequently and with whom they had attempted their hybrid interventions. The binder functioned as a sort of family photo album exemplifying the paradoxical nature of their role. Each person's "file" strikingly started with the mug shots from their previous arrests. This penal style of documentarianism was essential to the hybrid cops' daily interaction with the street based urban poor. As Donahue said "Every morning we go in the truck, we've got a camera, we've got our database. We joke around—we used to carry a shotgun and a rifle."

> Donahue: Here's a guy that's in a wheelchair…come across something like this and it's because it's a mental disorder, then we can 5150 him. That's why we take pictures…it just shows that it's—how would you like that if you had to walk over that every day or if it was in front of your doorstep or something? It kind of just—it's worth a million words…If there was a pile of feces or something, I'd take a picture of it. We try to give the whole picture…I figure the judge has no idea. He just reads the report and says 'Okay, yeah, he was laying on the sidewalk.' He doesn't get the whole picture. If you start looking at the photographs, then you can see the look on their face. How they're down and out.

Embedded in Donahue's impulse to document through photographs, is the activation of two rationales—a humanitarian sentiment for the person on the street who is suffering and a way to communicate this sensational suffering that validates their continued hybrid practice. The images are also tasked with communicating the urgency of how this street-based suffering impacts the "quality of life" for the "normal" citizens who must confront the realities of urban poverty on the streets of their neighborhoods. Donahue's statements reveal the undercurrent issue of how, even as the hybrid cops aim

to compassionately intervene, they nonetheless operate in a realm where there is always a priority to protect the rights and quality of life of the perceived "whole-citizens," the housed, non street-based population, who is unjustly impacted by the behavior of the street-based urban poor that Sanchez and Donahue encounter in all its corporeal grittiness. Their compassionate intervention from within the operation of the penal state simultaneously tasks them with public health intervention and controlling, containing, and penalizing those behaviors defined as abhorrent and criminal. Sanchez described treading that line as a savvy veteran cop:

> What we're doing works. We've seen the difference in the Tenderloin., but to get this to go citywide, we almost need a class at the academy to teach it. You got to be a social worker. You got to be touchy feely. You got to understand people's needs. You know where to go for the resources. You can't learn that overnight.

Their being adept at the hybrid role was predicated on the fact that they had both put in their time as the regular strong arm of the law and had each already proved their capability of showing brute force when the duty called. Their success as hybrid police officers required the potential of activating purely punitive force.

> Sanchez: I never forget that I'm a cop first. I'm a patrol officer first. But this is something that they're asking us to do and it needs to be done…the last one we had, a 148 [penal code], which is somebody who fights with us. Went and boom! We had no problem! That guy was on the ground handcuffed and we did what we had to do. So we don't ever forget that. But at the same time for a new guy? To put that on a new guy? …As a new officer, you should never let a guy get up. Because then when you get into a personal body space, they can bring harm to you.
>
> Donahue: In fairness to the officers—you can't have a new guy [do this job]—It's not advisable. I wouldn't advise it. You don't want a new guy out of the academy doing this job solely. Because we had our time—drugs and guns and knives. We've done all that, done plenty of it.

This baseline penal ideology that they bring to their unusual hybrid subject positions as advocate/punisher was what they viewed, in fact, as positioning them to better intervene in the lives of the street-based urban poor than the social service providers because only the cops have a mandate to interact with this population and then can and do actively *penalize* those they encounter. Penalization was seen as *the* critical mode for intervention with this population cast as "difficult," whose daily lives are characterized by routine relapse and repeated petty offenses to support their drug habits. The idea of practicing "tough love" mediated through their own penal logic contrasted sharply with their perception of the social service providers in the area who Sanchez and Donahue saw as relatively ineffective and enablers of unhealthy behavior.

Their ability to cite and arrest epitomized their unique repertoire of resources as adjudicators and saviors. Most importantly, the fact that as police officers they are not only *willing***,** but very much *accustomed* to being hated by those they now seek to help. This is especially true in the context of San Francisco, a city largely skeptical of the strong arm of the law. Yet, the officers also activated a particular gendered moral discourse with respect to their interactions with women. Sanchez and Donahue too drew on the trope of the soiled dove as they perceived certain women as having a deeply buried sense of worthiness, assumed to have been deeply buried by their histories of trauma and involvement in the drug/sex economy. These women, as "soiled doves." were not plainly criminal, so were deserving of a different sort of treatment. This assignment of a particular gendered "victimhood" was mediated by their own penal logic as police officers.

Sanchez simultaneously invoked a sympathetic, humanist narrative about the tragedy of women's suffering and a punitive demand that they take individual responsibility for their legal and moral transgressions, consistent with neoliberal political subjectivity. He reenacted the counseling he offers to women who are chronic drug users, while still demonizing crack-cocaine users, a highly racialized segment of the unstably housed urban poor.

> Sanchez: [It's] sometimes just talking to them. Saying, 'This is not what your parents had for you in life. It's not what they wanted for you. It's not what they wanted for you. Look where you're at.' We talk to them, break them down. One of the approaches, we will say 'Somewhere at some point'—some of them can't remember—[it's been] so long since they felt love from anybody. And I'm not saying we're the ones giving it—'but at some point in your life, somebody when you're a little kid, somebody held you and had dreams for you. Somebody loved you somewhere because you're here. Somehow someone loved you somewhere along the line. Where did it change? How can we make it go back to where you can fulfill that—for you, not for us.' We're going home at the end of the day to our family. Why can't you have that? It's got to start with you. No one's going to do it for you. You're not going to have Prince Charming anymore. He's not going to come by and lift you up on a white horse. You got to do it for yourself. You got to be on your own. Let's face it. The Tenderloin is not a place for them to rehab. Everybody who's got a crack pipe in their mouth does not want to die alone in the gutter. They want to drag someone down with them.

Sanchez is quick to deploy narratives about the importance of notions of love in interventions with the "worthy" women he encounters, but also quick to draw boundaries for me to demonstrate that when it is deployed by the cops themselves, it retains its penal character. Sanchez also toggles back and forth between having sympathy for the crack-addicted woman he is appealing to, yet also reproduces villianizing narratives about street-based crack users and their immoral, toxic behavior.

They recalled the story of a young woman named Anita, who they had interacted with numerous times on the streets of the Tenderloin. Their interventions with her were

set amidst the backdrop that Anita had previously had a conventional life—she was working in financial services at a major bank and was previously "doing something with her life." They rationalized her current street-based drug use and sex work by pointing to her history of trauma. A few years previously, Anita had a still-birth that "threw her over the edge." In the context of this traumatic loss, Anita had become homeless and addicted.

> Officer Sanchez: She wanted to feed that addiction more than anything. Finally, we told her—I remember telling her, 'Anita, you are going to hate my guts before this is all said and done because we aren't going to let you die like that.'
>
> Office Donahue: We exhausted all her resources.
>
> Officer Sanchez: We kept arresting her over—and we kept booking her. Finally, the one time she was just—everything coming out of her—just crying. 'I hate you! I hate your guts! I hate you!'…So we were able to get her. Now she's inside. She has a baby. She comes up on the streets and says hi. But, I mean we hope she can stay that way. Every time I see her on the street, I'm worried. I'm thinking, Anita, what are you doing out here? 'No, I'm picking up my friend's baby.' I said, don't worry about your friend's baby. You worry about your baby. Don't be out here on the street. You know how easily you can slip back. So we're kind of concerned about her, but she looks sober still.
>
> Officer Donahue: She asked us to go and talk on her behalf, to help her get into a room that was more suitable for her [at a local shelter].

Sanchez and Donahue were well aware of their unusual subject positions as both advocate and punisher. But, they felt that they were better positioned to intervene than the social service providers because they ultimately have the power to penalize those they encounter, a tool required for intervention with this perceived difficult population. Despite their hybrid role and how they often crossed over into the territory of social service provision, it was important to Sanchez to distinguish himself sharply from the social service providers, who he sees as relatively ineffective and as enabling unhealthy

behavior. Through his punitive repertoire, Sanchez can immediately execute what he perceives as a more effective intervention by utilizing a citation or arrest.

> Officer Sanchez: Waiting doesn't do them any justice. Everybody thinks, let's give them a break—the poor homeless. This young lady— [he pulls out her mugshot from the photo album]
>
> Officer Donahue: We talked to her dad so we know about her.
>
> Officer Sanchez: She was married to this guy and slept on the street for 15 years…Time went on. Time went on. I finally got them inside. They're doing well now, but they resisted and stuff. But look how long it took. That's what she looks like now [he points to her photograph]. Look at the difference. Blind in one eye, haggard from the heroin in just a few years. So we're not doing them any justice by giving them [a break]—come on! It's gotta be tough love or they die out here on the streets.

In addition to the quality of life citations, the 5150 mechanism was also an important part of Sanchez and Donahue's hybrid punitive/interventionist repertoire. However, using it forced the officers to interface with the public psychiatric emergency system (PES)—the medical arm of the state tasked with responding to mental health crises after a police officer or clinician has issued a 5150. From the officer's perspective, their utilization of a 5150 was an opportunity for productive intervention that often failed in the moment of passing someone from police detainment to the staff at the county hospital's PES. They, as Jenai did in regard to her SRO in Chapter 4, expressed frustration about the 72-hour temporal component built in to the mechanism and recalled what they perceived as the revolving door of PES. One woman, who they frequently 5150'd would quickly reappear on the streets still exhibiting psychosis "[while] the paper's still wet on the report." They perceived their repeated 5150s on her behalf as what ultimately got to get her housed. The officers use the same punitive metaphor of "wearing someone down" with regard to their interaction with PES staff.

> Sanchez: They get let out [from PES]…so we [repeatedly] 5150'd her and we wore out [the county hospital] until they finally said, 'Okay, we got to do something. Somehow.' And now she's inside. We still see her outside once in a while, but she's sleeping inside. That's the other problem we have with psych emergency. Letting these people out! She was already diagnosed with mental illness [and] that she shouldn't be on the street by herself. But because she walked away from the place and she caused so many problems, they said, 'we don't want to deal with her.'

Sanchez and Donahue perceived a failure on the part of PES to intervene effectively. They did not perceive themselves as being part of the same arm of the state as PES or even marginally systematically integrated, despite the fact that PES was executing the involuntary psychiatric hold that the police officers mandated. The officers felt instead that their work was actually made harder by the failings of PES, since the police were often left to clean up the literal and figurative messes that PES did not sustainably address, once a person ended up back on the streets.

> Officer Sanchez: We 5150'd her…Every time they let her out, she came back out in the same urine soaked clothing.
>
> Officer Donahue: We used to give her clothes and then she would soil those. It smelt so bad. We couldn't put her in the patrol vehicle. We put her in a wagon and it would stink the whole wagon up.

Sanchez and Donahue, feeling their hands were tied with PES, had also reached out to Adult Protective Services (APS) to see if they could coordinate to arrange continuity of care between being temporarily institutionalized with PES and the return to the streets 72 hours later. According to Sanchez and Donahue, in order for APS to intervene and provide community support once released from psychiatric hold, an individual needed to have a physical address as a point of contact. This woman, being unstably housed and moving between hotels, shelters, and nights on the streets, of course did not have an address. This bureaucratic hurdle prevented meaningful intervention on the part of the

woman and was not only frustrating to Sanchez and Donahue, but also indicative of what they perceived as the relative inefficiency of social services like APS in contrast to the immediacy of their direct, front line interventions as hybrid cops.

> Officer Sanchez: We had a meeting with [APS] once. You have to have an address as a point of contact for [a client]. They don't have an address so they can't do anything for them. So, *we* just got to find ways. So what appears to [be] the advocate? Allegedly, because they advocate from nine to five and then they go home and they don't have to deal with it! So who's really the advocate? …I mean, they're killing these people with kindness. We're not mean to them. We're stern when we have to be stern. But, we'll pick them up off the street.

Sanchez and Donahue recounted a hypothetical scenario. They urged me to imagine how a 5150 would play out: they encounter someone on the street they know to be on probation, who is threatening to injure and/or kill people. They take seriously the 5150 criteria and make an assessment whether the involuntary hold is mandated. This negotiation is revelatory of San Francisco's more liberal baseline encounters with probationers and parolees. In other contexts, such as Oakland across the bay, any contact with police officers as a probationer or parolee is considered a violation of their release and warrants re-arrest (even, as I saw ethnographically on another study, if someone is shot). Sanchez and Donahue say they will not 5150 someone just to get them a safe place to sleep off the streets or because a person is an "eyesore" because of quality of life issues, like being soaked in urine or feces. They fear the scrutiny of the social service agencies if they unnecessarily overburden the already taxed psychiatric emergency system. The officers believe they perform their mandate by engaging the person, seriously assessing their mental health situation, and if needed, taking them in to PES.

> Sanchez: You've got to be able to tell whether it's drug addiction, mental illness. If you're [going to] 5150 the guy…you've got to be able to diagnose a little bit. Is he schizophrenic? Bipolar?...One of my first

> questions—and it just happened yesterday—Are you diabetic? Have you eaten yet? That could also be mistaken [for psychosis]…Man, we could be doctors sometimes on some of the things we see. You just get to know, okay, this person is schizophrenic, yesterday's person was totally completely fine or bipolar. 'Hey, are you taking your medication? When's the last time you took it? If you're drinking the medication don't work.'
>
> Donahue: They have visions of grandeur, like they're FBI agents or the king of this or that or if they've got voices in their head, then we know they're schizophrenic.
>
> Sanchez: So, then you can start asking some of the questions and from there, you can say, this is definitely PTSD. What we do with that is—it'll vary. He might have PTSD, but that doesn't mean you can 5150 him.

The level at which the officers engage in street-based psychiatric assessment is striking, considering since, according to them, they had not received mental health assessment training in any formal capacity. Yet, nonetheless, they still used psychiatric diagnostic categories in their assessments. Sanchez and Donahue reported that developed this level of expertise over the course of their many decades in the Tenderloin, where conducting these quasi-mental health assessments and interventions were par for the course in the Tenderloin, an area with a population that has a high mental health issue burden. It had not become their explicit task to engage with the street-based population in this way until they formally became hybrid outreach cops, but even then they had not received any further specialty training in addiction or mental health. Nor had there been a coordinated effort to make a formal linkage between the hybrid cops and psychiatric emergency services.

The point after which Sanchez and Donahue make their assessment and turn a person over to PES is where they identify a critical defect in the system. According to the officers, at this stage PES will then "play God" and without coordination with the police department, let a person go after 72 hours where they can potentially hurt somebody on

the streets, instead of facilitating long-term solutions to mental health issues or providing resources for basic needs which might relieve mental health burden, such as housing vouchers. From their perspective, the person quickly returns to the streets, being the burden solely of street-based law enforcement, who have a mandate to engage with people who are either psychotic or creating quality of life issues. That burden, they believe, is not adequately shared with PES or the other social service agencies who do not have the same continuous front line *mandate* of interacting with this population—albeit through punitive intervention—because in the context of these sites of urban poverty, this population's behavior is deemed criminal and first managed punitively by the state. The lack of perceived coordination between the police and the psychiatric emergency services system produces what they see as an extremely fragmented mental health system of intervention—from the streets to PES and back again—and is source of incredible frustration for the officers who encounter the same people repeatedly in mental health crisis. This sense of antagonism that the hybrid cops have towards PES and APS, among the other social service agencies, is an important finding with public health implications for the administration of comprehensive services to the urban poor with co-occurring drug use and mental health issues.

In Jenai's interpretation in Chapter 4, this precise dynamic is discussed from the perspective of an SRO hotel resident and she assigns blame for the structural failing of the mental health system and its deployment of the 5150 mechanism to both the police and PES. She perceives them as operating systematically, with the police acting as the front line arbiters of mental health crises. Jenai's perspective provides the insight that the police did not reveal themselves about how the cops too negotiate the structural realities

of the revolving door of mental health crises in these urban spaces. They encounter and are tasked to intervene with the same people in crisis who repeatedly pose practical challenges in terms of sanitation and difficulty of transport, but they are the only state body mandated to do so outside of total institutions. Further, if the cops perceive that the action of taking a person into PES will not produce lasting intervention both for the greater good of the person in question, nor for themselves as interventionist cops, they may be less inclined to go through the motions of detaining someone in the first place, as was demonstrated in Jenai's hotel. This is a critically important site for further research to examine the complicated nexus of mental health crisis and intervention that occurs between the street-based urban poor, the frontline police officers who are the gatekeepers mental health detainment via the 5150 mechanism, and the clinicians and social workers who staff the city's psychiatric emergency system.

Summary Analysis

In this chapter, I have considered one aspect of San Francisco's unique version of neoliberal penality. That the hybrid policing model exists at all to address the "homeless problem" in San Francisco, is a testament to the urban poor's unmet needs with regard to housing, other social services, drug treatment, and mental health services. Just as in the previous chapter, these data shed light on the level at which the crises of the urban poor are left to play out in community settings and the penal state steps in as the primary mechanism to manage this population in these contexts. The city's institutionalization of police officers as frontline interventionists sheds light on implications which have both theoretical and practical significance.

It is evident how street-based police officers are directly implicated in the failure of the state to adequately address the everyday crises associated with extreme poverty and social marginality. It is tempting to outwardly demonize the agents of the penal state who intervene upon the poor through punitive mechanisms, but as the police officers in this chapter demonstrate, activating this role is not only extremely burdensome, but in neighborhoods like the Tenderloin, is unrelenting. Police officers are left to confront the visceral realties of homelessness, street-based drug use, and untreated mental health issues on a daily basis. To acknowledge the challenges and magnitude of this role does not minimize the fact that this configuration is an injustice enacted upon the poor.

The paradoxical role of the hybrid cops as capable of enacting punishment, social service, and humanitarian intervention provides insight into the social safety net in a postwelfare era. First, the hybrid model is implemented with no oversight, measures of effectiveness, or evaluation. Thus this critical, albeit problematic, frontline interaction between police and the street-based urban poor is left up to the savviness and personal discretion of the police who in this context fulfill the role of street-level bureaucrats (Lipsky 2010). Sanchez and Donahue had not received formal training as hybrid cops and so struggled to familiarize themselves with the landscape of social services. Further, they were not trained in therapeutic models of intervention among the chronically homeless and therefore relied instead on their punitive repertoire (e.g., citations and “tough love”) and activated a gendered moral discourse to delineate who is worthy of intervention and who is a lost cause.

Second, even though through the institutionalization of this hybrid model, the officers were by definition integrated into the city’s social safety net, they did not

perceive themselves as part of that system and had, in fact, developed an oppositional identity to the social service providers. To them, the failures of the social service agencies are infinitely evident because they see a large part of their job as devoted to picking up the pieces of those institutional failures. They assign blame to the social service agencies themselves and not to the broader structural conditions which may cripple those agencies from fully activating their potential or the very impossibility of correcting the crises ushered in by forty years of the retrenchment of the welfare state. That there are no established lines of communication or case coordination between the police and social service agencies served to fuel a contentious relationship and reduce chances for meaningful collaboration. Thus, the officers enact their version of hybrid intervention into the lives of the street-based urban poor without appropriate training, without formal utilization of therapeutic models, and with little to no collaboration with the broader social safety net. In the next chapter I consider the implications of this constellation of factors from the perspective of the women and how the fragmentation functions to create specific subject positions among them, where criminality and victimhood are blurred and women must negotiate moralizing discourses in order to continue to have access to the minimal resources the police may afford them.

Chapter 6

THE SOILED DOVE: SUFFERING AND SALVATION

In the last chapter I showed how hybrid police officers conceive of themselves as critical frontline responders to the everyday crises of the urban poor. However, they enact their hybrid roles with a lack of formal training and strained, if any, coordination with social service agencies. Their very existence speaks to the broader failure of the state to respond to the syndemics of the urban poor. Examination of how they attempt to enact their mandate gives insight into the fragmentation of the social safety net and the level to which implementation of these frontline interventions is based on their discretion. Thus, while the hybrid model is an attempt to blend punitive mechanisms with social service interventions, rather than using clinically-informed guidelines to inform their interactions, the police instead deploy a form of perceived compassionate intervention based on "tough love" and filtered through the gendered moralistic trope of the soiled dove. In this dynamic, both women and the police are implicated in a moral economy of suffering and potential salvation.

In the socio-spatial context where I conducted research, women have frequent encounters with police, whether it be through direct interaction or through witnessing their presence in community settings. In this chapter, I consider the symbolic complexity of women's interactions with street-based law enforcement, potential and actualized. In these interactions, women activate, grapple with, and contest their own gendered subject positions relative to this moral economy that casts them simultaneously as criminals and

victims. I argue that what is at stake in women's interactions with police is a negotiation of their own biolegitimacy, what Fassin (2005) defines as the "legitimization of rights in the name of the suffering body." Their social exclusion is so profound and so historically entrenched that, tragically, it is *only* their gendered suffering and not the potential for activation of their rights as full citizens that provides any glimmer of hope to minimize the daily struggles of their lives.

What is unique is that in this structural context, the primary frontline state institution through which they routinely must cultivate biolegitimacy is street-based law enforcement. In the context of the neoliberal "compassionate" city, the police are integral in the equation of women's everyday experiences of stability (whether they are arrested or not), their access to critical social services, and how women make sense of their routine suffering. The discourse of the soiled dove which circulates in these social spaces imbues women with a gendered moral subjectivity introducing a notion that if they embody worthiness and the moral resolve, they can harness the opportunities given to them and can be potentially capable of being saved from the wretchedness of their lives. But, of course, the reality is that their social marginality is so deep and the barriers to stability are so vast, that they bear little to no chance of having their lives transformed through the minimal interventions that the police are capable of granting them. However, they are nonetheless forced to continually confront their bifurcated subject positions and to manage relationships with police that toggle between brute punitive force and relationships imbued with familiarity, care, and potential salvation.

In this chapter I start by examining a scandal involving SFPD's unlawful policing tactics within SRO hotels. By outlining this incident, I want to demonstrate that even as

there is a hybrid model of policing in operation, based on a logic of compassionate intervention, there too exists the opposite end of the spectrum, where police enact aggressive control over these urban spaces. This type of policing took place alongside that which I examined in the previous chapter. Then, using ethnographic data, I will explore four women's varied relationships with street-based law enforcement, which has both practical and subjective implications.

The SFPD's "Betrayal of Trust"

During the time that I was learning about the hybrid style of policing in San Francisco, a scandal within the SFPD erupted, further illustrating the notion that the contemporary biopolitical management of the poor and socially marginalized is characterized by paradoxes. Despite San Francisco's ideological legacy of problem solving policing and its relatively sympathetic political climate for homeless issues, there too exists the contrasting actualization of penality, with explicitly oppressive consequences for the urban poor. In May of 2011, I attended a summit organized by the San Francisco Public Defender's office on the heels of several local scandals, requiring urgent action to address what some were calling the revelation of an "epidemic" of police officer abuse and misconduct within the ranks of the SFPD.

The sequence of shocking events begin with the alleged theft and consumption of drugs from the SFPD crime lab by an employee, which resulted in the closure of the lab's narcotics analysis unit and the dismissal of countless narcotics cases. Next came allegations of illegal SRO hotel raids by plain clothes officer units, followed by allegations of falsifying police reports, accusations of drug thefts and drug sales by officers, and even a charge that area police officers were involved in setting up a brothel.

Throughout the local media the series of events were interpreted as a betrayal of trust perpetrated by the SFPD upon the citizens of San Francisco and the shattering of the expectation that the SFPD should be at least relatively less prone to committing acts of abuse and injustice. This was a moment of rupture in the image of San Francisco as a politically-progressive haven, immune to the types of police scandals that routinely rock other major US cities, such as Los Angeles, New York City, and even Oakland just a few miles away.

The summit was held at the city's main library. This large, six story modernist building sits in a zone of transition between the Tenderloin and the Civic Center Plaza area. It is a contentious space because it serves as one of the few indoor spaces that homeless and unstably housed people are tolerated to spend time during the day. Even the nearby city shelter just a few blocks away requires that people leave during daytime hours, so people are forced to roam the city, often getting shuffled by police, private security guards, or shop owners. The Civic Center area, for at least a few blocks radius, is largely non-residential and is home to a large homeless population. There is a large outdoor plaza surrounded by municipal buildings and the businesses that serve the city government employees. Thus, at 5pm and on the weekends, the area becomes re-appropriated as a vast homeless encampment because there are fewer complaints here during these times from residents or business owners about people sleeping or congregating in open spaces or sidewalks. Plus, the area is also still easy walking distance to the free meal dining hall, the methadone clinic, the Tenderloin drug copping corners, and the bus lines that serve the County hospital. The main San Francisco Library building opened in the late 1990s, after the original building was badly damaged in the 1989 Loma

Prieta earthquake and it reflects the city's conscious ongoing strategies to address the "homeless problem," even in the smallest design details. This is a space where it is noticeable how the "streets" come inside into institutional spaces that become the only places of daytime respite. The bathrooms, especially on the first floor, are transformed into the defacto home spaces for the homeless in the Civic Center/Tenderloin area.

The summit featured commentary by Stewart Handlin, a criminal defense attorney with decades of experience in high profile cases; to my surprise, the newly appointed police chief Greg Suhr, a 30-year veteran of the SFPD, but just freshly placed in office a month previously; Peter Hurley, a police conduct consultant around the country, with over 30 years of experience working in departments; a fierce, young public defender, Anne Irwin, a woman whose family has a long history in San Francisco of advocating for the rights of the poor; and John Burris a well-known civil rights attorney who specializes in civil litigation regarding police brutality and wrongful death.

I was surprised to see the new police captain making such an early public appearance after his appointment, especially to stand up to the firing squad of what would undoubtedly be a passionate crowd. Greg Surh's appointment as chief, suddenly replacing the maverick Gascon, was the result of a particularly compelling series of political maneuvers. First, Kamala Harris, San Francisco's District Attorney from 2004 to 2011, was elected as Attorney General for the state of California. In the same state-wide election, Gavin Newsom, the contentious mayor of San Francisco from 2003 to 2010, ran and won the state's Lieutenant Governor seat after it became clear that he did not have the political clout to run for governor outright. Before Newsom was to leave San Francisco for the state capitol, he needed to appoint a replacement for the outgoing

Harris. A retired judge, Harry Low, was considered the obvious and least provocative choice for the DA appointment, and it was assumed, would not ruffle any political feathers. But Newsom, seeking to embolden his image during his transition from city to state government, made an unexpected move. After rejecting nearly a dozen other potential candidates, in his final act as mayor of San Francisco, Newsom appointed Police Chief George Gascon as District Attorney. It was said that after a series of frustrating meetings with his staffers to find a reasonable replacement for DA, someone reminded Newsom that Gascon did, in fact, have a law degree and would be a bold choice.

Gascon's appointment in early 2011, followed by his eventual election later in November to the position of District Attorney, sparked questions on two fronts. First, according to the rhetoric at the time he was brought in from the outside to serve as SFPD chief, he was tasked with radically transforming the department and helping to "take back" problem neighborhoods like the Tenderloin. Was this project of Gascon's considered complete? Or was it inconsequential to the potential political maneuvering within the criminal justice system that having a popular moderate might afford? After such fervent claims regarding his appointment as chief, was he breaking the promises he had made by leaving after less than two years at the helm of the SFPD? Further, though there is undoubtedly significant overlap and collaboration between the operation of the police department and district attorney's office in the criminal justice cycle of arrest, evidence collection, charging, and prosecution, Gascon's appointment represented an unsettling conflation of the healthy separation of power between the public prosecutorial arm of the local government and the police who patrol, cite, and arrest. He too became a

symbol for the blurring of state institutions that had at least been previously more bureaucratically and ideologically distinct.

Given his insider status with the SFPD, critics including Public Defender Jeff Adachi, wondered how Gascon would fare amidst allegations of police misconduct and suppression of evidence. With Gavin Newsom quickly headed to Sacramento, incoming mayor Ed Lee began reviewing options for the position of chief. Greg Suhr, a thirty-year veteran of the SFPD, San Francisco-native, and alumni of some of San Francisco's "old boy" institutions, was the kind of born-and-bred within the ranks appointment that people had expected before Gascon. Now here he found himself, sitting on a panel early in his appointment to address one story in particular that had just broken—police misconduct captured on camera at the Henry Hotel, an SRO located in the city's infamous 6th Street corridor.

The Henry Hotel is a privately-owned hotel that rents at daily and monthly rates and sits at the center of the city's "skid row." The president of the San Francisco Police Officer's Association was once quoted as saying that the hotel is a "drug infested shithole" (Schreiber 2011). The 6th Street corridor is, like the subway stop in the Mission, the object of constant police strategizing and concentrated sweeps by plainclothes officers. The Henry, like the Anza Hotel described in the previous chapter, is a site where the police are also called at least once a day, according to statistics from the SFPD's Department of Emergency Management, reported by the San Francisco Examiner (Schreiber 2011). Thus, the hotel has a similar reputation among the police as being a hotbed of drug use, mental health crises, sex work, and drug trafficking. The public defender's office had recently released the incriminating video which shows plainclothes

narcotics officers (during Gascon's tenure) illegally entering rooms in the hotel using the manager's master key. Allegedly, the police were convincing hotel managers to give them access to rooms with the master key, then covering surveillance cameras in hotel hallways as they entered the rooms. In these specific sweeps, drugs were allegedly found and the room's residents were arrested. But, a judge and prosecutor tossed out the charges because the video showed not only the illegal search and seizure in the SRO rooms, but also revealed that the police had subsequently falsified police reports and lied in sworn statements about being given permission to enter the premises in the first place. Once inside a room, the officers allegedly coerced men into saying that they had given officers permission to enter and search their rooms.

We watched a dramatic video montage of all the local news coverage of the scandal, played at full volume in the auditorium filled with approximately 200 people. Steward Handlin, the defense attorney who had once defended Geronimo Pratt, a Black Panther Party member framed for murder, set the tone for the commentary by proclaiming "These policeman don't think the citizens in hotels, SROs, have the same rights as people in Pacific Heights![3] And they think it's okay to break down their door because they're 'drug dealers' or 'drug users.'" All eyes were on Chief Suhr to respond.

"First thank you for having me," the Chief said, "This is a bit of an away game for me," he said as he scanned the row of panelists and the audience erupted in uncomfortable laughter. "It's okay, I can handle it…" he said. Chief Suhr then launched into a long winded speech about the importance of extensive police ethics training, vetting out cops who are "bad apples," and his commitment to maintaining the integrity

[3] Pacific Heights is one of San Francisco's wealthiest neighborhoods.

of the department. His speech was lukewarm and lacked specificity—exactly the sort of noncommittal tone one might expect from a recently appointed chief who was negotiating his new post amidst these serious charges. His dry statement, compared to the public defender's passionate response, was striking. Irwin purposefully reframed the picture of her clients who reside in the notorious, drug infested "shithole" on 6th Street. She recast them from criminals/addicts into ethical, truth-telling citizens worthy of protection from a culture of policing that is unjust and plainly oppressive to the urban poor. Irwin said:

> The Public Defender has a really unique and natural role as a messenger. We have more interaction—meaningful interaction—with the victims of police misconduct than anyone else in government, the media, the criminal justice system…We develop a relationship of mutual trust so that they can confide their stories about police misconduct to us…These stories from our clients about police misconduct are commonplace. Everything from a disregard for the Fourth Amendment, theft, perjury. The Henry Hotel videos, for example, are not the first time that misconduct has ever happened. They're just the first time for us that we've captured them on camera…Let me use the Henry Hotel incident as a sort of case study. We didn't sit down and say, 'Let's go out and dig up some police misconduct. Let's go out and amass a bunch of videos from single resident occupancy hotels and then sit down and watch and see if we can come up with something.' We just basically did our job. Two clients, both residents of the Henry Hotel, told us that what the police officers said in their reports is not what happened. We trusted them. We went out to the Henry Hotel, we got video from December 23rd, video from January 5th, and lo and behold, every word of what our clients were telling us, was true. Two for two. So the videos are just a small sample of what is clearly a, some would say, a culture or pattern…there are cultures that develop within certain units. I'll say it—I'll put it right out there that many of the complaints that we hear from our clients involve plainclothes units. Perhaps there is a culture that develops there that allows misconduct to happen and to continue to happen.

In Irwin's rendering, the pathology lies with the socio-cultural reality of policing in these inner-city contexts. Burris, the attorney who has been involved in nearly a thousand cases of police misconduct in the Bay Area, confirmed Irwin's assertion about a culture of policing and added in the role of race and ethnicity:

> There's no doubt in my mind that the cultures exist…There's a culture in some departments about how you treat the minority people in the community. This is not the elephant in the room and let's not be crazy about this! I have been representing people—blacks, browns, et cetera—over 25 years and I know that there's a disparity in how they are treated by police agencies…

Burris spoke specifically to Suhr's banal statement about the role of proper ethics training in combatting widespread police misconduct. In his numerous previous experiences addressing police misconduct, he had found that indeed, despite the best ethics training, "…once [rookie cops] go to work, the training officer or the supervisor says, 'Forget everything that you have been taught in the academy. This is how we do it in the streets here!'" The local enactment of police culture is what, the public defender alleged, we were witnessing with the case of the Henry Hotel. Further, the Henry Hotel incident demonstrates how, in San Francisco, patterns of police interaction with the poor were shaped by the unusual socio-spatial realities of the SRO system. Because of SRO's unusual status as transitory housing of last resort, police officers are inadvertently granted ethical wiggle room in how they police these home spaces and their residents.

Public Defender Jeff Adachi had recently called for a ban on the use of master keys by police to enter SRO hotel rooms, citing their use as a violation of tenant's rights. But Suhr suggested that the issue of master key use in SROs in the Mission and Tenderloin is the result of the relationship between police officers and the hotel management. The police are frequently called to the hotels and the hotels are the sites of constant plain clothes unit operations. Therefore, Suhr said,

> I know that in all these hotels, they just assume we not be breaking down their doors and paying to fix their doors. And then, the police department can't secure the door and you have to put a person on the door, or there's theft from other folks in the hotel…But I think that if there is lawful

> consent given, and a pass key is used, or the person's own key is used, it ends up being as many things are in this day and age, a cost issue.

Yet, the issue of "consent" in these SRO contexts is complicated. Hotel managers, often involved in illicit drug/sex trade activities themselves, may be compelled to consent entrance to the police because they fear a retaliatory watchful eye from SFPD if they do not. Residents may be coerced into consenting under the threat of brute force or future reprisal from the police. The use of master keys by police to enter rooms is particularly demonstrative of how SROs within the structural context of neoliberal penality. People are not afforded baseline essentials needed to survive in these spaces (e.g., food and sanitary conditions), yet their behaviors are surveilled and policed without restraint. These are the specific socio-structural mechanisms through which people in particular urban spaces are ascribed a secondary category of citizenship mediated by penality. As the public defender remarked:

> Can you imagine police officers arriving at the Ritz Carleton, informing the front desk that they'd like a key that opens ALL of the hotel rooms? And no, they don't need an escort throughout the hotel, they'll just be doing what they like. There would be public outcry…And let's be clear, these are people's homes. As much as anybody else's homes. There's no different constitution for people living in SROs. And they [hotel managers] say, the officers come in and they intimidate us, either physically or verbally into handing over the pass key. If this was happening anywhere but SROs, there would be outcry.

Being a Woman Worth Saving

Given the potentially wide spectrum of experiences regarding how women interact with police and the subjective implications, the following section examines four women's modes of interaction. Since their engagement with police is intertwined with their broader experiences of poverty, housing instability, drug use, and mental health crises, I have included extensive contextual detail. The four cases illustrate the following:

1) how purposeful avoidance of the police because of income generation through the illicit drug economy creates extreme social isolation, 2) how interactions with police can lead to rumination over one's morality and very humanness, 3) how routine interaction with police creates skepticism and critical reflection regarding the intentions behind police's compassionate intervention, and 4) the tragic implications of only being afforded some measure of gendered legitimacy through extreme suffering.

"There are no friends out here:" Extreme social isolation

In this case, fear of arrest because of the always looming presence of police results in extreme social isolation and staying in a problematic partnership because it offers more stability that the alternatives. This case demonstrates the impacts of purposeful attempts at total disengagement from interaction with neighborhood police, which is a critical component of how women negotiate neoliberal penality. I first met Natasha in Fall of 2011, through a good friend of mine who works for the opioid overdose prevention program and needle exchange. Natasha frequented Ladies' Night in the Mission, a special collaboration between multiple social service agencies to provide a safe space for anyone who identifies as a woman to access a hot meal, primary medical care, syringe exchange, clothing, hygiene supplies, and referrals for medical and mental health care. Ladies Night has been in operation for a decade takes one night a week on a block notorious for its concentration of homelessness, sex work, and drug activity. Ladies' Night is considered one of those "magical" spaces where women can come for respite from the violence and hustles of the streets, leave their existing street conflicts at the door, and spend time among an incredibly caring and devoted team of volunteer service providers. In addition to the basic services provided, Ladies Night hosts beauty

salon activities, massage sessions, and frequent holiday parties. The meals are notorious for being incredibly elaborate and decadent. Many women come in right at 6pm and hunker down at one of the many cafeteria tables set out for the entirety of the night.

Natasha did not come for the social scene as many women did, but instead came to access free syringes, injecting supplies, and to check in with the two women who regularly work the syringe exchange at Ladies' Night. These two volunteers, Janet and Emilia, are well-known, well-respected, and dynamic figures in the local harm reduction scene. They have formed long-term, deep relationships with many of the women in the Mission who are typically considered "hard to reach," including Natasha. Natasha is a 35-year-old woman, with light skin, and dirty blonde hair. She smokes crack often, but the drug she has a physical dependence on is heroin. She has been in the neighborhood and using drugs for about ten years. Natasha is originally from the South and has three kids, who now all live in her mother's care. She has not seen her children since coming to the neighborhood, but talks to them on the phone frequently. She originally came to San Francisco with a boyfriend and was instantly fascinated by the city. Initially Natasha slept in her boyfriend's truck, but their relationship soon disintegrated, when, she says, "I was introduced to [the] Mission." It was then she started staying in the hotels and immersed in the local drug scene because "…it was fun, you know. I went buck wild." Natasha had been using crack since around the age of 17, but during her time in the hotels, she had developed a serious heroin habit. She says of her initial experiences shooting heroin, "I loved it. I loved heroin. It was just the best feeling. And now I only do it to stay well [stave off withdrawal symptoms], you know." Natasha was now injecting at least three to four times a day. She has a child-like demeanor and is often dressed in pastel pinks and

purples and she wears her hair in a high pony-tail. She has blown-out amateur tattoos on her arms and hands, which are visibly swollen from years of injecting. Her current partner is a local drug dealer who moves a relatively high volume of drugs around the neighborhood. His name is tattooed on her neck and she works tirelessly every day as his drug runner, moving product into the City from Oakland.

Natasha was staying at the Northpoint, a private, daily-rate hotel. But, when we met, she often opted to go to a café around the corner because of the watchful eye of her partner and his potential suspicion about why she would be talking to us. We met her at the subway station and walked only a block and a half away from the notorious drug-copping block, to a café on the nearby intensely gentrified street. We all commented on how interesting it was to be this close to the hotels, but to be worlds away from the drug scene. Natasha never came here on her own and she knew that nobody from the hotels would ever come into the café we sat in. Natasha deeply trusted and loved Emilia already, and as another young woman who worked in the harm reduction scene and friend of Emilia's, I was instantly considered a trusted friend. In fact, the level of deep friendship she afforded me even on our first encounter was profoundly unsettling; since it drew into sharp focus how few people she actually had in her life that she could trust, especially in the drug/sex scene where most relationships were transactional, including to many extents, that with her partner.

At the time of our first meeting, Natasha had been staying at the Northpoint Hotel on and off for about three months. She was subject to the hotel manager's "musical rooming" or mandatory check out after 28 days, in order to ensure that she would not

gain official residency according to city policy. She had left the Yash, the hotel a few doors down and routinely stayed at the Northpoint because:

> It's pretty quiet there. That's why I stay there because it's quiet. It's a lot quieter that the other hotel [the Yash]. Yeah, and it's kind of crazy over there, you know? I kind of want to keep the heat off of me, you know? So I go where it's quiet because being around where everybody else is at, it puts heat on me with the police and stuff like that.

Natasha is referencing the recent transformation of the Yash Hotel, into a tightly packed, but extremely active micro- drug and sex economy, with the hotel managers at the helm, which I discussed in Chapter 3. Given Natasha's current work as her partner's drug runner, she could not risk getting entangled with the everyday (sometimes petty, sometimes serious) drama that came from the concentration of drug/sex trade activity that was now taking place constantly at the Yash. As she noted, "All the dope sellers are over there, you know? Mostly everybody's selling dope or prostituting." She paid fifty dollars a day at the Northpoint, ten dollars more than what she was paying at the Yash; but, to avoid the extreme levels of police activity and chaos, Natasha felt it was worth paying the extra cash. The Northpoint, just like the other daily rate hotels also charged visiting fees on top of daily rates, so that the management could claim their slice of profits from the sex trade going on there. At the Northpoint, any visitor coming in until 9pm was charged five dollars to enter the hotel, and after 9pm, they were charged ten. Natasha was familiar with these rates, because before becoming her partner's runner, she did sex work to survive. "When I was hooking," she said, "they was making a lot of money off of me, just by my dates." But now, given her current income generating strategies, an arrest could pose much more serious charges and contempt from her partner, who is key to her everyday, modest survival. She was proud that she was no longer doing sex work and the

threat of losing the minimal stability that she had established for herself prompted her to maintain a high level of vigilance about police interaction. She says of cops who police the hotels, “Yeah, they come in there, yeah. They know you before you know them…they do go up there and jack the place…they do like parole searches and stuff.” The last time she encountered cops in her hotel, she was arrested on an outstanding warrant from a heroin possession charge. She says that she was asleep in her hotel room when “…they came and woke me up…Yeah. They came straight to me.” She believed that the cops knew where to find her because “Oh, you got snitches on the block. You got people, you know, they’ll tell on you quick to keep from going to jail.”

Over the years, by circumstance and protective strategy, she had become personally familiar with the cops that patrol the corridor. “I know all of them,” she said, “I know the cops pretty well now. They don’t mess with me too much…I’m pretty cool with them. They don’t mess with me.” She believed that her strategy of avoiding drama and cultivating a relatively amicable relationship with the cops she sees repeatedly kept her from getting stopped and frisked as much as other women on the block. “They have their picks, you know,” she told me, “There’s certain ones [girls] that they mess with every time they see them.” “Why?,” I asked. “Maybe the girl gave them trouble,” she said. Her savviness developed over time as a sex worker in the corridor meant that she was always acutely aware of policing patterns. She knew certain cops’ shift schedules and when ones that were likely to stop her would be working. She adjusted her work patterns accordingly, to avoid those cops. Doing sex work without cop harassment at this point, she felt, was easier on the main thoroughfare. This challenged my initial assumption that women would be forced into more desolate surrounding streets to pick

up dates to avoid police contact on the busy street, which is loaded with pedestrians, traffic, and packed buses all day. The notorious sex work stroll just a block away, she said, had become a site of such constant police monitoring, that it had become impossible to work there. Natasha was grateful that she was able to stop doing sex work since connecting with her current partner, who she felt took good care of her and helped her to manage her habit. In the past she has experienced violent and traumatic incidents while doing sex work, including being robbed, beaten, and left in a desolate part of the city while working. She never reported the incident to the police or sought out medical care for her injuries. For her, an incident like that, she said, was more an assault on her pride than anything else.

Thus, working for her partner was a welcomed improvement in her quality of life, despite the dangers. For the first time in nearly a decade she was able to meet her minimal needs and also have a small measure of domesticity, even if it was in the confines of a cramped SRO hotel room. She described, in striking juxtaposition to her sex work and drug running, how now she was able to pass her free time quietly doing something she loved: coloring in children's coloring books. In fact, when Emilia and I offered to bring her some the next time we saw her, she specifically requested the My Little Pony characters and Jelly brand pens, a child-like request that, considering the realities of her everyday survival and management of her intense heroin addiction, resonated with us in a deeply tragic way. In order to take some time together to process what this signified, we immediately went to the craft store and loaded up on coloring books and colorful pens to give to Natasha the next time we saw her.

A few weeks later, Emilia and I ran in to Natasha at the subway station plaza and she excitedly told us how she had recently gotten onto methadone. She had been approached randomly by an outreach worker from a new methadone clinic site and they offered to take her straight there to enroll in an available slot. She agreed to go check it out, despite never having been on a methadone program before. She had bought methadone illicitly on the street, however, when she could not get the heroin she needed to stave off withdrawal. When she got to the clinic, only about nine blocks down the street, she had seen several people from the neighborhood in the waiting room. The first week, she only managed to get to the clinic three days, had planned to go every day the following week, but as I later learned, she never returned. As soon as we turned the corner off of the busy drug-copping corner, she immediately said, "Other than that, just the police has been hot as a firecracker…always running real hot!"

The escalation of violence described in Chapter 3 had directly affected her. Her friend was shot in front of the Prachi Hotel and another friend was killed near the plaza. Shootings in the district are unfortunately commonplace, but when they come in clusters and on the major commuter corridors such as these had, they bring along a particularly intense and visible display of police presence in the following few weeks to assuage public concern. For that reason Natasha had been staying inside her hotel as much as possible. Nonetheless, a few days prior the cops had "jacked" her on the street—meaning they stopped her and questioned her—but luckily she was not carrying any drugs at the time. She said the police had been crawling the area at all hours and stopping people for the most mundane offenses, including jaywalking. She said "I'm trying to avoid the police, so I stay my butt inside at night all the time! I don't go outside at night at all, not

event to get a cigarette. Nothing. I'm so scared." She attributed the intensification to the notorious cop Banner, who "has got it in for somebody" in the neighborhood. People involved in the hotel drug/sex economy in both the Mission and Tenderloin, all know about Banner, who they describe as a mean and menacing cop who will consistently bust people for anything he can once someone gets on his bad side. Everyone knows that Banner can make people's lives hell if he wants to. So, Natasha had been staying inside and was taking pleasure in cultivating her tiny home space—she had rearranged her room and hung her few colorful dresses up on the walls. She was happy that she was not having any bed bug outbreaks in her room now, but knew that people down the hall were getting severe bites daily. On this day, though, she did show me what appeared to be a pretty severe spider bite on her back that was oozing and giving her a lot of pain.

She reported that things were going "So, so" with her boyfriend. They had made a plan to leave San Francisco in about six weeks and head to Las Vegas. She called it their "exit plan," but lamented that despite the plan, money had gotten tighter recently. Plus, she said, "you know, my boyfriend's taken with another woman." We were surprised at how she told us so matter of factly, since this man seemed to be the center of her world at the moment and was her only promise for a more stable daily existence. The last time he went to jail, however, she felt that she did not treat him right—she tried moving on with her life, rather than staying in close touch with him through visits and letters—and so felt that his relationship with this other woman was understandable given her transgression. The other woman lived in a hotel on the same block, but Natasha said that they had not had direct conflict yet because "she stays in her place and I stay in mine, you know." The troubling detail she offered, however, was that this other woman was HIV positive. In

fact, that was part of the appeal for her boyfriend, Natasha suggested, because the woman got a lot of "funding" as a result of her HIV positive status. She had a hotel room paid for by an HIV social service agency and now Natasha's boyfriend had moved in with her. Both my and Emilia's almost innate HIV prevention messaging kicked in and we questioned whether Natasha and her partner were still having sex and whether they were using condoms.

"Oh, they don't have sex," she told us, and she quickly shifted back to talking about their upcoming "exit plan." We eventually were able to meander back to questions about her health to assess whether she would be in a space any time soon to get an HIV test or formal HIV prevention counseling. Her responses revealed the confluence of neoliberal penality and social abandonment. "What's your health like right now?" I asked. "My health's pretty good," she responded. "Do you get care anywhere?" I asked. "I usually get my check-ups when I go to jail—or, I'll go—sometimes, you know, if I'm ready for a checkup, I'll just go to the emergency room for something. I'll tell them something's wrong with me," she said. Emilia and I both encouraged Natasha to visit the Resource Center, just a block away from where she stays, to easily get connected to primary care and a social worker. But this very block is precisely the place she said she was avoiding during the day at all costs because of the recent intense police surveillance of the sex trade.

We encouraged her nonetheless because she was also experiencing symptoms from an old injection-related infection site on her arm. She was no longer muscling, or injecting directly into her fatty tissue, which produces elevated risk for abscesses. But, the problem with her arm was that when she had previous abscesses there, the doctors

"had to cut it all out." So, she was left with bones that had no muscular or fatty tissue to support them and thus, experienced extreme chronic pain as a result. She hoped to at some point start the process of getting approved for SSI because of this disability. Her years of injection meant that it was hard to find a vein in her arms and hands to inject into, so she was currently injecting in her femoral vein, near her groin, the most risky place to inject besides the jugular because of its proximity to a main artery.

It was nearly a month before I ran in to Natasha again. I called her from the street and she came down from the middle of the block to meet me, energized by what was going on in her life. We headed to the café—the place that had now become her welcomed respite from the cramped hotel room. I was fine with this because I was well acquainted with the Northpoint hotel and the management, since it was one of the hotels that we went into weekly during outreach. Since the last time I had seen her, she had moved out of the Northpoint Hotel and had bounced from the Prachi to the Astha, where she was now staying.

> Natasha: Well, I made it out of the Northpoint and got me a good lawsuit going.
>
> Andrea: Oh, tell me about that, what's going on?
>
> Natasha: I got him. I got him. I got him. [she is referencing the young manager at the Northpoint.]
>
> Andrea: You got him?
>
> Natasha: Yeah, I got him good too.
>
> Andrea: How do you mean?
>
> Natasha: Well I got him on the case where they charge a visiting fee. That's illegal. And this coming from the lawyer's mouth. I'm getting pictures of the carpet, how nasty it is. There are no fire alarms, no smoke detectors.

> Andrea: Oh shit.
>
> Natasha: No fire extinguishers. Bed bugs. Used old towels. Overcharging me.

A local non-profit agency who does community organizing around issues facing people living in SROs, had put Natasha in touch with a lawyer and had given her advice about the kind of documentation they would need to charge the hotel owners with misconduct. During my time as an outreach worker, one night a month a representative from the SRO Collaborative joined us for outreach. They distributed pamphlets about tenant's rights and also small, discreet receipt books. The idea was that tenants needed to document both their rental payments (which could be used to prove their residency after 28 days) and when managers illegally charged visiting fees. These receipt books were hard for women to hold on to for two reasons. First, if the managers saw that women were carrying them, they might kick them out of the hotel and not let them stay there again. Second, for unstably housed women managing daily drug use, personal possessions of any kind were hard to keep, especially those that were not essential to survival. Nonetheless, Natasha was determined that the lawyer would take her case, which she envisioned would eventually result in a cash payout, recuperating the visiting fees she was illegally charged over the years. Natasha welcomed the idea of extra cash because, though she said her boyfriend was dominating the heroin trade in the area, they had to dip into their savings to help his children with some medical issues. Thus, their "exit plan" she described the last time we spoke had been pushed back even further.

> Natasha: Yeah, we are through with this shit. On our exit date, we have got plans. We are going to start brand new. We are going to start brand new. He's going to get a job. We are going to live a normal life. He is going to go to work every day, come home. Like normal people.

> Andrea: Yeah. What about it is so bad for you? I mean I know there are probably a lot of things, but what right now makes you want out?
>
> Natasha: I'm just tired of it, you know? I'm not getting any younger. I want to sit down and be able to sit down in my own house and kick my feet back [with] my man, just be happy.
>
> Andrea: Right, yeah. That makes sense because being out there is a constant, right?
>
> Natasha: I want a house. I'm tired of living in motels.
>
> Andrea: You were talking about how you don't hang out with too many people. You basically just go up into your room.
>
> Natasha: Right I don't. Because hanging out with people gets you in trouble. That will get me busted.
>
> Andrea: Because you think people talk, or what?
>
> Natasha: They will snitch on you in a minute for a hit…some of them will snitch on you in a minute for a hit of crack…
>
> Andrea: So you are not trying to have too many friends out and about?
>
> Natasha: Right, because ain't none of them are my friends…none of them. There are no friends out here.

Natasha's acquisition of relative stability as a result of her relationship with a drug dealer also meant that she had developed hypervigilance about avoiding the cops. The stakes were much higher if she were to get arrested as the partner of a drug dealer. Her current lifestyle, which though still filled with daily challenges, was a great improvement over the everyday violence and hustling of street-based sex work. Therefore, Natasha purposefully isolated herself from potential direct interaction with cops and from social interaction with people whose desperation in their own lives might result in them snitching on her to avoid arrest for minor offenses. The weight of this reality is palpable. The ubiquity of penality in these contexts is such that people can leverage someone else

getting “busted” as a means to help them with their basic survival. The constant risk of getting busted by the cops was a tremendous source of stress for her. She feared losing the fragile relative stability she had secured and also re-incarceration. The daily threat led her to extreme social isolation. In fact, she stressed that it was only her occasional interactions with us and her coloring books that gave her any kind of joy.

I did not see Natasha for about three months, after I had an unexpected surgery and took a break from field work. When we met up to talk again, it was surprising to see just how little had changed for her, despite the hopeful narration about the lawsuit and “exit plan” the last time we spoke. When we met, Natasha looked tired. She was eager to go somewhere off of the block of hotels to talk. She said that the lawyer was finally supposed to get the lawsuit against the management at the Northpoint going in the next few weeks, which had been delayed by the holidays. Because of the lawsuit and the intensification of the drug and sex trade at the Yash, her options for hotels to spend nights in were further limited. She had moved around various hotels on the block, but had avoided the Yash, which was still “off the chain.” She said “I would rather buy me a tent and sleep out on the sidewalk than to stay at the Yash.” With the Northpoint out of the rotation of potential hotels to stay in, she had spent time at the Astha, which was “filled with bugs.” She took pictures of how her “body was eaten up from head to toe.” She was happy to have finally settled at the Parth Hotel, the small, coveted hotel that was known for being much less chaotic than all the others on the block. The managers were known for being extremely selective about who they let stay there.

> Natasha: It’s the cheapest and the best out there. Yeah, it’s quiet, you know? The rooms are a lot more decent, you know? They’re not all beat up. They’re old, but they’re not all tore up. The walls aren’t written on, all that. It’s really clean there. I don’t have to deal with this. And, over there,

> I don't have to check [out] every 28 days. I just fill out another card in somebody else's name.
>
> Andrea: Oh, really?
>
> Natasha: Yeah. [The manager] does it because my boyfriend, he's been there forever. So, he's like the security there and stuff. You know, so I don't have to worry about checking out all my shit and moving it for one day and then back again.

Natasha was willing to enter into mutually beneficial collusion with the management at this hotel to dodge the city's hotel residency policy because it meant ensuring safer, less chaotic housing, without the constant destabilization of musical rooming. Plus, now she was living in the same building as her boyfriend, which meant that when he needed her, she did not have to leave the building and expose herself to any police interaction. But, she was still handling business for him, managing incoming calls from people who wanted to buy drugs. "As long as it's ringing," she said of her cell phone, "I'm making money. But there are days when it don't ring at all." Sometimes, "People are broke. And sometimes, even if they're broke, it still rings off the hook. 'Credit, I'll pay you tomorrow.'" Natasha takes credit from a few people, but not many.

The new living arrangement had its perks, but was also incredibly complicated. Her boyfriend was still sharing a room with the other woman. This was incredibly distressing for Natasha, and, for the first time, their mutual "exit plan" that she had talked about so much before had transitioned into a plan that did not necessarily include him.

> Natasha: I'm thinking of a plan though. I'm ready to leave. I'm tired. I'm tired. I'm worn out. I'm thinking of a way to do this but [she pauses], I don't know.
>
> Andrea: What's your plan look like? What's some of the stuff you're thinking about?

> Natasha: My God. How to get out. I want to leave. I don't want to do this no more. Yeah. I don't want to be the other woman. I'm tired of that…I don't know. I don't know.

Natasha was overwrought. She was feeling like this might be the right time to leave, but felt trapped by something she could not really describe: the promise of the lawsuit and some cash for herself, her boyfriend, and her heroin habit. She worried, "I'll get myself all worked up. And me, when I start getting in a hurry and doing things too fast, I fuck everything up. I start messing up everything." Natasha felt stuck and that there were so many pieces of the puzzle to put together if she were to seriously try to leave. I reminded her that this is exactly what case managers help people to do—figure out all the components of goals they want to meet and then help them tackle the pieces one by one. I reminded her that she could get connected with a case manager immediately at the Resource Center, just a block from where we were standing. I also reminded her that she could come to Ladies' Night if that was more comfortable, and start the process then. I wondered if her extreme social isolation because of her desire to avoid the police is what had kept her from connecting with case management at the minimum, as so many women do.

Natasha's case demonstrates how the ubiquity of potential for interaction with police altered her movement in the neighborhood and lead to extreme social isolation. Her only respite, at this time, she said, was coloring in her children's coloring books and heading around the corner to the café with us. That she felt trapped by the fear arrest kept her in a problematic relationship with a partner who was seeing an HIV positive woman simultaneously. But all this seemed to be materially her best option and she felt like she deserved the "punishment" from her boyfriend in any case. Her carefully constructed and

maintained peace was not much, but she greatly feared losing this comparatively stable existence to the alternatives that were looming threats everyday (e.g., jail, more sex work, living in a more dangerous hotel, living without the perceived protection and companionship from her partner).

The "Hooker with a Heart of Gold:" A Soiled Dove Redeemed

The next case demonstrates how a woman, with a long history of drug use and sex work, activates her own version of the soiled dove trope to give meaning to her own suffering and validate her survival. I met Liliana at the Sun Hotel on Mission Street, while doing outreach in the hotels. The Sun Hotel is just one block away from the main concentration of hotels and therefore, the scene outside of the hotel is significantly calmer. The Sun is run by the DAH program and was leased by the city in 2003. During outreach we were not allowed to go upstairs and see people in their rooms, but instead the hotel clerk posted behind a glass booth would call women down to the lobby area when we arrived. We always wished we could go upstairs, especially since we knew that this method of interaction meant that people who were really high did not come down because they physically could not, or they did not want to be seen high in front of the hotel staff. I later was able to go upstairs when I started interviewing another woman, but for many months, I had no idea what it was like upstairs. We always posted in the clinical communal sitting area, which had two faux leather couches, a flat screen television, and a kitchen which was kept under lock and key. The refrigerator doors were bolted shut by a large chain and padlock. Despite technically having access to a kitchen, the women were still always hungry, as many did not have money to purchase food to prepare in the kitchen.

The sack lunches we brought which stocked peanut butter sandwiches, chips, and a sweet were usually what women asked for first. The outreach team posted in the kitchen area, spread out our large outreach bags, and waited for women to stream down gradually from upstairs to get supplies. They would generally visit with us for a few minutes downstairs, updating us on all that had happened the previous week. Doing outreach in this hotel was significantly more relaxed for us outreach workers. It was like a moment of respite for us on a busy shift. At the Sun we were not cramped in a narrow hallway and forced to crouch down on the soiled carpets to lay down our bags. We were not getting stepped over by people exchanging drugs, nor smack in the middle of frequent disputes between people in the other hotels or on Mission Street. We were never questioned or threatened here and the downstairs space was seen as relatively therapeutic, as it also housed the case managers during the day and various social events.

Most of the women who lived here were still active drug users (there was still an active drug economy operating in the hotel despite it being publicly run) and, as I discussed in Chapter 4, like most of the supportive housing hotels, many had severe chronic health issues that limited their mobility. To be sure, the overall daily struggles to survive and manage acute health problems and addiction were not necessarily minimized here, but the housing environment provided a little relief from some of the usual stressors of hotel living. Liliana showed up one week, having just been placed at the Sun by the DAH program. At first she was very distant, but warmed up to us after a few weeks of seeing her there. Liliana is a 57-year old transgender woman with dark brown skin and brown hair. She is of Puerto Rican descent, but had moved around a lot as a kid because her dad was in the military. Her mother passed away in a car accident when she was four

years old. Liliana was in the car with her when her mother died. She grew up in the care of her father, who was an intense disciplinarian and verbally and physically abusive.

When Liliana started questioning her own gender identity at an early age, the violence from her father escalated and he used to yell at her in Spanish and English, "if God had meant for you to be in a dress, he would have put you in one when you were born." Her transgenderism was a huge source of conflict between them and her father spent little time at home. He eventually started throwing her out of the house regularly and Liliana started hanging out on Hollywood Boulevard in Los Angeles doing sex work. She left home for good at 15 years old, after her father told her "If you ever come back home in drag or whatever, I'll kill you." She did not feel like this was an empty threat because her father kept guns in the house. During this time she started using drugs—at first snorting cocaine—and became immersed in sex work in Los Angeles. She said sex work in Los Angeles was somewhat glamorous and gave her a sense of purpose, but that things started going downhill when she picked up a more serious drug habit. Drug use plus her transgenderism brought a particularly intense level of scrutiny from the LAPD. She said:

> I've done probably…maybe a hundred prostitution [cases]…so they told me if I ever get arrested, I would go to prison. And they might have been trying to scare me…I've been busted so many different ways, so many different times. And I mean, I would get out—get out from jail—and go right back in…I mean, I had—I had boyfriends a few times, but nobody that I could really—no lasting relationships. Nobody to go home to. Nobody. So any time I got out of jail, it was always, you know, you have to go right back out into the streets and start a new life.

Liliana came to San Francisco in 1982 and landed immediately on the famous transgender sex stroll. "Everything was popping then," she said. "The [transgender] girls were like, back to back. There was cars like, ten cars for each girl." After a few years in San Francisco, her drug use intensified and in her late twenties, she started injecting

cocaine, followed by heroin, among other drugs. She described almost a sense of inevitability about the escalation of her drug use in San Francisco, which was tied to the city's specific history as a drug use epicenter. In San Francisco, she said "people are just discovering—in the quest to discover drugs…This is the city where drugs became known. A drug mecca and sex mecca."

In the beginning, she stayed frequently at the Oceanside Hotel, a hotel known for its transgender sex trade and was shocked to realize just how cutthroat the industry was, as people competed for dates to maintain their habits and hotel rooms. This is one of the few hotels at the time, she said, that rented to transgender girls, who had bad reputations for causing problems in the Tenderloin hotels. "Everybody's out for themselves," she said, "whether it be the tricks, the boys, the girls. Nobody really gives a damn about anybody else. And they would easily stab you in the back as quickly as—your life meant nothing to anybody. That's the way I felt." She worried for her safety a lot during this time period, especially since her drug use had escalated to a point that she was "just a total mess in broad daylight." Nonetheless, she said "It's strange, because no matter how bad it got, there was always somebody that saved me. Or, not somebody to save me, but somebody would say 'you don't belong in this, doing this.'" She ended up staying at the Oceanside for the previous twelve years, until she moved into the residential drug treatment program.

Liliana was clean and sober at the time we first met. After decades of living and working around Polk Street, she had gone into a residential program. Her release from that residential program is what got her placed at the Sun Hotel. So her "recovery" was still tenuous and something that she struggled with on a daily basis, considering the

neighborhood she was living in and the availability of drugs any time she should want them. Perhaps it was because she had just come out of an intensive abstinence-based residential program, but Liliana maintained a particular reflective narrative about this previous period of intense drug use and sex work. She said that during this time she had crossed the boundaries of her own self-worth and through her recovery had come to realize that this was not her authentic self. Even in the depths of her own methamphetamine and heroin use, she felt that there was a clear differentiation between herself and the real "crack people, the parasites" who lacked true principles. She felt that it was her duty now to narrate her story to others who needed help and that this was the way that she could fully redeem herself from her past transgressions. After she got some minimal amount of stability, through either General Assistance or SSI, she hoped to start the process of becoming a peer counselor.

At the time we met, she was scraping by on nearly no income and barely managing to survive. So there was a certain amount of urgency and desperation for her attached to our encounters. I do not doubt that our rapport was authentic, but Liliana was living day to day on pennies and so the meager food and cash I brought with me were actually critical to her survival those days that we saw each other. This time of intense poverty was incredibly depressing for Liliana. She was glad that she was sober and not doing and sex work, but she also knew that those aspects of her previous life could provide her some livelihood, so it was always tempting. Each time I came to visit Liliana at the Sun Hotel, she never wanted me to come up and see her room. I heard from another woman, whose room I spent a lot of time in at the Sun, that Liliana's room was always filthy. Strangely, Liliana never wanted to leave the hotel to get a bite to eat either. Instead

she asked one of the case managers that worked on the first floor if we could have access to a small meeting room just off of the main lobby. Each visit we sat in this space at a cafeteria table and talked. It was nice to have the privacy, as Liliana was very soft spoken and she often cried during our visits.

Liliana has Hepatitis C, but is HIV negative. She suspects she got Hepatitis C from sharing needles back when she first started injecting. She remembers that she did not learn how to inject herself for a while, but would go to a restaurant in the neighborhood where people could go and get injected by a "doctor" in the bathroom. After watching and learning people inject her, she started to inject herself; in fact, after that she became so skilled at injecting that people would ask her to inject them on a regular basis. This was a valuable skill to have in her street life. She said:

> Liliana: It's also how I got more dirt on dates and drugs and all that. I also treated people somewhat good. I mean, I might have been scandalous in some ways, but never as scandalous as some people. Like I didn't want to shoot up people that had never done it before. And I wouldn't shoot up people that were like sixteen. Even though there were 16-year old girls and boys [that] were like 'Can you do this? Please. Please.' There were times when I did [inject other people], but it would be one of my top rules. Because even when I was really deep in my addiction, [I had] some principles in my drug addiction. A lot of my values went down, but [there were] things I said I wouldn't do.
>
> Andrea: But you had your limits…
>
> Liliana: Yeah, I had my limits. I didn't want to hurt other people, even though people tried to hurt me every which way…of course anybody that has been into drugs can tell you…
>
> Andrea: You mean around people trying to be violent toward you or hurt you?
>
> Liliana: Yeah. There were times when I had to get violent or defend myself. I thought that I would never get out of this alive. But somehow I did. I fought my way or I could claw my way. It's even worse when you are really high or you have a lot of—you thought you did something right,

> but you didn't. Or they were using you the whole time and you were so high that you didn't realize it and then it clicks.

Liliana had processed the past choices she had made for survival to a certain extent, but by no means was she in a place of confidence or necessarily hope for the future. In fact, she had an incredibly meek demeanor, spoke in almost a whisper, and questioned all her current actions. Even in our conversations, she sought my approval for the choices she was making in her life. Over many visits, we processed whether or not she should attend the city-wide Gay Pride festivities. This would be the first time she had ever attended the event sober and was not sure if she was ready. She ruminated over this intensely and wondered how she would confirm her own self-worth at Pride if she was not trying to pick up casual sex dates and get high. In all of our interactions, however, she always returned to the question of her own morality. In the past, she said, "I did all kinds of things. But, I do believe that all through that I never really wanted to hurt anybody…that there was a good person. That goodness stayed in me, you know what I mean?" But, she felt that she had to transform herself to a certain extent to survive in the illicit drug and sex economies. She said, "For a while I felt like I was a fish out of water. Once I got the hang of it, I learned the ropes and it is a whole—it's a whole game in itself." Further she said, "if you don't play it dangerously, like I've seen people get killed."

Liliana had been in countless situations where she feared for her life. She had been threatened and physically assaulted, but as she told me:

> But somehow I've never really got to where somebody really wanted to *kill* me. Somehow I've managed to calm him, or there is something about me that people see, the *humanness*. I think it was just not my humanness—my realness—that they could see that I'm not…Maybe you could call me a hooker with a heart of gold.

Liliana utilized her own version of the soiled dove trope to define herself as a woman forced to make difficult choices in order to survive. But she applied this term to herself retrospectively, after she had been through years of a drug treatment program, had stopped doing sex work, and was no longer using drugs. This narrative was now functioning to make sense of all the turmoil she had gone through in the past and the palpable struggle to survive in the present. For her, activating the trope of the soiled dove—and her own sense of ultimate worthiness, buried deeply by her involvement in the illicit economies—is how she made sense of the suffering she was able to endure. At the time we met, Liliana rarely had any interaction with police. She spent her days in her small hotel room, only leaving when the hotel staff had arranged a field trip somewhere or to go get the hot meal at Ladies' Night, just a few blocks away. But she recalled her days at the Oceanside, where she had frequent interaction with police because of her involvement in the sex trade and the routine violence that happened around her.

In the past, because she was constantly on the streets engaging in sex work, she had formed some longstanding relationships with the cops that patrolled the area. In this interaction, she describes the dynamic that Sanchez and Donahue also describe about appealing to a woman's sense of worthiness, assumed to be deeply buried. That the officers activated this discourse relative to her was very meaningful and gave her a sense of hope.

> Liliana: There was this one cop that remembered me when I first started hanging out on Polk, when I first came. And he was always nice to me.
>
> Andrea: He was always nice to you?
>
> Liliana: Yeah…he was one of the first cops to bust me. And that is when I first started getting high…I used to go out there in the daytime and get good dates.

Andrea: But he was nice to you.

Liliana: He was nice to me. And I remember him giving me a lecture or something. I think he said, 'You don't belong…you are the type of girl that doesn't belong.' Because he treated the transgender girls like they were girls. I think he was one of the few ones that was a cop that really treated transgender girls like they are human. Or at least me. He treated me like I was human instead of 'You guys are gross…' But he cared about me. He really did. He said, 'You don't belong in this type [of life]. But he knew what I was doing speed too. He said 'You are wasting your life…' And I had seen him again. He said 'You are still here?'…But I could tell by the face…he still had respect for me. Even though he had seen me down at the [police] station…I had gone from being okay to looking like—he still respected me. He pulled me to the side and said, 'I hope you get out of this someday.' But he was one of the first cops ever, ever in my life, besides being in jail and those cops talking to me. There was one cop in jail that used to date a girl. He paid for my bail.

Andrea: He paid bail for you?

Liliana: I didn't have anything sexual with him, I don't think. He just wanted to talk to me. But he had done that with other people. He was a closet case…And he liked me too. I wasn't deep into my addition yet too and he was real nice to me.

Andrea: So he helped you out by paying your fine or your bail?

Liliana: He made it so that I didn't have to go, my case could be dropped. But there was no sex…but I was always very leery. You know, like anybody else because that was my lifestyle. But those two cops, I think that they both knew that I was—they saw me for whether I was a drug addicted whore, transsexual, transgender, or whatever—they saw the human part. At least that's what I felt…But they talked to me like I was human. And that was very rare for anybody…You know, I was so used to—I was just so used to discrimination and prejudice and stereotypes that sometimes I feel that I never would get out of that. That's what I was telling you. Because I didn't think that anything was better for me. Because I lived in those stereotypes. And I knew what people thought of people like me. They think there was no hope because I became one of those people…the thing that I always wanted people to see what that I was—I was human. There is a human part of me…Fuck you, I have a right to be here. I'm doing the best I can in the situation that I am in. Yes, I'm a whore. Yes, I'm a drug addict. Yes, I'm a drug user, but you don't know my life…It

> makes me want to cry, Andrea, really because I don't—I just always wanted people to see that I am human.

There is a certain tragedy to this dynamic. Liliana felt that the only recognition of her humanity came from a police officer. The recognition of her humanness is penally-mediated and is thus tenuous. At any moment the dynamic can shift to overtly punitive dependent on how police officers enact their moral adjudication of her in their routine interactions. In fact, it is more likely for them to enact punitive oppression because that is the officers' primary mandate. As Sanchez reported in the previous chapter, "I never forget that I'm a cop first." Further, Liliana's quest for recognition of her humanness signals a complex gendered moral economy. She must situate conceptions of herself relative to the discourse where she can, in fact, be a soiled dove redeemed and transformed into a legitimate, worthy body. But the very potential for her to be transformed also signals the fact that at times, she is relegated to a subject position of not fully human. Her very humanness, minimized by her intense degree of social exclusion, was tragically reaffirmed through penal mechanisms and was only then a means by which she could accrue some sense of biolegitimacy. But she recognized that in order to maintain her minimal biolegitimacy, she had carefully tread the moral line and not commit transgressions.

The Street Hustler

In contrast, Sheryl, who I introduced in Chapter 4, defied the contours of the trope of the soiled dove and therefore, uniquely negotiated this discursive construct. I met Sheryl on the busy street one morning and suggested we go grab a coffee further in the Tenderloin, she looked up at my air-conditioned office and said "Damn it's hot…you don't wanna go up there?" It was true that it was unusually warm in San Francisco that

day. Sheryl was covered in sweat and out of breath when she arrived, having just pedaled a few miles from the county hospital. I imagined that a relatively cool and quiet office sounded much more appealing that cruising through the heat in the Tenderloin, where the stench from the steamy sewers could be unbearable on a hot day. At this point, we knew each other well. So on this day, I purposefully directed our conversation to my questions about her interactions with police. Her experiences were largely in the context of her past history of street-based sex work, and upon arrival in San Francisco, being perceived as and having the markers of a "high risk" injection drug user.

> Sheryl: Well, there's two kinds of cops. There's clean cops and there's dirty cops.
>
> Andrea: So you have experience with both or…
>
> Sheryl: Yeah.
>
> Andrea: Tell me about the clean cops.
>
> Sheryl: They're kinda cool actually. They kinda like look out for you and stuff. And sometimes they're willing to bend the rules, if they're willing to give you a chance. But the dirty cops will do a lot of stuff that ain't cool…When I was young and lived in Hawaii and I was a prostitute and stuff there was a lieutenant. He was a high ranking officer and I used to work late at night and he used to tell me like before I get in the cars and stuff that he would pull me over. And make sure I got the money immediately so that when he came through, I would already have the money and he would arrest the trick. So that I could get away and not have to date [perform the sex act on] him. And I think that had a lot do to with my mom and her history of being a prostitute down there and stuff. So I guess my mom asked him for favors to look out for me and stuff.

Sheryl's mother had done sex work almost all her life, but when Sheryl was old enough to go out on the streets, her mother had already stopped. Her mother's partner was a pimp (Sheryl's term) and she remembers that he would sit for hours at a local bar while the girls that worked for him would cycle through to drop off money from their day's work.

Sheryl: I was mostly a street person, you know. And like at night time when we needed money for drugs or when the girls were sick [going through opioid withdrawal] or whatever, I would just go and catch a trick real quick. And sometimes I'd be in and out of cars so much that I never even had time to stop and get high. You know what I mean? I was real young. It was like that for a while.

Andrea: So what were you doing then?

Sheryl: Back then it was good drugs. I mean, we had like China White and Brown Mexican dope. But it wasn't tar. We had Persian and we had cocaine to free-base. And it's not like now. You got all kind of crap in there.

Andrea: Right because black tar came through here at least like fairly recently compared to other shit, right?

Sheryl: Right before I left home in '95, that's when tar started to hit Honolulu…and that's when they started mixing coke with speed. It started out with that first and then you know, then pretty soon there was no freebasing anymore, it was just smoking crack.

Andrea: And so did you get high with tricks or anything?

Sheryl: Oh yeah…I used to get busted by the cops all the time. Because I would be so fucking high that I couldn't—after a while being out there—I couldn't tell the difference between a cop and a trick anymore. So then I ended up going to prison…I was just so out of it, yeah…But I mean, it was the same cop always busting me, but I just couldn't tell because I was so fucked up…I used to flag down tricks a lot…or, we'd catch each other's eye or whatever…I wouldn't go too far from the neighborhood to—you know it could be an alley, a parking lot, it could be anywhere to stop and do the date real quick—and at times, I'd just get busted. It wasn't too bad, but I wish I'd had condoms. But it's when, you know, that I didn't have condoms or a date didn't that was always a problem…I didn't really want to do the date without condoms. You know sometimes you couldn't afford them or they wouldn't buy them…I'd just be like, it's not something I wanted to do. And when I was really young I didn't care. Until I learned about HIV and stuff…

Andrea: So when did you come to San Francisco?

Sheryl: I came to San Francisco in '95 and that's when the cops seems a whole lot different out here. You know, one time I got stopped by the Civic Center, just because I was an IV [intravenous] drug user. It was like 2 o'clock in the morning and I guess I was crossing the street from the

> waterfalls to like the library to go somewhere and get high. And the cops stopped me in the middle of the streets to search me…There was no way around. No fucking way anybody would even hear me if they just threw me in their car or whatever. And they were like 'You know, if I get poked by one of these fucking needles bitch, I'm gonna blow your head off right here.' 'Cause they were scared. But that's when I just figured, these motherfuckers is a trip! And I started hating them.
>
> Andrea: That was your first encounter with cops in San Francisco, that moment?
>
> Sheryl: Yeah. That was the thing, you know. They were just ugly.
>
> Andrea: So what happened then after that? Did you get arrested?
>
> Sheryl: No, that time that they stopped me I didn't get arrested. They didn't get poked, thank god.
>
> Andrea: You had syringes on you?
>
> Sheryl: Well I told them, you know, I don't know where all the needles are at. So like, if you stick your hand in there, I'm telling you now…I don't know. I really don't fucking know. Because I'd have them all over the place. I was a mess!
>
> Andrea: Were you homeless at the time?
>
> Sheryl: Yes.

At the time Sheryl and I met in 2010, she had been homeless for twenty years. In her early days living in San Francisco, she supported herself through doing petty burglaries and robberies. But then, she heard rumors that because of the three strikes laws in California, if she were caught for a third petty burglary or robbery offense, she would be doing serious prison time. With this fear of a third strike, she said, "that's when I started hustling, selling a little dope." Since she had been in San Francisco, she had not done any more prison time, but had already intermittently "given" five years of her life to San Francisco County Jail. She had never been arrested for prostitution in San Francisco because soon after her arrival had reached her limit with sex work. "I was just over it,

man!" she said. "I'd rather be dopesick, laid out with no dope, than trying to mess around [with sex work]." At the time we met, as I mentioned in Chapter 4, she was in transition period, having just come out of jail, was not using drugs, and temporarily housed at the Zachary Hotel in the heart of the Tenderloin. Before she was granted SSI she was deliberating which hustle to pick up in order to survive. During this period of "clean time" and post-release, Sheryl's views on the cops were pretty cut.

> Sheryl: Right now I'm kinda clean and I'm not using drugs, but I still hate the cops, man. I hate them in fucking jail and I hate them out here. They're just—they think they can get away with anything. I fucking hate them for real.
>
> Andrea: So how often do you have interaction with the cops?
>
> Sheryl: Not too much, but the last time I went to jail I mean, fuck man! I'm telling you man. I'm telling you, I'm telling you. I was ready to throw down with some of those punks. I fucking hated them! I hated the way they treated the women, everything. They just think they're in there, you know, they can do whatever the fuck they want.
>
> Andrea: You don't have to talk about it if you don't want to, but what do they do to women?
>
> Sheryl: They was just throwing them on the ground and stuff like that if they disobeyed an order. Trying to say that they are way out of hand. I mean, they didn't even do shit like that to me when I was in prison and I was loud and shit! And they turn around and are doing that in the county jail. I mean come on man! That's why my back is all fucked up now. They slammed me up against the fucking table and shit! I was spitting up on the fucking ground! I was dopesick!

She said that the violence she had endured at the hands of the guards in county jail contributed to her ongoing chronic pain, which she also medicated with opioid use over the years. Sheryl became intensely emotional and her tough affect cracked. She started to weep.

> Sheryl: It sucks. I mean, even people who are on GA or SSI…if they're injured, you know, they just for some reason, they can't mentally or

> emotionally can't do anything. Because they're stuck in a fucking rut. They end up—seems like everybody ends up selling dope! It's just—it's a way of life. It just really sucks. It's sad…[The cops] they keep waking them up and moving them around. Waking them up and moving them around. It's sickening.

I was struck by how at this point in her life, Sheryl did not have similar relationships of familiarity with police that other women seemed to cultivate. Two things were distinct at this point about Sheryl. First, since stopping sex work more than five years before we met, she engaged in crime that did not have the potential to activate the gendered discourse of the soiled dove. Sex workers are more easily conceived of as victims in need of rescue and salvation, but her subsequent hustles of robbery and burglary—masculine gendered crimes—do not carry alongside them the discourse of a fallen woman in need of redemption. Second, Sheryl identified as a lesbian and rarely had formed intimate partnerships with men either for love, safety, or to secure her basic needs. Her relationships with men and conceptions of love were never a source of romanticized potential salvation from her street life.

Even her interactions specifically with Sanchez and Donahue, the hybrid cops of the Tenderloin whose job it was to supposedly compassionately intervene in her life, did not spark reflection in the same way about her own gendered self-worth, though she recognized their paradoxical hybrid positions. She did not have close personal relationships with the hybrid cops and though, because of their persistent presence in the neighborhood, she could not avoid them altogether, she tried to demonstrate minimal respect, in hopes of it being reciprocated.

> Sheryl: No. I don't really look at them, like I don't know who they are. I try not to disrespect them as much as possible…You know, whether they're there or not because I'm sure someone's always watching. If it's Monday through Friday, you don't wanna sell no dope in front of the

> fucking preschool. Whether they're outside or not! Because it's the school. Even if there's no teachers, there's nobody there, they're all in class. Who cares! It's a school!...Or I try not to like throw litter all over the place. Do little things to try to be disrespectful and shit.
>
> Andrea: You think that the cops respond to that respect?
>
> Sheryl: Yeah, they'll tack time on you, oh yeah [if they feel you're disrespecting them]. Especially Donahue. One time, right up here we were ducking behind a van and shit. It was like on a Saturday, Sunday, I don't know what day it was.
>
> Andrea: What were you doing?
>
> Sheryl: Trying to take a hit getting some chiva [heroin]. There was three of us and everybody was talking. We were all talking. We'd been up for days. [Donahue] rode up next to the van, got out by the van, and came right up on us and I didn't know he was there until he was standing right there. 'What the fuck are you doing? You know this is a school?' I go, 'Oh man! No, I did not!...He goes 'Pick up your fucking shit and get the fuck up out of here! And I better not catch you over here anymore!'
>
> Andrea: He didn't give you guys a citation?
>
> Sheryl: No, because he could have.
>
> Andrea: Does Donahue know you guys?
>
> Sheryl: I don't know if he knows me by name or anything, but there's only one of him and 3000 of us or more [laughs]. But I'm sure he does know me though. Because I've bumped into him a couple of times.

Sheryl knew that Donahue was capable of facilitating a free shelter stay through a referral, however, since he had seen him do so for one of her friends. But at this point, just having been released from jail, trying to get settled back in the neighborhood, and not using drugs, her strategy was to avoid the cops. She was not currently strung out on heroin, so the likelihood of her encountering the cops on the streets was minimized because her participation in street life was very different at this time. At the time we first met, Sheryl was composed and maintained a cautious distance in her personal

interactions. She carried herself with a tough affect on the streets. As I mentioned, Sheryl stayed clean off of heroin for several weeks after we met, though she did still occasionally use crack and other drugs. As I mentioned in Chapter 4, after her multiple displacements from various SROs in the Tenderloin, she became "strung out" on heroin again. Her relationship to the police, and the hybrid cops specifically, shifted as she engaged in street-based drug activity (buying drugs or using with people on the streets) and as her body transformed back to physically looking like someone who was actively using heroin.

> Sheryl: I just got a ticket the other day. For jaywalking! He said 'Girl, I have been watching you for the last week. You jaywalk everywhere you go!' He said, 'Tonight you just jaywalked right in front of me, man!' [she said to him] Man, I'm sorry, man! I be like, fuck! I said, 'look…I got excited and ran across the street. I didn't know it was you coming down the street until you got a little bit closer. I thought it was a random car…he did a check on me and everything. And he wrote me a ticket at he said 'Just take this down to the Homeless Coalition, they'll take care of it for you.' I said, well, then why are you giving me a ticket? I mean, as many tickets, like to give out 20 tickets, what does that do for you? He goes, 'It doesn't really do anything.' Well, then why are you giving me the ticket? Fuck!
>
> Andrea: What'd he say?
>
> Sheryl: He had to give me the ticket. Man!

Sheryl was, as Sanchez and Donahue were, reflective about the meaningless charade of being issued a citation that she does not have the means or intention of paying. Both parties engage in a dramaturgical moment of obligation, but both parties also know that nothing will come of the citation. Her strategy, even in these familiar moments, however, was to avoid establishing a relationship with the police that was too close. She recognized that regardless of the fleeting familiarity they might establish, the police ultimately are in control of the terms of the interaction.

> Andrea: Are there some cops that you see all the time? I mean they see you obviously.
>
> Sheryl: Yeah, I try not to talk to them—get friendly with them—because I mean, you just start a whole new thing. I try not to get friendly with them and talk to them and stuff. You know how some people be like, 'Hey, what's up?' I'm like, shit, I try not to do all that stuff.
>
> Andrea: How come?
>
> Sheryl: Because I don't want a relationship with them! The further away they are from me, the better. Because they switch up! At any time, they switch up. They just switch up. They're cops, yeah! They'll be in a bad mood one day and just decide to take your ass in. So the further they are from me, the better I feel…a lot of times I seen the newbies [rookie cops] coming up on the block and you know just talk where people are hanging out just to see what's going on. They don't really give a fuck what's going on. They just trying to get to know people and see, you know, get to know that neighborhood. And I just speed past that. I don't care what they're talking about.

She was particularly reflective about the implications of Sanchez and Donahue's supposed compassionate documentarianism. In her interpretation, there always existed a sinister penal element.

> Sheryl: Oh Donahue, him yeah. That motherfucker. He takes pictures of you before you can get up and shit! He'll examine the whole area. Film it all. Then he wakes you up and films that too! Fuck!
>
> Andrea: So he's done that to you?
>
> Sheryl: No, I watched him do it. More than once he's done that shit!...Yeah, you know one time this dude was doing this [makes motion of someone standing up, but in a heroin nod]. He was on the corner…trying to stay up, right? And he's been there for days and days. And Donahue's just sitting in the car and they're laughing at him! I said, 'Bro!' I walk by him. 'Bro, get up! Get inside and get up!' He's all 'wha, wha whaaaat?' He looked up and seen Donahue, right? And they were laughing at him! I don't know what he had on him! He coulda' had sack of shit, you know what I mean? …That motherfucker, he plays with big dope. Dude, you can't do that!
>
> Andrea: What was he on?

> Sheryl: Heroin, you know. He was high, high, high. And he had been up for days days days.
>
> Andrea: And Donahue would roll by with the camera?
>
> Sheryl: Mm-hmm. He'll film the *whoooole* thing. So that when he needs support, right, if he decides to do something right, maybe later on he'll say 'This one time: Boom. This is another time: Boom. This is another time.' And he got all the evidence on film.
>
> Andrea: So you think that's what they're doing? They're just getting the evidence?
>
> Sheryl: Yup! Yeah! Just saying, you know, 'This is the character.' You know what I mean? And I don't think he's trying to build bad character. I just think he's trying to build, like you know, 'This is the type of person this is.' Regardless of what they are. But like I say, most of the times he's filming people that are sleeping on the street. And I think the end result is—I don't think he's really trying to take them to jail or anything. A lot of times they were taking people to the hospital! Because people can't move! That's why they're there. They're obviously sick. They can't move and they're really sick. They don't have a wheelchair, they can't MOVE. They're older, you know…Oh, you know that's why they're not being like 'hey, hey, hey get up!' They're not doing that shit no more because they're realizing that people are really motherfucking sick! That's why they're there!
>
> Andrea: And so they're picking people up and taking them to the General?
>
> Sheryl: General. Or, just putting them in housing. Eventually. Like if he catches them too many times, right? He'll be like 'This is what you can do. This is what I can do to help you.' Whatever. So he's doing outreach too…

Despite the fact that Sheryl knew the hybrid cops and that they had access to social service resources, she simply was not willing to interact with them, even if it promised access to meager resources. For Sheryl, regardless of what the hybrid cops' intentions might be in the moment, it was the fact that they were ultimately located within the penal state the made her suspicious. She also had plenty of previous negative experiences with cops and therefore recognized that the power

differential between them was too great—the cops could "switch up" at any moment.

The Tragic Mess

In this final case, I show how Lucia was keenly aware of the gendered moral economy that was the backdrop of her everyday suffering. Further, she recognized the benefit of occasionally tapping in to it strategically in moments of exceptional crisis. However, her case demonstrates the absurdity these interventions are in the face of her historic and current trauma, everyday violence, and struggles with alcoholism. When I first met Lucia she was three days into an alcohol detox, for which she had no medical supervision. Lucia is a 51 year-old woman with light skin and reddish brown hair. She is HIV positive, wears dentures, and is very thin. Her primary drug of choice is alcohol (vodka specifically), though she occasionally uses crack and various prescription pills. She had been advised by various friends and providers that this was extremely dangerous, but decided to try it nonetheless. In fact, her doctors had offered to admit her into a medical detox facility, but Lucia refused and opted to try it alone.

Lucia and I met on a Monday. The previous Friday is when she started detoxing. At 5am on Saturday morning before the sun came up, Lucia had a major seizure on the corner of Mason and Eddy Streets, a very active corner in the Tenderloin. She had been out on the streets all night, even while detoxing and lamented that "I almost made it through the night" before seizing. The first time we met, she described in great detail, but very matter of factly, the experience of seizing, hitting the concrete, and "busting" her head open. The next thing she remembers, she was in the emergency room at the county hospital. Someone must have called her an ambulance, but she had no recollection.

When she woke up in the hospital bed, she was alarmed to see the blood soaked cap she had been wearing and thick pools of clotted blood on her pillow. She had several staples put in her head on what was a pretty serious wound, though was able to go home the same night. Lucia said that hospital staff did not give her pain medication—perhaps they suspected she was an opioid addict—so she was self-medicating the pain with pills she purchased off the streets. She narrated the story the seizure in a pretty casual tone, but all the while fidgeted intensely and moved restlessly back and forth in her chair. No doubt her body was still in active physical withdrawal from alcohol. She was still feeling disoriented from the seizure and despite the recent hardships, told me "I love Jesus Christ, though. I don't have a rosary, but I have this." She pulled out a pendant with the image of Christ from under her shirt. "Haha, it's got blood on it though." The pendant was indeed smeared with blood from the fall.

I accompanied Lucia while she ran several errands downtown one morning. First, she needed to go to the check cashing store to report a stolen check, then she needed to go to the nearby clinic to get her blood drawn for follow up care after the seizure, and if there was time, she would show me her room at the Alden Hotel on Eddy Street. On the first few occasions we met, she was dressed stylishly in a studded velvet cap, a loose sweater, and sneakers with an all-over print of tiny skulls. She was immediately extremely warm with me and our friendship developed quickly. My mother had just been diagnosed with breast cancer and over the first few months of knowing each other, Lucia called often to inquire about my mom's health and even sent along a medallion of St. Peregrine inside of a Christmas card for me to give to my mother when I visited for the holidays. Lucia did not have many women friends and spent most of her time drinking on

the street “with the Indians,” a group of Native American men who congregated daily mid-block to drink alcohol and socialize.

As we approached the corner that day, I saw some hesitation in Lucia’s step. She peered down the block to the area where a large group of young African American men were congregated. This was one of the locales that the Tenderloin Police Captain talked about where young men from the East Bay come daily to sell drugs to the neighborhood residents. As we got closer to the group of men, it became clear that two men were having an argument, shouting directly into each other’s faces as a larger group of men surrounded them. We got about ten feet from the group, when Lucia grabbed my arm and pulled me into the busy street. “Come on!,” she yelled, “let’s not get in the middle of that!” She pulled me suddenly into traffic and ushered me through oncoming buses and street trolleys. “See,” she shouted back at me as she noticed my nervousness about getting hit by the traffic, “this is how I get jaywalking tickets!” This was the first of many times that I got to see the level of caution by which Lucia navigated the neighborhood. On one level, she was trying to shelter me from situations that might be potentially dangerous or uncomfortable. On another level, Lucia had a hypervigilance that always seemed simultaneously rational (because of the intensity of the neighborhood and her past history of trauma) and also at times seemed like debilitating paranoia.

We went to the busy public clinic at the edge of the Tenderloin. This clinic space can be intense, and though on the morning we went it was reasonably calm and Lucia was seen quickly, she was still anxious and jumpy while we were there. Plus, the long, narrow hallway that serves as the waiting room for patients had quickly filled with the stench of an overflowing toilet in the nearby bathroom. Lucia was anxious to get out of

the clinic. She had her blood drawn and immediately suggested we get a cup of coffee and head to her hotel. It quickly became clear to me that Lucia was quite popular (to some infamous) on the streets of the Tenderloin. At every corner we turned, there was someone else to greet her excitedly, shouting "Hey, baby!" across the street to get her attention. We passed a man sitting on a fire hydrant and Lucia stopped to tell him about her seizure. "But, have you been drinking?" he asked. "You better not be drinking. I don't want to see you out there on your corner like that." He then gestured to the corner and told me that Lucia will always be on that corner if she is drinking. Many of the local business owners knew Lucia as well. As we passed a thrift store, the mother and daughter who work there peered out the doorway towards Lucia. Lucia looked at me and chucked, recalling "They're looking at me 'cause they remember me running down the block naked the other day." A few days before detoxing, Lucia had gotten drunk, blacked out, and does not remember how, but ended up on the street completely naked. She made it two blocks before two police officers approached her. They knew who she was and where she lives, so rather than arresting her, they simply walked her back to her apartment building and ensured she got back inside her apartment.

Lucia lives in a small studio apartment run by a drug treatment program. She is enrolled in their sober living program and was fortunate to secure permanent housing in this building. Unlike many of the options for housing in the Tenderloin, Lucia has a small one-bedroom apartment. The unit has its own bathroom, a kitchen, and even a walk-in closet. I was surprised at how much it looked like any other apartment building in San Francisco—drab grey carpet, white washed walls, and plain wooden doors. Lucia opened her apartment door and we squeezed by a huge pile of clothes, probably four feet high,

near the front door. Lucia had built a small altar with a few images of Jesus, some dried flowers, and other trinkets. She had a twin bed, a small television and stereo, and a shelf with probably 60 orange pill bottles. Lucia was not on HIV medication, so they were likely a mixture of anti-depressants and pain relievers. The room smelled strongly of cat urine. Lucia has had a couple of cats in this room in the last few months, but they get taken away by the management after she drinks, blacks out, and the cats end up roaming the building. Lucia explained that she used to have nice, antique furniture in her room, but that one night while drinking she had inexplicably loaded all the furniture into the elevator and put it out on the street. Lucia's apartment was fairly average, albeit a little messy, except for one thing. The carpet was filthy, covered in a thick layer of cigarette ashes amongst stains of other various colors. And, in the corner near the bed, there was a small pool of vomit that had been stepped in and smeared into the carpet.

Despite the fact that Lucia's living situation appeared on the surface more stable than many of the women who live in the daily rate or even supportive hotels, Lucia really struggled with her mental health and history of trauma and a constant state of intense anxiety about her own safety. Lucia often felt fearful of violent retaliation in her own building because of previous conflicts with two men who lived on the floor below. She had invited them into her room one night while she was drunk and they stole a check, forged, and cashed it. She filed a formal complaint with the bank, but her fear of retaliation from the men was so intense and all consuming, that she quickly withdrew the complaint and made a plan for how she would survive with almost $400 less that month, nearly half of her monthly SSI earnings.

She told me that one night while she was sleeping, she heard someone screaming "Bitch!" into her doorway. The couple in the room next to her also frequently had verbally and physically violent arguments. Lucia felt that sometimes when the man was yelling, his shouts were directed at her. She also worried that he would break and climb through the window of the airshaft that they shared. She felt that the anxiety of her home life would be exacerbated by continuing to drink alcohol and that is why she decided to detoxify the weekend she did. However, stopping drinking meant losing her social network and she became extremely isolated. In fact, the other day she was walking down Eddy Street and saw that her friend was handcuffed against a wall and surrounded by several police officers. Her friend often gets intoxicated and becomes violent. On that day he had punched a man on a bike and the man had pulled a knife on him. As Lucia was passing, her friend called her over. But, she opted instead to walk down the block and watch from a far. Lucia said that since she had gotten her SSI check on the 1st of the month, she was trying to avoid her drinking friends, but unfortunately, she said "I don't know anybody else. Since I've been in that life." She too was strategically practicing social isolation to keep herself away from conflicts, maintain her safety, and to avoid police contact.

Over the next month, I saw Lucia's stress levels escalate significantly. She still had not been drinking, but her depression and anxiety intensified and were almost unmanageable. Her street vigilance had also intensified. One day we were walking down Market Street together and she took off her glasses and put them away. When I asked why, she told me, "I don't like to walk in the street with my glasses…I've gotten my nose broken too many times." Her social isolation was taking its toll as well. She hoped maybe

she could find a friend on the street that was not too drunk and could maybe watch a movie with her. Or, she said, maybe she would go and spend a night in the homeless shelter nearby. She felt increasingly unsafe in her apartment and in order to avoid spending time there, would take long strolls around downtown. She even had the local nuns come and cleanse and bless the space, but she still felt uneasy.

During this time Lucia had gotten a concerned call from her doctor at the county hospital's HIV clinic, where Lucia received her primary care. According to her most recent labs, Lucia's T-Cell count had dropped drastically, down to only 73. They had never been this low, as she usually fluctuates between at least 150 and 300. Her doctor was very concerned. Lucia had missed her appointment at the clinic the week before and the doctor was interested in trying to arrange transport from the Tenderloin to the hospital. Lucia was already anticipating the conversation with her clinician and that she would likely be advised that it was time to get antiretroviral medications. Current Department of Health and Human Service guidelines recommend that people be counseled to initiate HIV medications when their T-cell counts drop below 500. But Lucia did not want to be on medication at this time and hoped her "numbers" would improve simply because she had stopped drinking.

While we were walking around the neighborhood one day, the man who Lucia identified as her long-time stalker passed us on the street. Since I was walking with her, he did not make any attempts to engage with her. They had a troubled relationship that spanned several years but one incident in particular had left intense physical and emotional scars—he had brutally attacked her on a nearby street. After this incident, Lucia had vowed to get a restraining order and never see him again. But in the last few

weeks he had approached her in front of her building and asked her for a cigarette. She regretfully told me that one day recently she had gotten intoxicated and apparently invited him up to her room in a complete black out. She woke up in terror because she opened her eyes and he was asleep on the floor.

Andrea: You guys were in a relationship?

Lucia: He called it that. I went out with him, I figured out, five weeks in two years. It was like a week and then…I didn't go out with him for two years…and then I went out with him and couldn't get away from him for a week. So I mean, all together it was like a month in two years. It's not a relationship. It's not like some heavy duty living together boyfriend/girlfriend. We were like a little fling. That's what I told him one day too. As long as you feed his ego, he's okay. But when he sees you doing real good, like today…he goes, "Oh hi." He sees us looking all nice and then he's doing real bad. He's still homeless after all these years and with all the rain.

Andrea: Was he violent with you other times too?

Lucia: No, he hit my nose a couple of times, fighting with him. I get drunk and I just kinda go [but] I wouldn't want to fight with him. Then he had this camp and I went down to his camp with him. I went down to his camp and I couldn't get away from him! One night he hit me and the cops were right down the street and I started to holler for the cops. He says, 'If you say anything, I'll get out [of jail] and I'll kill you!' He's just horrible. But, when I got drunk last time and it was on the street, instead of him coming up and being violent and stuff he actually helped me a couple of times and gave me a Saint Michael card—tried to be friends. That's why I ended up inviting him up like that. I had OD'd [overdosed] because I took too many pills and then he tells everybody oh that he saved my life and all that. And I was like, I would have been fine! But when he gets real gross, he looks at you like a money—it's all because you have your [SSI] check and shit. Like the day I left him I had just gotten my check. And he came looking for me. Everybody was like, 'He's looking everywhere for you!' And I just didn't come back to camp. I had an appointment to go see the lady about my housing and I just kept going.

Andrea: So where were you guys at the time?

Lucia: I just left him like that and then I ran into him on Church Street the other day. I had my check and I was smart. There was this real tall homeless friend of mine named Bill. I told him to go with me to get my

> check, so he was with me when he found me. And he's like 'You're cheating on me already?' I didn't see him for like eight months. I ran into him at the clinic and he acted all like just 'Hi, you got a light?' But then he found out where I lived and he started going down there. He'd run up behind me, 'Can I talk to you?' I said no, I don't wanna talk to you. [He said] 'I'm gonna fucking kill you!' Then he'd go off on me. For the first years after I left him.
>
> Andrea: But you weren't at this building where you're at now?
>
> Lucia: It was even worse because there's nobody around down there on those streets walking.
>
> Andrea: And where's that?
>
> Lucia: Down 6th and Howard. So like, you'd be walking on a block and you'd be all by yourself…I didn't want him to know where I lived up here…finally he just started walking by and he'd say hi or something. I didn't like his look too much today.

He had attacked her in the past and she had attempted to get a restraining order. But the police could not serve him the papers because they could not find him due to his own housing instability. Regardless of whether the restraining order would have prevented this future attack, the police had failed her when she needed and sought preemptive protection.

> Andrea: Did you ever get the cops involved in any of that?
>
> Lucia: At first I had a couple of stay aways, but they could never serve him the papers to go to court, press charges, because he's homeless and you have to find him within eight days…which is a really screwed up law. If you're homeless, by the time the court date—if it's not served, then it's no good. So, I was—the first time he hit me—I was staying at the hotel up here…And I was right here getting a cigarette butt. And he came up behind me and just pow! [he started punching her in the face] Broke my jaw…And I get to the corner and he's sitting there…like he was going to play it off like he didn't do it…
>
> Andrea: So then what happened? What did you do?

> Lucia: [he shouts at her] 'Well you better get outta here or I'll chop your head off!...Then they took me to St. Vincent's or St. Anthony's or whatever, St. Francis. I was in so much pain and I was shaking because I didn't have my drink on me. I was a real heavy alcoholic. So I left the hospital, walked back, bummed two dollars, got a half pint, for the pain! …I was sitting right over there and the store called an ambulance. And two cops sat there and watched me drink the bottle. They knew I needed it! I was like, I said, 'Please don't take this because I just got it for pain! And so they just let me sit there and drink in front of them. They said, 'Who did this to you?'
>
> Andrea: Were those cops that you knew…?
>
> Lucia: Oh yeah, probably. But they just let me drink and said 'Take a seat.' Bit half my tongue off! And my tongue has a big old slice. That's where all the blood was from. My friend said 'I'll loan you two dollars to get a drink, but I doubt that they'll charge you looking like that! You know, blood all over my hands and shit! But I did, I went right in there and they gave me a half pint.
>
> Andrea: Oh, so they gave it to you?
>
> Lucia: Well, I paid. But they gave it to me. Even looking like I normally do, they would say, 'No, no.'
>
> Andrea: Do people do that where they kinds cut folks off like that?
>
> Lucia: Well the cops had actually told them [the shop keepers] not to serve me anymore.

The irony of the fact that the penal system was not able to protect her from a documented and repeated stalker, but was able to intervene and regulate her drinking behavior is astonishing. As we were walking down the street, Lucia showed me the fence where she and her drinking buddies used to sit until a shop owner called the police so frequently, they finally decided to relocate. But they still occasionally sat along this fence, especially when the sun moved and the other side of the street was too shady and cold.

> Andrea: Did you guys get tickets?

> Lucia: No! Not until—the cops would actually write a ticket and go 'Go ahead, tear it up.' Because they know we tear them up. 'You can rip it up.'…

Lucia's days spent binge drinking and smoking crack on the streets of the Tenderloin had made her a recognizable figure to shop owners, neighborhood residents, and police. Her motivation to be on the streets was sometimes simply social and other times triggered by the paranoia she experienced while alone in her apartment. But since she frequently blacked out while drinking, she put herself at great risk for violence and regular encounters with the hybrid cops. She was very aware of the gendered nuances of her interaction with the police on the streets of the Tenderloin. She said:

> If they tend to take a liking—like if they think that you're fixable, they'll bother you more. If you're a girl that they think has possibilities. If they think you're just beyond help then it's just kind of like 'give 'em tickets and leave 'em drunk on the street.' But if they think that is' somebody that's fixable, they keep picking them up and anytime they see them drinking so that they figure they'll [the woman] get tired of it and they get themselves in help [a drug treatment program] and stuff like that. They see you in really bad shape and they figure if you're in bad shape, 'we'll take her in and maybe she'll get tired of going to jail.' They took me in one time, two times in row! They take you down and put you in a drunk cell.

She acknowledged the complexity of her relationships that toggle back and forth between familiarity and punishment:

> There's a couple [cops] I like and I've had them buy me a drink! Down on the street one day. I forget what it was and I warned them about something [she tipped them off]. And he says, 'You want something from the store?' And I said I need my drink for the morning. And he went in and bought me a half pint [of vodka]. Yeah that was funny. I could have gotten a whole pint. I still think about that too. He was like, 'do you want something to eat too?' And I'm like 'No, just my drink.' Then I started getting myself in a little bit of trouble and they didn't want to help me out anymore.

In many ways, Lucia was the most challenging relationship that I developed during dissertation research. Part of this was a result her drug of choice—alcohol. When she drank and blacked out she often made disturbing choices (e.g., inviting her stalker into her room) and could be violent. In fact, during one appointment with a researcher on another study at the community-based field site that I also worked at, Lucia had assaulted the interviewer, calling her a "Bitch" and throwing a large terra cotta pot at her, striking her in the face. Lucia was permanently banned from the field site and everyone who worked there was instructed that if she ever attempted to come back inside, they should call the police. After this, when I would run into her on the street, she was a mess physically. She was no longer putting effort into how she dressed or maintaining basic hygiene. She could also be sexually explicit when drunk and could not maintain any physical boundaries. I often ran into her on the street while she was belligerent and she would have blood caked on her face.

What Lucia's case makes apparent is the absurdity of the interventions that happen within this gendered moral economy, when her need for mental health treatment and social support are so great. The "favors" that cops did for her in cases of extreme crisis (e.g., taking her home when she is blacked out rather than arresting her, allowing her to drink on the street after suffering a brutal assault) point to the failures of both the penal and social service systems to intervene meaningfully in her life. That she had to grapple with the gendered moral delineations of whether she was "worthy" enough to be granted these measly acts of kindness speaks to the level of social suffering that is sanctioned in these contexts of extreme poverty and social marginality.

Summary Analysis

As these four sections of case material show, women have varied modes of engagement with street-based law enforcement. But what is a telling commonality, is that they all have frequent experiences and conscious modes of engagement with them. Natasha lives in the quasi-institutional SROs, as a drug runner for her boyfriend. She actively avoids police because engagement with them could, at any moment, destroy the minimal amount of stability that she has been able to establish for herself. As a result, she is extremely socially isolated and endures a relationship that poses immediate HIV risk. Liliana lives in an institutionalized SRO and is no longer engaging in sex work or using drugs. However, she uses her past friendly interactions with police as a way to make sense of her prolonged suffering. That she perceived the police recognized in her a glimmer of humanness is now extremely meaningful for her, as she did not receive this recognition from other sources during her addiction. Sheryl wages an important critique of the hybrid interventionist cops. She suggests that despite the friendliness or minimal amount of help that they may be able to afford her, she ultimately cannot trust them because at their foundation, they fulfill penal mandates. Finally, Lucia's case demonstrates the absurdity of help that she is afforded in these contexts, when her need for intense and sustained intervention is so great.

Taken together, the cases demonstrate a tragic situation—that within the context of poverty in the postwelfare era, women's only recourse for survival may be through participation in illicit economies and/or to leverage their gendered suffering in a moral economy. However it is significant that this leveraging must be done through the channels of the penal state. Thus, there is no escape from the bifurcation of their subject positions as simultaneously criminal/victim and women are forced to ruminate and

negotiate their own worthiness through the juridical lenses of an institution whose primary function is to penalize them, even as it promises minimal care and potential for salvation.

Chapter 7

GET SICK TO GET SAVED?

In the previous chapter, I showed how women negotiate a context where social services and referrals are mediated by the police, who traditionally only perform right-hand functions of the state. I show how in my ethnographic context, there is a blurring of the division between the left and right hands of the state and women in this context develop strategies in this context to access resources needed for basic survival. In this chapter, I consider an institution whose primary mandate is to deploy care—the safety net public hospital, where women access primary care for chronic and acute conditions, In this chapter, I reorient this analysis to show how too, even in a critical traditional left-hand institution of the state, the right hand's punitive logic penetrates into clinical interactions between doctors and patients. These interactions which one might imagine are wholly therapeutic become infused with moralizing discourses and punishment, especially in regard to women's current and historical drug use. Thus, this traditional left-hand institution administers care alongside punishment, which can result in great bodily suffering for women.

Using case material from two key informants, I examine how women manage their chronic health issues, while also being marked as "addicts," and navigating punitive logic that is deployed by their primary care providers in clinical interactions. Women's history with addiction and how they are marked as "addicts" becomes central to their experiences even as they engage with relatively progressive institutions of safety-net health care. In this chapter, I seek to theorize the ways in which the categories of

“addiction” and “addict” circulate in the context of hypermarginality and function, as Raikhel and Garriott suggest, as a “trajectory of experience that traverses the biological and the social, the medical and the legal, the cultural and the political” (2013: 8).

Specifically, I examine how women negotiate care for their acute chronic illnesses in a large, socially progressive public hospital, yet confront unique challenges because of their histories of and current drug use. I demonstrate how though the barriers to accessing critical care for their ailments may seem paradoxical given the network of social services available to them, that, in fact, “addiction”—conceptualized here as a particular trajectory of experience for the hyper-marginalized urban poor—contributes greatly to the interruption of their care, shapes their negotiation of interactions with primary care providers, and intensifies their bodily suffering. Addiction in this context, therefore, is not meant to reference women’s individual drug using practices or the level to which they are physically dependent on particular drugs, but instead, a point of reference to examine the experience of accessing chronic care while negotiating the stigmatized subject position of “addict.”

In this chapter, I will first provide an overview of the County Hospital and its role as a safety net institution in the provision of medical care and social services for the urban poor. Next, I will contrast the experiences of two women, examine the precursors to the emergence of acute health issues, and their experiences of navigating the broader care system. I hope to demonstrate both how both habitual drug use and being ascribed the subject position of an “addict” intersects fragmented service provision and ultimately contributes to their further hardship and bodily suffering. Further, I demonstrate

paradoxical blurring of the left and right hands of the state and show how in a traditional institution of "care," punishment is also deployed.

The County Hospital, located at the eastern border of the city's Mission District, is the county hospital run by San Francisco Department of Public Health, in collaboration with the University of California, San Francisco. It is the center of the city's safety net health care system, offering emergency, urgent, and chronic care to indigent urban populations, and is a global leader in HIV/AIDS research and health care provision. The campus houses a large main hospital plus several other buildings that house various clinics, administrative, and research programs. For the hypermarginalized, the sites at the hospital that are critical nodes in their network of care are the emergency department and wound care clinic, located in the main hospital, Psychiatric Emergency Services (PES) located in a stand-alone building on the south edge of the campus, and the methadone clinic, HIV/AIDS clinic, and urgent care clinic all located in the same building, where I was also employed. The hospital is the city's only level one trauma center, so the emergency room is often an impacted, chaotic environment as it receives all the city's gunshot wounds and other trauma cases. The staff work in a high-stress and often challenging environment, as they confront not only acute medical issues, but also the social issues that impact the provision of routine medical care: homelessness, mental illness, active drug use, patient distrust of the medical system, and other barriers to providing and maintaining continuity of care for this population. This is the site where the most acute of the "everyday emergencies" of the hypermarginalized play out.

The two case studies below trace two women's negotiation of managing their acute chronic illness issues within various clinics at the hospital. There are critical

differences between them that reveal the politics of entitlement to health care and social services (one is HIV negative, the other is HIV positive; one does not have GA or SSI and hustles daily for survival, the other has SSI and MediCal; one moves between the daily-rate private SROs and shelter stays, the other is more stably housed at one of the city-run supportive hotels). Both women are long-time veterans of the drug scene and are extremely savvy, opinionated, and capable of advocating for themselves. For these reasons, it is particularly mystifying that they both encounter barriers to accessing the services and care that they need, which causes extreme bodily suffering, emotional distress, and the intensification of their chronic health issues over the course of the time that I was doing research. These cases demonstrate the implicit ways in which their navigation of engagement with institutions of care is mediated by their bifurcated subject positions of "patient" and "addict," and therefore the lines between therapeutic and punitive interventions into their lives are blurred.

"I'm just blessed": Homelessness, Addiction, and Acute Kidney Failure

I do not remember the first time I met Lilah. Perhaps it was because she is one of the most well-known figures around the Mission hotel corridor among residents, clinicians and outreach workers, and researchers working in the area. In fact, when one of the large epidemiological studies I worked on was operating out of a community-based field site nearby and Lilah walked in to screen for the study, my coworker told me that Lilah was nice in this context, but she maintained a cautious distance. My coworker had seen her violently assaulting another woman near the subway stop and noted that no one in the bustling drug scene there who witnessed the beating had dared attempt to intervene. Although Lilah and I had a good relationship (she saw me largely as a well-

meaning outreach worker and resource for getting into paid studies), I had heard many notorious stories about how unpredictable and erratic she could be, especially while high on Klonopins. Klonopins are a benzodiazepine used to treat seizures and panic disorders. They were one of Lilah's favorite "party drugs," although she primarily used heroin and crack. Timo, the outreach worker who used to live in the hotels himself, told me how the first time he ever met Lilah, she was high on Klonopins. She had pulled a gun on him and tried to mug him, though the gun later turned out to be a fake. Her partner, another long-time veteran of the Mission drug scene, who we occasionally saw in the daily-rate hotels and who I knew from other studies, truly dreaded Lilah on Klonopins. As it is, she "doesn't take any shit" he said, but while she was under the influence of Klonopins, he was bound to get threatened, punched, and kicked.

As I mentioned in Chapter 3, Lilah was a nearly two-decade veteran of the daily-rate hotels. Like many of the women in the corridor, she regularly cycled between jail, drug treatment, shelters, hospitalizations, and staying with friends. I had met her in 2010, but in early 2011, I started seeing her on a regular basis. One night at the Yash Hotel, she opened her room door to get supplies from the outreach team and we were all shocked to see how emaciated she looked. She was wearing a baggy sweatshirt, jeans, and a beanie. This stood in contrast to what we often saw her wearing on the streets, near the local sex stroll—short skirts, shiny tops, zip-up boots, and extravagant wigs. Lilah had recently been terminated from her long-time methadone program, a privately run clinic on the Western edge of the Tenderloin. Though Lilah herself could never understand the entire rationale, apparently a counselor from the clinic had allegedly seen Lilah exiting a building early one morning and suspected Lilah had been involved in a burglary there.

She had not been arrested or charged with anything, but the counselor nonetheless told her that she was terminated from the program, for suspicion of violating clinic rules. It was no surprise that Lilah was not able to engage in a formal dispute resolution process to get herself re-enrolled with the clinic—her opioid dependence was such that after missing one methadone dose, she was immediately experiencing violent withdrawal symptoms.

Lilah did have access to an extremely low-threshold intervention into this initial problem of getting terminated from her methadone program: the outreach team literally showed up at the door of her hotel while she was battling withdrawal and we provided her with a referral to enroll at the methadone clinic at the County Hospital. But here is where system failure starts to become clear: first, why was Lilah, a long time opioid addict and methadone clinic patient terminated from her program without linkage or referral services from the clinic to one of the city's other methadone programs? There exists no formal coordination between them in a situation such as this. Her termination was solely punitive. Second, the SRO outreach team, as a matter of circumstance, encountered Lilah and we were able to provide her with a referral to the other clinic a few days after she was terminated. However, in the few days between, Lilah needed to treat her acute withdrawal symptoms which were intensely miserable and so she had already quickly immersed herself in the drug scene and was purchasing opioids on the streets to alleviate some of her excruciating pain and sickness. Because of our model of service provision as low-threshold outreach workers, we did not coordinate directly with the methadone clinic to which we provided referrals. So we had no institutional channel of communication with the county clinic to say we had referred somebody who may be in need of follow-up. Lilah would have to handle that all on her own (linkage to the clinic,

transportation), even in acute opioid withdrawal. This potential moment of linkage to methadone enrollment demonstrates the limited capacity and fragmentation of these safety net social services to meet the needs of a patient suffering through intense withdrawal. Plus, in retrospect, no one considered her withdrawal an "emergency" in the same way it would have been if we had encountered her with an acute injury like a broken leg. She would have to, in the mean-time, endure intense pain and misery.

Over the months of my field work, I stopped seeing Lilah regularly, as she bounced around between hotels and the shelters and I was hospitalized and recovering after surgery. In fact, it took Lilah nearly a year and a half and near death from kidney failure to get re-enrolled in methadone. On this night in early January, as the outreach team provided the referral to the county clinic, Lilah recounted the terrible pain and discomfort of methadone withdrawal she was currently enduring. She had tried injecting heroin, methadone pills, and oxycontin that she bought on the streets, but nothing was alleviating her withdrawal from her daily dosage. The weather had been unusually cold and damp and so the crippling chills from withdrawal were amplified. She was nauseous, in pain, and immobilized. A month later I finally saw her again at the Yash. She still was not re-enrolled in any methadone program and had been buying pills on the street to mitigate her dope-sickness, but she needed to take at least five pills a day in order to avoid the onset of severe withdrawal. By March, she was still buying methadone pills and also occasionally doing Klonopins, much to the chagrin of her partner.

The first time I sat down with Lilah to do a life history interview in early 2012, we were already well-acquainted with each other. She was still buying drugs on the street and was managing her withdrawal from methadone as best as she could. When we sat

down to talk, I was surprised by how she immediately launched into gritty details of her early childhood sexual trauma and multiple suicide attempts before the age of 18. She was born and raised in San Francisco, by a single mother who Lilah readily acknowledged had serious mental health issues. Starting at the age of nine, Lilah began to endure sexual abuse from her mother's boyfriend. Lilah's mother refused to believe the allegations when Lilah came forward. This caused intense conflict between Lilah and her mother and at nine years old, Lilah made her first suicide attempt—she took a handful of sleeping pills that belonged to her mother. The second time Lilah attempted suicide, she threw herself off of a building and miraculously survived with few injuries, except for a knot on her head, which remains to this day. The third time, she slit her wrists. Her mother admitted her into a mental institution, where she spent several months. Upon her return to the household, Lilah's mother eventually caught her boyfriend in the act of abuse. Her mother apologized profusely for not having believed Lilah and they have spent years trying to rebuild their relationship. But, as Lilah says, "the damage had been done…I had my childhood robbed from me." She endured much subsequent trauma and physical and emotional abuse in her household before she turned 18. She says of her childhood:

> Nobody was malnourished, but there's a lot of things, deep, heavy things that went down. But, we're still living. So I'm blessed. Even though I came through that way, I mean, I'm still here…I'm still here. And God obviously has a plan for me because I literally tried to kill myself. I would have been dead three times! And I'm still here. He gave me a chance…Obviously he doesn't want me to go. He's not going to let me go until he gets rid of me.

When she was 18, she became involved with a man who was using heroin and she moved out of her mother's house. She says that "that was the beginning of the end." She

started using heroin and drinking alcohol regularly, then eventually started using powder cocaine and crank. In the early 1990s, Lilah actually managed to secure one of the now-coveted Section 8 housing vouchers, which were then more readily available. Section 8 is the program run by the U.S Department of Housing and Urban Development, which provides vouchers for low-income families to secure housing in the private rental market. Funds are dispersed through municipal housing offices. Demand for this program in San Francisco is so high, that it was often rumored that the wait list for Section 8 housing was nearly a decade. As of 2014, demand is so great that the San Francisco Housing Authority has officially closed the wait list and no new applications are being accepted. Lilah was placed at the San Francisco Housing Authority Rosewood Projects just a few blocks away from the hotels. These low-rise cinderblock projects were demolished and rebuilt in the mid-2000s, but back then they were a notoriously rough housing project. Lilah recounted her gendered experiences of moving in to the unit:

> The first night I moved in there to Rosewood, boy I was scared to death. It was off the hook! And they seen the only woman coming through here too. That was fucked up! It's like wow, they seen me coming. And I wouldn't buy no drugs over there because I didn't want anybody to know that I did anything. Because I didn't want them to take advantage—try to take over my house. I heard them taking over single women's places and shit, so I stayed really low key. And I started coming over to the Mission [to buy drugs].

Lilah describes this time period in the drug scene with a kind of romantic nostalgia for the days when the dope was in abundance, it was infinitely better than today's heroin, and "nobody had to steal nothing from nobody." At this time, heroin users could also run credits with the dope sellers and if you brought in three customers, you would get a free baggy of heroin. The abundance and accessibility of heroin at this time, she said, meant

that “there was no reason people needed to be [dope] sick over here,” so the level of the visible, street-based desperation of the heroin addicts that one sees today simply did not exist. Plus, she said, “There was respect, you know what I’m saying? And it wasn’t a lot of people running around here stealing and jacking people.” This image of a romantic past she had experienced when she first arrived in the neighborhood contrasted with what she saw now:

> Lilah: It looks terrible. It just looks—it just don’t look right. It’s not the same at all.
>
> Andrea: Did it feel safer back then?
>
> Lilah: Yeah! Safer. I’m serious, it did! It was safer. You didn’t really hear nobody getting beat up…none of that! It was safer! You know what I’m saying? And the police—it’s funny too because you didn’t see so much prevalence—police prevalence—out there that you do now. It looks bad, it really, it’s like when you see a lot of police and shit, it’s a negative thing. It don’t look good. That don’t look good. And it just, you know, it’s like a bright, sunny side back then. Now it’s just dark, grey area. Dirty. And it’s funny, but that’s how I feel. People all the way around. I mean, even dope—they call the dope fiends—or whatever. They had smiles on they faces! I’m serious!...you didn’t see nobody sitting there, [begging] ‘Huh, can I get something to eat, ma’am, blah blah blah.’

Eventually, due to bureaucratic complications with her GA check, Lilah missed payments on her unit at Rosewood, which with her subsidy was only $80 per month for a one bedroom apartment. She lost her Section 8 voucher and slot at Rosewood. With no other housing options and a familiarity with the corridor where she bought drugs, she went directly from there to a daily-rate SRO.

Now that Lilah, because of her methadone program termination, was forced to buy drugs on the streets regularly to stave off withdrawal, she was reflective on this past era of abundance:

> Lilah: Mission Street is hard as hell to find anything these days. Seriously. I mean, at one time years ago it was okay. But now, you very rarely can find anything over here. That's really tough. Especially pills and shit…you gotta go downtown for your pills. But it's always been like that. Pill Hill [a corner well known for copping pills in the Tenderloin]. I mean that place is getting really hot because of the police, but as far as finding any pill you want, you can get that in the [Tenderloin], not here. You be lucky if you find a Tylenol over here.
>
> Andrea: I wonder why the pills don't make it over here?
>
> Lilah: Well, like I said, they done fucked up and ran people off so much.

Lilah is referencing the recent intensification of police presence in the Mission, after a series of high profile shootings and recent gentrification, which had generally increased police presence.

The next time I saw Lilah was nearly five months later. I had not seen her in the daily-rate hotels during outreach or other fieldwork and we had all wondered whether she was incarcerated or in a drug treatment program, or worse. I was at the hospital one day to visit someone in an in-patient hospital Ward, but I had missed the window for visiting hours. As I was lingering I, not-surprisingly, ran into Lilah near the bus stop where people from the hotel corridor often congregate to wait for the buses after appointments or getting their methadone doses. The hospital is spatially close to the hotel corridor—in fact, it's just a mile away and would take about 20 minutes to walk from the hotels. But people rarely walk. So the two bus lines that feed the hospital from the Mission and Tenderloin and the associated bus stops where people wait become fascinating extensions of the hotel/drug scenes. This is especially true at certain times of day, when people flock to the methadone clinic.

Lilah was looking incredibly thin and I was shocked to hear that since the last time I saw her, she had been notified that she was in acute kidney failure and had nearly

died. She was on her way to the dialysis clinic, her mandated treatment. While we excitedly caught up, Lilah took me through a maze of breezeways, unmarked stair wells, and multiple elevator rides to finally get us to the dialysis clinic. The campus is vast and includes several old red-brick tower buildings (one's classic image of an eerie mental institution) and then a large main hospital building. Because the buildings are old and have undergone many additions over the years, the campus is a very complicated maze that is difficult to traverse. Lilah navigated us through like a professional, however, though I doubted I would ever be able to replicate the path we took. We were greeted at the clinic by two nurses and Lilah was led to a large red reclining vinyl seat.

Lilah started to unpack all the provisions she had brought with her to pass the time, various snacks, drinks, and magazines. The nurses came and began to examine the catheter port that she had surgically installed to receive the dialysis. She knew the nurses would be upset with her because she had, once again, ripped off the dressings that are supposed to keep the surrounding surgical wound more sanitary. Next to Lilah's chair there was a man, fast asleep and snoring. The man looked street homeless—he was dressed in layers of tattered black clothing and had large bundles resting next to his chair. The nurses hooked Lilah up, put a mask on her face to minimize risk for infection, and started up the dialysis machine. Lilah, knowing that I was eager to hear, began to retell the story behind what led to the discovery that she was in acute kidney failure:

> Lilah: Anyway, how I got sick. I was at the Diamond Hotel and I was sick and I thought it was due to—my tooth had flared up—my wisdom tooth was flared up. I had a temperature and I was kicking methadone from the clinic because they terminated me. So I was buying pills as best I could, but I couldn't buy too many pills. My habit started getting—it wouldn't suffice. So I ended up—it was like maybe two weeks after I had been off of methadone, after I couldn't buy no more pills, okay. I ended up buying some dope from this guy named Dice. Well, come to fine out later it was

not dope. It was some kind of sugar mixture that they had made up. So I ended up coming to the Hospital because I had an abscess on my neck. It just blew up. It burnt a hole in my vein. The needle would go straight in. So I went to the hospital for that and it ended up busted…on the bus on the way there. So I turned around. You know, I was relieved. So I went up to the Diamond and laid down. In the meantime my rent had got behind and I was having a hard time, so they told me that I had to move out. He couldn't do it no more to hold me [give her credit on her room until she could pay.] So I was sick. I didn't have no help. I pulled all my stuff out of the Diamond. I was sitting at the [subway] station, I was just thinking and I was saying to myself, 'Man, you know I'm tired of this lifestyle' blah blah blah. 'I'm gonna go try the shelter route…I need help.' I didn't want to sleep on the street. So I went there and I was sick still because I had a temperature and all that. I went and got me a bed, a ninety day [shelter slot].

Now in the meantime my legs and stuff are swollen, but I didn't know what it was. Well, this one was a little more swollen than the other one, so I figured maybe it's water or something. You know, anyway, I went to the shelter, checked in for that night…I was sick. Didn't have no money still. I still had this thing [referral], so I was gonna try to get another free slot [temporary shelter bed] somewhere. In the meantime, I went on Mission Street, trying to [do sex] work and all that shit. I get lucky and catch a date or whatever. I end up buying a bunch of Klonopins, some Phenergans, some methadone pills and I took them that night. Took 'em, blacked out. I ended up here at [the] hospital. 5150. So when I came to and stuff, they said that I had tried to kill myself. I'd been there for three days…they let me go after three days and I went to the shelter. I hadn't lost my bed because I told them I was in hospital blah blah blah. So in the mean time, I'm hurting, I'm swelling, but…

Andrea: Did they 5150 you out of the shelter or out on the street?

Lilah: Out of the street. For whatever reason. They found me out. Anyway, when I came to I was at the hospital, like I said. And some reason or another, I had in my pocket, when they started to release me—I looked and it was a paper that said a referral for [the methadone clinic]. So I went, somehow or another even in my daze. I must have told the doctor that I needed help and I wanted to get on the methadone program. So he must have given me this referral. That's the only way, but I didn't remember how I got it. So that morning, I went in there at 9 o'clock to try and get on [enrolled in the program] and I was still so extremely induced by the drugs. I went through the first interview with [the intake coordinator] and then we had to get the appointment where he had to draw blood and they needed me to take the pee test to see how much—what I was having trouble withdrawing from. And so I go to the bathroom and I

> did everything else. I got in the bathroom and pee and…it was 9:45. At five minutes to 11, he's knocking, knocking, knocking. I had passed out in the bathroom. I was loaded and whatever the case may be.

The nurse told Lilah that she could not complete the remaining registration process that day and told her she would have to come back the following day because their registration hours were over. Here, another system failure is evident. Lilah is released, disoriented, after an intense drug-induced black out, which apparently was severe enough to warrant a 5150. Somebody, possibly the doctor who handled her case in the emergency room, like we outreach workers, had provided her with a much-needed referral to the methadone clinic, which is just a block away from the main hospital. Miraculously, Lilah makes it to the methadone clinic in her state, started the enrollment process, but then passed out in the bathroom and is told she has to come back later. Instead of being directed to some sort of post-release respite at the hospital, Lilah is allowed to leave the hospital disoriented.

> Lilah: So, I'm crying crying crying. But I'm high too at the same time. Anyway, I finally leave somehow and I end up passing out again at the bus stop down here. And this lady got me to Capp Street. I kept saying I wanted to get to Capp Street, that's what she tells me.
>
> Andrea: Did you know her?
>
> Lilah: No! I didn't know her! I was on Klonopins and still kinda blacking. So she guided me back to Capp Street and so I got to Capp Street…And that night at the shelter my fever spiked. It was like 103 or something like that. So they called the ambulance.

Lilah does not recall getting to the Mission, what she did there, or how she ended up back at the shelter in the Tenderloin. The ambulance that picked her up at the shelter was directed to a private hospital located just five blocks outside of the Tenderloin in the upscale Nob Hill area, though they are not accustomed to working with poor drug users

as most get routed to the county hospital. Lilah says that they kept her for a few hours in the emergency room, but then released her. So she came back to the shelter, where she suffered through the night in excruciating pain from her leg and still disoriented from the black out. The next day, Lilah woke up and managed to walk several blocks from the shelter at the western edge of the Tenderloin, to catch the bus down to the hospital to enroll and receive her methadone dose. The urgent care clinic is just a few steps away from the methadone clinic. Relieved that she was not dopesick after her methadone dose, Lilah decided to stop in and see if she could get treatment for her leg. The doctors at urgent care ran tests and gave her some water pills to relieve the pressure. But because the waits at the urgent care clinic are often long, Lilah began to worry about whether she would be able to check in to the shelter on time—something she needed to do in person—or else risk losing her shelter slot.

Here, more system failures make themselves evident: the urgent care clinic does not have a direct line of communication with the shelter system to report that Lilah is in the middle of receiving critical care, despite them both being city-funded agencies. Further, because of the extreme demand for shelter beds, Lilah was required to report in-person at the shelter within a particular time frame to prove that she could keep the slot, or else risk losing her bed for the night and face sleeping on the streets or having to hustle money to pay for a daily-rate hotel room. This entailed her catching the bus all the way back downtown and walking several blocks to the shelter. This is tiring for anybody given that the direct bus line between the two neighborhoods is often cramped and, at times, overwhelming. But Lilah had just received her methadone dose and, like everyone, was extremely drowsy. The urgent care doctors made her promise to come back after she

checked in, but she did not. As she says, she disappeared into the abyss of the Tenderloin. In the meantime, her test results came back and showed that she was in the midst of acute kidney failure and she was at extremely high risk for a heart attack. She needed to be admitted immediately to the hospital. Three days went by before anyone could find her. Lilah did not have an operating cell phone at this time and the shelter staff was not notified by the urgent care clinic that Lilah's situation was grave, because confidentiality regulations prohibit programs from sharing information without a signed release form.

Knowing that Lilah did not have a working phone, the urgent care staff had not pre-emptively had her sign those forms in anticipation of potentially urgent test results and the need to coordinate communication. The hospital was allowed to contact Lilah's mother, who she had left as an emergency contact on her intake forms. Her mother lives about a hundred miles outside of San Francisco. With the urgent information about Lilah's condition, her mother managed to drive into the city and then simply lingered around the hotel corridor for hours, finally finding her at the nearby McDonald's. Her mother would not let Lilah out of her sight, until she was sure she returned to the hospital, where clinic staff explained the severity of her condition:

> She said, 'your kidneys have failed.' I was in shock. My mouth flew and I was like, what? And she said it's to the point now, she said, you might possibly be on dialysis. And I don't think there's a shot. I had size 13, 14 kidneys, which they said were turning big. And this one doctor was sitting there and I heard him say, 'What a waste.' I mean he didn't see me, he didn't know I was listening. But it hurt my feelings.

They admitted Lilah to the hospital and soon after she had the surgery to insert the catheter port to receive dialysis. "It was all a blessing, actually," she said. "So, by me getting kicked off of the clinic and all that. Probably if I wouldn't have gotten kicked off, I probably would have died in the streets because I didn't know [about the kidney

failure]. And that was a blessing." The way in which Lilah was terminated from methadone without much explanation because it was assumed she was involved in criminal activity is demonstrative of her imposed hybrid subject identity as an addict—someone who is simultaneously both cast as criminal and diseased. In fact, her potential criminality in this case overrode her need for drug treatment, since the suspicion of her involvement in the burglary had precipitated termination without much explanation.

Further, her need for re-enrollment in a methadone program and the mitigation of her suffering from withdrawal was not considered an acute medical crisis by those of us that encountered her during this time. In this state of crisis, she was also subject to the dysfunction and fragmentation of the safety net system. Her termination and withdrawal would force her back into buying street drugs in an effort to stop dopesickness and the only option for generating income for minimal survival was through sex work. Yet none of this was not treated as the urgent health crisis that is really was. This cycle of withdrawal, suffering, and desperation is often seen as merely routine consequence of one's addiction to drugs and not as urgent health crisis requiring immediate and sustained intervention. This is an implicit moralization of people's health issues related to addiction relative other acute health issues, which are seen as more "real" and intervened upon with ethical obligation and urgency.

Lilah's acute kidney failure, which was not detected earlier because after termination from methadone she had no regular engagement with clinical care, effectively re-classified her in terms of the moralization of her health issues. She was not able to shed her imposed "addict" subject position, as the "what a waste" comment from the doctor that she overheard demonstrates. But, no doubt now her re-classification as a

patient near death from chronic illness would take precedence as she navigated the safety net system. Lilah was particularly aware that her acute chronic illness diagnosis would now bring material differences to her life, by repositioning her within terrain of entitlements for which she was eligible. Her kidney failure diagnosis meant that she was now officially "gravely disabled," which would make her eligible to apply for SSI and have access to a different pool of permanent supportive housing. She immediately began to reflect on how this potentially meant that her time in the shelter appeared to be coming to a close:

> As far as the shelter system is concerned, it's terrible. They have people in there that are mental cases. I mean to the point of severe. They can't take care of themselves because there's not mental health services available. They put them in a shelter, okay. It is so dirty and it's so—it's repulsive. It's better to sleep on the streets.

Despite the fact that only a few weeks previously, Lilah was near death, she recognized that this had afforded, for the first time in years, an actual glimmer of hope for getting stabilized. "I'm just blessed. I'm happy to be here. I mean, I have changed a lot of my ways so I can live. I don't do as much drugs as I—I don't do heroin or nothing—but even crack is down to a minimum." I was struck at how Lilah, fully recognizing the injustice of the system failures that she confronted, was in the position after months of suffering to feel privileged to simply be alive and have a new chance at even minimal stabilization. She knew the acute kidney failure was the only way she might get "saved" and after years of experience of system failures intersecting her history of addiction, this was a realistic assessment. I now turn to a contrasting case, that of Monica, who has certain characteristics that on the surface would appear to place her in a less vulnerable position relative to managing her acute health issues. However, her case demonstrates

that in the midst of these minimal interventions, she still suffered excruciating pain and stigmatizing narratives about her drug use.

"'That's Real Brutal to Me:' Managing pain as a long-time drug user"

Monica is a 53-year-old, HIV positive Latina woman who has a long history of heroin and crack use. I met her while doing outreach at the Sun Hotel. Despite the fact that she had debilitating mobility issues and the Star did not have an elevator, she still made her way down into the lobby area each week to get supplies and update us on her health issues. Monica was always in need of bandages, antibiotic ointment, and medical tape. She has severe chronic wound issues, which she attributes to her long-term heroin use. She has had abscesses all over her body at various injection sites and over the years had had multiple skin grafts on her arms and shoulders to repair damage from soft tissue infections and necrotizing fasciitis (i.e., "the flesh eating bacteria"). Many of these skin grafts have not adhered properly, and as a result, Monica has wounds on her legs, arms, shoulder, and back that continually re-open, are painful, and ooze. In this way, Monica is a person that wears the evidence of her years of injecting heroin on her flesh—she cannot mask that she was an injector since part of her arms have large and deep indentations where infected tissue was carved out. During the time when we met, she was no longer injecting anything and was well-established at the methadone program at hospital, where Lilah eventually enrolled. She was also engaged with her primary care at the HIV/AIDS clinic upstairs.

In addition to her wound issues, Monica has intense and debilitating chronic pain from two primary sources. She has a crushed disk in her back and a curved spine—her doctors have recommended spinal surgery—and she had a break in her knee years ago

that was never treated, for which she needs a total knee replacement. She attributes these issues to the decades she spent sleeping on the streets in San Francisco and the East Bay. Every day, Monica's knee is swollen, often to the point where she cannot bend it, since her body is accumulating excess fluids there because of the original trauma. Monica uses a cane, often falls out of bed and around her hotel room, and using the shared bathroom and shower down the hallway can be grueling. This is Monica's self-identified most pressing health issue, since not only is it causing constant unbearable pain, but it has also limited her social life. Monica is an incredibly social and outgoing person. And even though the Sun Hotel often sponsors group activities and field trips for the residents around the city, she has yet to receive a wheelchair from MediCal and Monica cannot attend because she simply cannot keep up with the group. Monica cannot even stroll a few blocks around her hotel or make it to the plaza to socialize with people in the vibrant street scene. This has caused extreme depression and unwanted social isolation.

In late 2011, Monica felt like the debilitation from her knee had become intolerable. It deserves mention that Monica still manages to ride the bus daily to the hospital to receive her methadone dose and so has regular contact with clinicians, social workers, and therapists. The last time she had received any kind of treatment for her knee, she went to urgent care and they drained the excess fluid that was producing the intense swelling. However, Monica was still unclear about the official diagnosis, or whether there was a long term solution. Monica only knew that the clinicians at urgent care told her that she would simply need to come back to the clinic every two weeks to get the fluid drained to relieve the pressure. The urgent care clinic is one of the few places where people can access medical care on the day that they need it. However, like

the emergency room, it is crowded, the waits are long, and the concentration of sick and suffering people can be overwhelming. The entrance to the urgent care clinic is managed by an armed security guard. In May of 2011, her primary care doctor told Monica that she would need to come back soon so that they could initiate serious conversations about knee surgery. This prospect terrified Monica and she "no-showed" for several subsequent primary care appointments.

Services at the HIV/AIDS clinic are delivered using a "bio-psycho-social" model of care. This means that people are assigned a primary care provider (which includes both physicians and senior nurse practitioners who are HIV/AIDS specialists) at the HIV clinic. Every patient then has access to on-site case management, coordinated efforts by clinical social workers at the clinic and in partnership with community-bases agencies, and psychotherapy services. Monica has regular access to these providers, but is also assigned a social worker at the methadone clinic, and a case manager at the Sun Hotel, which, as a DAH housing unit, has on-site supportive services. Given the number of social workers and clinicians that Monica has regular access to, it is mind boggling that she did not have a grasp of her acute knee condition or of a coordinated plan to address it. After Monica "no-showed" for her primary care appointment, she went approximately six months without receiving care for her knee. She was still dosing daily at the methadone clinic and picking up her medication at the pharmacy at the hospital, but had not been upstairs to the HIV clinic during that time. She had been simply suffering through the pain, all the while building up anxiety about the prospect of surgery. The fact that Monica was able to disengage with her primary care, even in the context of a seemingly abundant safety net of providers suggests that here too the line of communication was broken.

Though some communication was made, as I show below, between the HIV/AIDS clinic, the methadone clinic, and the pharmacy, the on-site case manager at the Sun Hotel was not brought in formally to ensure that Monica would stay engaged with care, even though she sees Monica daily at the hotel.

Monica's absence from the HIV clinic had triggered a response from her primary care doctor, Dr. Manning, who is the clinician who manages Monica's overall care plan, including, most critically, her HIV medication and pain management prescriptions. These medications are administered in a "medi-set" at the pharmacy, a method used for patients that have been determined to need assistance with adherence and managing multiple pill regimens. So, Monica goes in weekly to the pharmacy to pick up her medi-set, which contains her weekly allocation of HIV medications, pain management prescriptions, and blood pressure medications. She has not been granted the coveted methadone "take home" doses, so must go to the methadone clinic daily to get those separately. Because Monica had "no-showed" for her primary care appointments a few times, Dr. Manning had instructed the pharmacy to pull all of the pain management medications out of her medi-set, until Monica complied with a primary care appointment. The pharmacy had called Monica to let her know that her medications were ready for her, but that Dr. Manning had sent a message via the pharmacy: Monica would not have access to pain management medication, including the fentanyl patch, until she came in for a primary care appointment with Dr. Manning. The fentanyl patch is an extremely powerful opiate analgesic, used to treat severe chronic pain and often one of the only effective pain regimens for people who are excessively tolerant to opiates as Monica was because of years of heroin use. Monica was livid. Not only did she feel like Dr. Manning was

disrespecting her by playing games and punishing her, but Monica felt that Dr. Manning had made a poor clinical decision to cut Monica off from the fentanyl patch cold-turkey, rather than tapering her use.

Monica had to endure an intense withdrawal from the powerful patch. Monica had braved the withdrawal and subsequent intensification of her chronic pain as a matter of principle. As she was told by the pharmacy, Dr. Manning would restart her opiate analgesics if Monica simply showed up for a primary care appointment. One day, I saw Monica at the Sun Hotel during a memorial for another woman who we both knew, who had recently died of AIDS-related infections. Monica approached me in tears and said that she can "no longer live like this" because the pain from her leg had "ruined" her life. Through an existing referral from the HIV clinic, she had managed to secure a coveted appointment with the orthopedic clinic and asked if I wanted to go with her.

On the day of her appointment, it was pouring rain, so Monica managed to procure some taxi vouchers from the case managers in her building. While we were waiting for the cab on the sidewalk, undercover cops were swirling around the block. Unfortunately, Monica was only able to get fifteen individual dollar coupons, which does not cover the round-trip fare. So we had to take the bus back. When we arrived, it took us a few minutes to navigate the maze of the main hospital, but eventually we stumbled upon the orthopedic clinic waiting room, which was overflowing with people. The scene was pretty bleak—there were dozens of chairs packed tightly into a long, narrow and stuffy room and people with intense orthopedic issues were waiting, all sighing, squirming, and swearing about the long wait. We checked in on time, but the receptionist told us the wait would be at least forty minutes. There were no seats available and

Monica could not stand. So, we decided to go to the hospital cafeteria for a coffee to pass the time.

I have always seen the hospital as a critical and telling extension of the social worlds of the hypermarginalized urban poor of the Mission and Tenderloin. It is the site where people access urgent or emergency care, it houses the methadone and HIV clinics, the wound care clinic for abscess treatment, as well as psychiatric emergency services. On this day, walking around the hospital with Monica, this conceptualization was supported. Monica ran into multiple people from the hotel corridor throughout the hallways of the hospital. When we boarded the elevator to head to the cafeteria, there was a small plastic crack baggy on the floor, which Monica somewhat jokingly picked up to see if there was anything left in it. This prompted Monica to tell me stories of how she could buy and smoke crack even during times when she was previously inpatient in the hospital. When we tried to stop to use the bathroom, Monica quickly came out and said the woman who went in before her was rifling through her stuff to find her "works," or injection paraphernalia, to inject drugs in the bathroom. Monica knew this would take a while, so wanted to search for another bathroom. While we sat and waited for time to pass, Monica, perhaps triggered by being in the hospital setting, recounted her history of trauma and hardship, including losing her unborn granddaughter as a result of severe physical violence perpetrated against her daughter.

We finally made it back up to the clinic and were called in to the exam room at 4:15, an hour and forty-five minutes after her scheduled appointment time. Without any provocation, Monica told the nurse who had called us back that I was "her worker" and I followed her in to the exam room. Monica unabashedly changed into a dressing gown

and then we waited in the exam room for an hour and half, with no update from a doctor or nurse. In the meantime, Monica discovered a drawer full of hospital gowns and stuffed one into her coat to use as a bathrobe at the hotel. The long wait with no update was particularly searing given that when Monica was asked to report her level of pain using the pain scale when we first entered the room, Monica had said it was a sturdy level 8. When I had gone to the ER a few months earlier for an appendicitis, I had reported that my pain was at a 7, and startled, the nurses immediately gave me a morphine flush. It is unclear whether Monica could have been administered a pain management regimen at this clinic, but we both knew that the clinicians could see on her medical records that she is on methadone and they could tell just by looking at her that she was a long-time injection drug user. Monica sat on the exam table weeping in pain, before a young doctor in her early 30s with long blond hair and blue eyes entered the room and asked Monica to explain what was wrong.

The doctor observed the extreme concentration of fluid around Monica's knee and asked if she had ever gotten treatment for a fracture or had knee surgery. When Monica said no, the doctor pointed to a large scar on Monica's knee and inquired about its origin. Monica responded "This is when I used to shoot dope. I had necrotizing fasciitis. I had the skin eating virus. And that's where they tried to do a skin graft and it didn't take." The doctor leaned back on her stool, glanced down at Monica's chart and said: "Let me break it down for you. Your x-rays don't look good. You've got tons and tons of arthritis in there. So the thing is, I'm gonna go ahead and recommend a knee replacement." Monica burst into tears, but kept listening. The doctor went on: "Are you currently using drugs?" to which Monica responded no. The doctor said "Okay, you're going to need to

show—are you in a program or anything like that?" Monica said yes, she is on methadone, to which the doctor replied "Okay, I'm going to see an entire year of clean UAs [urine analysis] for all drugs that are not prescribed in order for the surgery to proceed."

At this point, Monica started to wail and cry and the doctor matter of factly told her that if Monica is doing any drugs, the risks for an infection with a knee replacement are astronomically high and so therefore the required year of "clean tests" is simply non-negotiable. Monica screamed at the doctor "Doctor! That is totally unreasonable! I've tried and I've been trying! But there's no way! You should see where I live! There is no way to get away from it!" The doctor, perhaps surprised by the intensity of Monica's reaction, reached out and puts her hand on Monica's foot and said calmly, "I understand. But I'm just telling you, the risks for infection are so high, we're gonna need to see that year." Monica was so emotionally overwrought, she almost left without getting any treatment for her knee. The doctor reminded her that she could drain the fluid from her knee again today and give her some steroid injections, which should relieve some of the pain. But, this solution is very temporary and she will have to get the same treatment every three to four months and Monica will see very little improvement in terms of overall pain and mobility. Monica went on talking about the impossibility of going on living like this with the excruciating pain and the doctor stepped out prepare for the drainage and injections.

While the doctor was out of the room, Monica wept and screamed even more intensely about the impossibility of getting a year of clean time. Then, she divulged to me that the spinal surgery she was told she needed for the crushed disk had actually been

scheduled, then canceled, because within the last few months she had, in fact, injected heroin once. She “muscled it” (injected directly into her fatty tissue, rather than intravenously) and had gotten an abscess. She went for treatment at specialty wound care clinic and through this channel, the spinal surgeon had gotten word that Monica was using drugs again and he canceled the surgery. Interestingly, the institutional mechanisms for communication between programs functioned properly here, to disclose and punish her illicit drug use. Monica lamented that she had only injected that one time, but because she got the abscess and sought treatment, it had revealed her intermittent drug use to the hospital staff.

It was during this time, however, that Monica’s pain management prescriptions had been pulled from her medi-set, so Monica had been using heroin and crack intermittently to self-medicate the pain. The vicious cycle of her suffering was immanently clear at this juncture—she was temporarily relieving her chronic pain by self-medicating with crack and opioids, but this self-medication is what ultimately prohibits her from accessing a permanent solution to her excruciating pain. The doctor came back with several large syringes. Monica laid back and the doctor proceeded to pull barrel after barrel of yellow-tinted liquid from around Monica’s knee. She extracted the liquid and then just pushed it out of the syringe and into the sink and it splashed around the porcelain edges.

Monica got moderate relief for a few weeks after the steroid injection and drainage. She had started to put in motion a request at the HIV clinic to be assigned to another primary care physician. In December, after she continued to skip appointments with Dr. Manning, one of the social workers from the methadone clinic called a

mediation meeting between Monica, Dr. Manning and other social workers at the HIV and methadone clinics to see if the issue could be resolved, or if care did need to be transferred to another clinician. I was at the hospital that day and was able debrief with Monica after the meeting. Monica was very angry because Dr. Manning had approached her after the meeting and asked to speak to her in private. Monica had refused. Monica had decided not to bring up the issue of Dr. Manning pulling her pain management medication during the mediation meeting, again upon principle:

> I'm not gonna beg her for my meds! She knows I'm hurting!...See that's why I didn't say nothing about it. Because I already know that if I would have said something about me being in pain, she would have said 'Well you already know what you have to do: make an appointment with me." I could already see her bitch-ass saying that!

Despite the fact that Monica could have potentially resolved the hold on her pain management medication that day by simply going upstairs and meeting with Dr. Manning, she felt so disrespected by her doctor that she was willing to continue without her prescriptions to send a message. Dr. Manning's form of intervention to prompt Monica to come to the clinic and reengage with care was too punitive and triggered within Monica an intense affective reaction to betrayal and disrespect, with intense bodily implications.

> You know, because like I said, I know her and she'll say 'Well you know what you need to do—come and see me first.' So in the meantime, I gotta suffer. She's done this to me before. A few times, you know! She'll say, 'You know you gotta come and see me.' And I don't want to bring up about the fentanyl because once I hit her on that—I forgot to bring the letter too, where she wrote on there, teasing me with a copy of the prescription. Telling about—with an arrow drawn pointed to the patches, saying you know, 'You'll get your pain patches as soon as you come and see me.' And I think I was just waiting for an appointment at that time and that happened. But I ended up withdrawing and kicking [from the fentanyl patch]! So, you know, why should I get back on it, you know what I mean? And she didn't bring it up after that, about nothing. I was so pissed!

> I've been mad since then, really. That's where it started…And I mean, come on! And we got a good enough rapport…and as it is, I see her every three weeks! Come on, Dr. Manning!...I miss you for a week and then you're taking me off? You're calling the pharmacy at that! And telling them our business and then they have to call and tell me about the appointment? You think I don't—I already know I have an appointment. I see you at the methadone clinic, they tell me every day! They remind me every day for about the week before. E-v-e-r-y day! I already know about it! I know about my appointment, you don't have to tell me again, you know? It's good though. But I know when my appointments are. But she doesn't have to call the pharmacy and tell them to tell me! I just didn't think that was very professional…All she had to do was call the pharmacy and say, 'Put her shit, her controlled—her shit on hold.' Not, you know, 'Can you call her and tell her. And tell that if she don't make her appointment by this date, there's not gonna be no controlled substances.' And like teasing me!

Here, because Monica's experience of care was mediated by her subject position as a long-time heroin addict, the institutional mechanisms designed to ensure she received care (e.g, appointment reminders, incentivizing clinic attendance) were offensive and juvenalizing. The other thing that deepened Monica's frustration was that at the subsequent mediation meeting, another mechanism designed with good intentions to serve patients' needs, Dr. Manning had immediately inquired about when Monica was willing to go "into program" (i.e., enroll in a drug treatment program). As she said, "because she's wanting me to go NOW into program, as soon as possible. That's another thing she's always on me about. When I'm ready to go, I'm gonna go! I'm gonna get my knee. I gotta get my knee done. But I gotta have other things too, you know, *ready*." Monica also felt that she had been denied the right to get a second opinion because no one had given her a referral to another doctor in the MediCal network. Monica wanted to be sure that she did indeed need a total knee replacement and she also wanted a second opinion on orthopedic requirement of an entire year of clean time. Indeed, I had heard in various research and clinician meetings that there was an ongoing internal debate among

clinicians in the HIV/AIDS clinic, who were very accustomed to adopting flexibility in their treatment plans to accommodate their triply diagnosed patients (i.e., those patients with addiction, mental health, and chronic disease). They felt that the orthopedic doctors, who may not have same legacy of socially progressive service provision as the HIV doctors, needed to implement this flexibility to adapt to the unique needs of the patient population.

By early January of 2012, while Monica was still trying to navigate changing doctors and figure out next steps for her knee surgery, she was notified that her blood work had yielded abnormal results, including high potassium levels, which indicated potential precursors to kidney failure. This scare made Monica rethink her decision to change doctors, because with another acute problem in the mix with her HIV, high blood pressure, and chronic pain, it might simply be more efficient to stay in care with Dr. Manning since they had worked together for seven years. Monica was weighing the efficiency of staying with Dr. Manning versus having to endure what she perceived as continued insensitivity and disrespect.

> Monica: I just don't feel comfortable really seeing her because she's gonna start, you know blah blah blah blah about her—and I don't wanna go through all that shit again with her, you know? I already cleared all that outta my head. I don't need her drama, you know what I'm saying? And I already know how she is and how she's gonna talk and stuff. So it's like, I just wanna start with the new. And I don't wanna start stressing with one more appointment with her. As long as she's taking my blood work and all that and if something serious she'll, you know what I mean, send it on. I would just go in there and let her check me, that's it. I don't wanna sit there and blah blah blah about nothing. Just do what you gotta do and let me outta here! Because her little sessions of an hour/hour and a half of asking about your drug programs and stuff, you know, I'm not in for that right now.
>
> Andrea: Does she do that every time?

> Monica: Yeah! Every time. 'So how you feeling about program?' Remember when she brought it up in that meeting? You know about 'how good you did in the program, you know I remember…' She's always gotta bring that stuff up and stuff. I mean, you know, and I try to tell her too, 'Dr. Manning, I'm not in the *mood* right now for that. I don't wanna *hear* it right now. I'm not thinking about a program. Every month, though! Come on now! When I'm ready, I will say something! And it really got—it just irked me!"

In the meantime, with still no sense of a plan for her knee and now this new acute problem with her kidneys, Monica was still managing her chronic pain on her own. She was smoking a lot of marijuana that she bought on the streets because she felt Dr. Manning was also leveraging a medical marijuana prescription against her clinic attendance. She was also occasionally smoking crack for the pain but as she said "I don't wanna keep smoking crack, either, you know what I mean? I can't afford that shit. And I don't need that fucking mind trip of all that, wanting more and shit like that." Regardless of the ongoing debate between clinicians about the required clean time for major surgeries, the regulations about active drug use and surgical procedures would undoubtedly be slow to change. I asked Monica where she was at in terms of her knee pain and the prospect of being able to achieve a year's worth of clean time.

> Monica: The knee. I mean I could bend it like if I'm sitting down a little bit, I can bend it a little bit. But when I'm walking, I can't bend. It won't bend. It hurts so bad.
>
> Andrea: And you think that six months would be something you could wrap your head around?
>
> Monica: I don't know. It might be. I still say it should be like 90 days. Something like that. Three months is enough…ninety days, maybe a hundred and twenty days. Four months. That should do it. You know, I still say 90 days is cool to have a surgery. You know what I mean? That'll get all the shit out of my system. You know a month, it's all out. But, you know, through the mind trip and shit. Going through the program for ninety days or something and then get out and then have the surgery. And

> then…I won't be able to go back home anyway after the surgery. I'll still be clean and shit through all the healing.

Besides the major hurdle of having to maintain clean time, Monica also had the very practical concern that if she went into an inpatient drug treatment program, then had the inpatient surgery with the required recovery time, that her slot within the DAH program and room at the Sun Hotel would be put at risk. All of these concerns, plus the chronic pain, and new anxiety about her kidneys was quite emotionally overwhelming and on some days, immobilizing. Despite all of the practical matters relating to her health care, she was also still extremely angry with Dr. Manning and could not shake the feelings of disrespect and juvenalization she was feeling. Monica unfortunately was at the center of the debate among clinicians about how to handle the prescription of opiate analgesics to long-time heroin users with chronic pain. In Dr. Manning's likely best-intentioned attempt to get Monica re-engaged with much needed ongoing primary care, she had inadvertently also triggered Monica's complicated subject position as a "junkie/dope fiend." By Dr. Manning "dangling" drugs that Monica desperately needed to treat severe chronic pain, she had created a situation whereby succumbing to her requests meant surrendering to the notion Monica is, plainly, an addict who can be swayed by the promise of opiates. Monica would rather suffer through the pain, than actualize that identity.

> You know, I'm just real frustrated with her because she asked me why I left her. And I told her exactly why. I didn't tell her the whole story, I just told her that, you know, we just don't see eye to eye anymore about a lot of things. And you know, I don't like the way she dangles the drugs over your head when you need something for pain and stuff. And I don't need to beg like that…She's seen me in enough pain that she knows. I don't understand. That's real brutal to me. It really is. It's kinda hateful to me. Couldn't she just like think about how somebody could be in real pain all the time and when she's home relaxing and enjoying her life and stuff how

> we're struggling out here and stuff? That's why I need a doctor that's like been around the corner a couple of times. Somebody that understands and has a little sympathy…Crazy life, girl. I'm still hanging in and trying to do what I gotta do. Strugglin, but doing it. Every day I look at my mom's picture and I pray and tell her—Please…

Before she could tell me the prayer she invokes to her mother, the alarm on her cell phone rang loudly and interrupted her. It was the alarm she sets daily to remind her it is time to go to the methadone clinic.

Summary Analysis

The cases of Lilah and Monica speak to the paradox of how, within the context of a socially progressive and relatively robust safety net of services for the hyper-marginalized urban poor, significant barriers related to implicit systems of knowledge and practice regarding addiction impact access to care and bodily suffering. One would think that the important contrasts between them (e.g., Lilah is HIV negative, Monica is HIV positive; Lilah did not have GA or SSI and hustles daily for survival, Monica has SSI and MediCal; Lilah moves between the daily-rate private SROs and shelter stays, Monica is more stably housed at one of the city-run supportive hotels), would yield significantly different outcomes in terms of access and continuity of care. But, in fact, they both fare pretty poorly and, at times, are completely disengaged from care. In a practical service provision analysis, it is baffling how that as Lilah and Monica suffered with regard to their acute and chronic health issues, both women were almost always approximately one mile away from the hospital, yet it was extremely challenging to maintain contact with them.

Also, it is clear that communication between various nodes of the safety net of social services needs to be improved to ensure that continuity of care is maintained and

the effects of acute health crises minimized. This fragmented service provision undoubtedly contributed to the intensification and prolonging of their bodily suffering. In fact, both women went through periods of *unwanted, forced withdrawal* from their supposedly more legitimate addictions—methadone and the fentanyl patch—forcing them each back to the illicit drugs for which they must endure a moralizing gaze and be cast as making pathological, irresponsible choices relative to their overall and acute health priorities. It seems as though, despite their best intentions and desires, neither can escape addiction as their trajectory of experience, as they are relegated to subject positions as "addicts," which primarily mediates their experiences of care, resulting in intensified bodily suffering. These cases make further clear the blurring of the right and left hand functions of the state.

Chapter 8

CONCLUSION

In this dissertation, I examined the experiences of a sub-set of the urban poor—hypermarginalized women whose daily experiences are defined by extreme poverty, housing instability and the management of chronic illness, drug use, and mental health issues. I located their experiences within the socio-spatial contexts in which they reside, including the SROs through which they attempt to find respite from street homelessness, the neighborhoods in which they live, the city of San Francisco whose policy is driven by compassionate principles, and the broader context of neoliberal poverty. The contemporary reality is such that this sub-population lives in a state of "everyday emergency" (Benjamin 1968; Bourgois 2011) where each day is a struggle to secure resources needed for basic survival, including food, shelter, and acute medical care. This ongoing state of emergency triggers complex institutional responses and thus, the urban poor become enmeshed in long-term negotiations with institutions whose objectives are to provide care or social service resources. These negotiations become essential to everyday survival.

In this dissertation, I examined three critical institutional domains that women negotiate in their attempts to maintain some measure of stability and to mitigate the effects of hypermarginality. These are: 1) the housing system of last resort in San Francisco, single room occupancy hotels, 2) street-based law enforcement in the neighborhoods in which women reside, and 3) the county hospital which provides care

for chronic and acute health issues. These institutions are important sites of inquiry because they are key nodes in women's "local geography" of survival. However, through long-term ethnographic research with women as they navigate these domains, I found that the contemporary state interventions into the conditions of extreme poverty, homelessness, addiction, and mental illness that I examined locally are paradoxical in that they at once administer help driven by compassionate and humanitarian principles alongside unintended harmful consequences filtered through punitive logic. Thus I argued that in order to understand the nuances of the extreme edges of poverty in contemporary US urban contexts, we must go beyond merely chronicling the suffering on behalf of the poor. We must also turn our analytic lenses on how the poor engage with the institutions tasked with ameliorating the conditions of hypermarginality. I find that though they provide resources needed for survival, they also function to reinforce and reproduce hypermarginality.

This dissertation has two primary theoretical interventions into the field or urban ethnography and the anthropology of poverty. First, I offered a reconceptualization of the structural violence framework that has been utilized by many anthropologists who investigate poverty, homelessness, and drug use in inner-city contexts. The structural violence framework was an important analytic turn away from behaviorally-focused research and researchers who utilized it moved the discipline in the direction of examining behavior within the context of large-scale structural forces. However, I argued this approach focused too sharply on the suffering of the hypermarginalized and consequently obfuscates their interaction with institutions who are tasked with intervening upon their suffering. This approach has also masked the ways in which the

urban poor strategize savvily within institutional constraints to mitigate the conditions of hypermarginality. Thus, my analysis is focused not on the violences enacted by structural forces, per se, but on the paradoxes of how modes of intervention play out in the everyday lives of urban poor women.

Further, my approach to examining these institutional interventions was guided by Bourdieu and Wacquant's model (Bourdieu 1998, 1999; Wacquant 2009) of how populations are managed through different sectors of the state. Bourdieu conceived of the left-hand of the state as those institutions and social actors within them who broadly conduct forms of social work, including health, housing, and education. Wacquant added to Bourdieu's model by theorizing the contrasting operation of the right hand of the state, which includes the police and justice and correctional administrations. As Wacquant (2009) conceived it, in the contexts of urban poverty the functions of the left hand or "helping hand" of the state are "supplanted" via regulation through the right hand. In his use of Bourdieu's model, the left and right hands have distinct undercurrent logics—the left drawing on an ideology of "protecting" and "enhancing life chances," while the right regulates through punitive governance.

In my research in San Francisco, I found that the urban poor are managed through a configuration where the boundaries between the left and rights hands of the state are increasingly blurred. For my research population, punitive and compassionate governance are intertwined to the point of indistinction. This indistinction results in a situation where the urban poor are cast simultaneously as criminal/victim; deserving/undeserving; worthy of punishment/worthy of salvation; and human/inhuman. For women, this configuration also includes gendered moral discourses about their

ultimate worthiness as women. The consequences of this indistinction are such that institutional interventions administered by the left hand of the state that should confer respite or relief, also confer harm and punishment. Paradoxically, those right-handed institutions that previously only punitively managed the poor also now perform active care and social service provision.

However, the impact that this configuration has on the left-hand institutional interventions is of most significance, since the assistance they attempt to offer in order to address the conditions of hypermarginality is consistently interrupted by punitive mechanisms. Thus urban poor women find themselves in an inescapable cycle of suffering and hardship, even when they are actively engaging with and connected to the institutions that are supposed to be sources of help and stability. The "help" is constrained by punitive mechanisms and thus never allowed to fully actualize. But further, the "helping hand" of the state in these contexts paradoxically functions to deepen hypermarginality as too often any minimal advocacy comes with adjudication. I demonstrate this phenomenon through ethnographic research with a cohort of women in three institutional domains: housing, law enforcement, and safety net clinical care.

Housing of Last Resort: SRO Hotels

In Chapters 3 and 4, I outlined the housing system of last resort in San Francisco, SRO hotels. I showed how these hotels operate along a continuum, from the daily rate hotels that I define as *quasi-institutional* to the various supportive housing hotels I define as *institutionalized*. The daily-rate hotels are only managed by the right hand of the state, in the form of police sweeps and responses to the routine violence that takes place within them. As I showed, these hotels function as critical low-threshold housing for people who

live at the most extreme edges of poverty and provide some respite from street homelessness. Yet, women must endure violence and deplorable conditions within them. Ethnographic analysis of these daily-rate hotels is essential to understand subsequent the municipal attempt to institutionalize SRO hotels in order to address these conditions and to make them viable spaces and more therapeutically-oriented housing for the urban poor.

Despite the intentions of those who sought to institutionalize SROs in San Francisco, my ethnographic research demonstrated how an intervention administered by the left and of the state in an attempt to confer "ontological security" to chronically homeless people is too often disrupted by the intrusion of law enforcement, who in Wacquant's model is part of the traditional right hand of the state. I showed that in institutionalized SROs, routine crises are common and related to the fact that these hotels are purposive concentrations of people with addiction and mental health issues. Yet, in the absence of social services located in the hotels that are robust enough to address these crises, law enforcement paradoxically acts as the most reliable front-line responders to the health and mental health crises of the urban poor. This leaves inhabitants in a paradoxical situation where they reside in spaces that purport to be at least minimally therapeutic, but they are, in fact, managed primarily by the punitive force of the police who are routinely called in to the buildings.

Thus, even though on paper women may appear to be "stably housed" and engaged with whatever minimal services may be available at hotels, subjectively they may still feel totally socially abandoned and their experiences of violence and instability may remain unchanged. Further, their subjective negotiation of being defined in these spaces as simultaneously criminal and victim has significant negative impact on mental

health and well-being. Thus, these well-intentioned interventions of the left hand of the state are muddled by elements of the right hand.

Street-based Law Enforcement

In Chapters 5 and 6, I examined urban poor women's engagement with what we traditionally think of as the right hand of the state—street-based law enforcement. In response to the unremitting everyday emergencies of the street-based urban poor in these contexts, I found that law enforcement incorporates elements of the left hand of the state into their everyday functions. In Chapter 5, I outlined San Francisco's hybrid policing model, in which certain officers are tasked with blending their "normal" punitive policing with social service provision. The officers, as a matter of policy, must toggle back and forth between using punitive and compassionate intervention in their interactions with street-based women. However, the provision of therapeutic intervention is muddled by police officers' potential use of citation and arrest at their own discretion. Thus, at any moment, the "helping hand" of the state is circumvented, as ultimately police officers operate with a foundational punitive logic.

In Chapter 6, I examined this hybrid dynamic from the perspective of women who negotiate their interactions with police. These cases showed women's frequent interaction and conscious modes of engagement with police. While police may offer some minimal access to resources, the potential for their punitive intervention is always looming and thus, women are limited from fully actualizing the social services that the police may facilitate. In this context women have to negotiate with police, however implicitly, whether they are "worthy" of getting the social service resources at the police's disposal or whether they deserve "tough love"—that is, "care" through overt punishment such as

citation or arrest. Women do not have access to resources as a matter of human rights, here; instead, they must establish legitimacy in the eyes of the police officers in order to be conferred care. This configuration, which also blurs the left and right hand functions of the state, creates a situation where women try to eke out minimal resources for survival through an institution whose primary mandate is to punish them.

Clinical Care: The Safety Net Public Hospital

In Chapter 8, I examined women's experience of clinical care at the safety net hospital where they must manage their chronic and acute health conditions. In this traditional left hand institution of the state, I showed how the right hand's punitive logic penetrates into clinical interactions between doctors and patients. Here, because of women being marked as "addicts" or "non-compliant," the lines between therapeutic and punitive interventions are blurred. Thus I showed how women are not able to fully actualize "care" for themselves even though they desire to do so and attempt to within the most constrained circumstances. The moralizing gaze from service providers about women's long-term drug use results in decreased effectiveness of the traditional left-hand interventions and, in fact, result in intensified bodily suffering on the part of women.

Summary Analysis and Implications

In each domain that I investigated ethnographically, I found 1) deficiencies in the institutional interventions seeking to intervene upon hypermarginality and 2) an active *undermining* of life-enhancing interventions by punitive logic that is interwoven in all of these institutions of "help." The deficiencies are related to the gross underfunding of traditional left-hand institutions. However, within the context of the configuration that I found ethnographically, even as the right hand of the state administers "help" to the

hypermargnalized there is little to no coordination with other agencies to carry people through to sustained stability. This material reality also intersects the socio-cultural reality that the urban poor are still subject to intense stigma in all the institutional terrains in which they interface. The urban poor continue to bear the blame of these institutional failures as they are marked as "addicts," "service resistant," or "non-compliant" patients. In this dissertation, I found that it is in fact the blurring of the left and right hand of the states in each of these domains which sets up hypermarginalized populations for their continued "failure" to get stabilized and promotes continued suffering, even in a relatively resource-rich context such as San Francisco. My research showed how challenging it is to live a life defined by these tensions, where at any moment advocacy can shift into adjudication. Any gains made towards minimal stability are repeatedly disrupted.

In terms of practical resource allocation for the problems plaguing the urban poor neighborhoods, this configuration is a tragedy because despite the millions of dollars allocated to address the "homeless problem" in San Francisco, few visible gains seem to be made. Thus people question whether the homeless "can be helped" and this sentiment fuels the shrinking municipal, state, and federal budgets allocated to these complex social problems. But in terms of the urban poor's subjective experiences of *living*, this phenomenon institutionalizes a deeper tragedy—the perpetuation of everyday crises and suffering of the poor and institutionalization of a low level of what constitutes living. Our contemporary state interventions into poverty are at work to merely "salvage" lives in utter crises on a daily basis and not designed to promote and facilitate the enactment of a "good life" over a prolonged period of time. These institutions implicitly *require* that the

poor suffer deeply and dramatically before they become entitled to help from the state. Then, when someone enters the realm of entitlement, they become subject to navigation of bifurcated subject positions and simultaneously receive care and punishment.

Urban ethnographers and anthropologists who work in the areas of poverty, homelessness, and drug use are uniquely positioned to shed light on these institutional failures because quantitative evaluations may miss the nuanced ways in which these institutional interventions perpetuate hypermarginality. As academics, if we want to succeed at truly multifaceted and thick descriptions of the "institutional circuits" (Hopper et al. 1997) of the hypermarginalized, we may need to strategize about getting better access to institutional spaces, such as jails, drug treatment programs, psychiatric emergency facilities, and courtrooms and other criminal justice contexts, so that we can *in real time* trace the people's movement through the institutions intervening in the everyday crises of the poor and where further deficiencies lie. This may require reimagining the parameters of our research so that it includes embedded social workers, bureaucrats, law enforcement, and clinicians as part of larger research teams who have access to institutional spaces that ethnographers may be barred from. In my future research I seek to delve further into novel ways to conduct ethnography in the institutional geographies of hypermarginlity.

From a policy perspective, focused institutional coordination between agencies is desperately needed so that when one institution "lets go" of a client, the important linkages are already forged in terms of the next institutional intervention. However, this may require coordination and resources as a matter of municipal policy to link, for instance, hybrid police officers to psychiatric emergency and to the homeless services

people should access when released from psychiatric detainment. This may mean forging technological innovation so that coordination and treatment plans can be shared across institutions to maximize impact.

Finally, from a service delivery perspective, we must continue to institutionalize principles which work against stigmatizing and pathologizing conceptions of the urban poor who struggle with addiction and mental health issues. Within public health and drug user social movements, such a model already exists in the principles of harm reduction. However, even in a relatively socially progressive context such as San Francisco, harm reduction principles and practices are still marginalized in clinical care and social services. Continued training and implementation of models which actively combat stigma are needed so that they hypermarginalized are granted fuller access to the institutions designed to serve them.

APPENDIX A

Ethnographic Cohort (n=30)
*all names are pseudonyms
**indicates core ethnographic sample

	Participant*	**Synopsis**
1	Allie	Allie is a 19 year-old Asian woman who cycled between daily-rate hotels in the Mission. Her drug of choice was heroin and she also did sex work. She ended up at the daily-rate hotels after she was fired from her job at a drugstore nearby.
2	Angela	Angela is Latina woman in her 40s who I first met in the Mission at a city-run hotel, but she eventually moved into the Tenderloin. I visited her SRO room in the Tenderloin in a large building, where she had become extremely socially isolated.
3	Amanda	Amanda is a white woman in her 50s who lived in a daily-rate hotel in the Mission and had been granted residency by the management and lived permanently in a room near the manager's office. Over the course of my field work, she was diagnosed with breast cancer and had a mastectomy and started chemotherapy at the County Hospital, while living in this SRO in a cramped room with no bathroom.
4	Belinda	Belinda was an African American woman in her 50s who lived at a city-run supportive housing SRO. Despite being connected to HIV/AIDS clinical care at the county hospital, she was not on medication and had an advanced AIDS diagnosis. She continued to use crack-cocaine frequently. She died over the course of my field work. I attended her memorial at the hotel.
5	Betty	Betty is a white woman in her 40s who cycled between the daily-rate hotels. She used heroin and crack-cocaine and had a history of sex work. She was involved in a partnership with a man that often turned violent. When I met her, she was seeking resources to be placed in a domestic violence shelter after a violent assault from this man. She was unable to get housed at a shelter and was forced to live a few doors down from her assailant.
6	Bridget**	Bridget is a 49-year old HIV positive white woman who during my field work was very transient and often cycled between jail, time on the streets, and transitional housing. Over the years she has had extensive criminal justice involvement, mostly for drug possession and drug sales charges. She primarily uses methamphetamine and other stimulants. She described a history of trauma and violence in her past, but had a strikingly upbeat demeanor.

7	Cecilia	Cecilia is a Latina woman in her 40s who lived in the daily-rate hotels. She was actively doing sex work and was in constant negotiation with management over their illegal practice of charging "visiting fees" to sex work clients that came into the SRO where she frequently stayed and worked (see Chapter 3). She was working with a local advocacy organization to attempt to document instances of this illegal practice in order to try and get her money back.
8	Claudia	Claudia is a Latina woman in her early 20s who had a history of drug use, but became pregnant while living in the daily-rate hotels and stopped using drugs at this time. This connected her to social services, but towards the end of her pregnancy, she was back in the Yash Hotel. The outreach team continued to provide her with additional vitamins, food, and support until she transitioned into more stable housing.
9	Diana	Diana is a white woman in her 50s who had lived at the Ashtha hotel for many years. She spent her time at the local subway stop during the day and was connected to local gang members, though the nature of her ties to the illicit drug economy were unclear.
10	Elaina	Elaina is an African American woman in her early 20s who lived in a daily-rate hotel with a very active illicit drug economy. She was known to have robbed people in the Mission District, including some people on her block, therefore her safety was tenuous. She was an active speed user and often described paranoia. Over the course of my fieldwork, her partner was shot in the hotel that they were staying in, though he was dragged out onto the street before the police arrived, so that the police would not enter the hotel.
11	Gia	Gia is a white woman in her late 20s, who lived in the daily-rate hotels in the Mission. She was very explicit in her strategies for avoiding police interaction on the streets and in the hotels. She both used drugs and did sex work.
12	Janet	Janet is a white woman in her 40s who lived in the daily-rate hotels in the Mission District. She stayed primarily in a hotel with an active illicit drug economy and reported that the hotel management would rent out the bathrooms at night for drug dealers. She had a history of drug use.
13	Jenai**	Jenai is a 55 year-old mixed race (her own term) woman who lives in a large city-run hotel in the Mission District. She describes herself as "bipolar" and has a violent history with her current partner, who resides in the same hotel. She has a history of drug use and was managing chronic health issues, such as high blood pressure. Despite having secured permanent housing through a program at her hotel, she still considered herself homeless.

14	Liliana**	Liliana is a Latina transgendered woman in her mid-40s. At the time of my fieldwork, she lived in a city-run SRO in the Mission District. Previous to that she experienced years of homelessness and also stayed at daily-rate SROs. She has a history of drug use, sex work, and experiences with childhood trauma and violence. Over the course of my fieldwork she did not use drugs. Previously, her primary drug used had been heroin, however she had also used crack-cocaine. She was placed in the city-run SRO after completing a drug treatment program. She had zero income during the time we knew each other and every day was a struggle for basic survival.
15	Lilah**	Lila is a 44-year old African American woman who for over a decade has cycled between daily-rate hotels and also street homelessness. She has a long history of drug use, sex work, and experiences with childhood trauma and violence. Over the course of my field work she suffered from kidney failure and started dialysis treatment, while still living in a city-run homeless shelter. Her primary drugs used were heroin and crack-cocaine. She had also been on methadone for several years. Over the course of my fieldwork she was cut off from her methadone program and endured violent and painful withdrawal while cycling between the streets, shelters, and daily-rate SRO hotel rooms.
16	Lorena	Lorena is a Latina woman in her 50s who I met at the Prachi Hotel, where she worked cleaning the hotel. Eventually, her daughter took over management of the Yash hotel and Lorena moved there, where she continued housekeeping work. This transition also afforded her obtaining own, larger hotel room. Lorena's daughter and her husband eventually became very involved in the illicit drug and sex economy in the Yash, transforming the hotel into what many women described as a "brothel."
17	Lorraine	Lorraine is an African American woman in her 40s who at the time of my fieldwork was staying at one of the large city-run shelters. She took me on a long tour of the shelter one day, but eventually her mental health issues (paranoia) escalated at which time I tapered contact with her.
18	Lucia**	Vanessa is a 51 year-old HIV positive woman who identifies as mixed race. Her primary drug used was alcohol. At the time we met, she was living in a supportive housing program that she secured through a drug treatment program. She never told me that she had a mental health diagnosis, however, she often described intense anxiety and paranoia, which could sometimes be debilitating. She often drank to the point of blacking out on the streets of the Tenderloin and was picked

		up by the police often. She has a long history of violence in her life, including recent assaults by an ex-partner.
19	Marla	Marla is an African-American woman in her 40s who moved between daily-rate hotels in the Mission. On the day that I joined the SRO outreach team, Marla's sister was either pushed out our fell out of an SRO hotel room window, sustaining severe injuries (see Chapter 3). Marla was an active heroin user and did sex work.
20	Monica**	Monica is a 53 year-old Latina woman who at the time of my fieldwork lived in a city-run SRO in the Mission District, though had been street homeless for many years previously. She suffered from serious chronic pain, had wound issues from long-term heroin use, and is HIV positive. She was on methadone and engaged with clinic care at the County Hospital. She had previously used heroin frequently and during the course of my field work used crack-cocaine.
21	Natasha**	Natasha is a 35-year old white woman who lived in the daily rate hotels and worked as a drug runner for her male partner. She had a history of sex work, however, since entering into a relationship with this current partner had stopped sex work. She cycled between a handful of the daily-rate hotels in the Mission District, however since starting to work as a drug runner, preferred to stay in hotels which drew less police activity. She had a serious heroin habit and desired to start methadone maintenance or stop using drugs altogether.
22	Reyna	Reyna is a white woman in her late 20s, known for her extremely tough affect. Throughout my fieldwork, she cycled through the daily-rate hotels and did sex work in order to survive. She had been pregnant several times before, though none of the children lived in her care, having all been taken away by Child Protective Services. She was pregnant during the course of my field work and remained in the SRO and doing sex work until the birth.
23	Roshelle	Roshelle is a 50-year old African American woman who is HIV positive. At the time I met her she was enrolled in a drug treatment/transitional housing program in a neighborhood some distance from the Tenderloin. She had a long history of initiating violence herself and many of our conversations were about how she managed her rage episodes. Though she had a history of drug use, at the time we met she was not using drugs, but was occasionally doing drug running.
24	Sheryl**	Sheryl is a 45 year-old HIV positive woman who has a long history of incarceration and experienced violence at the hands of police on the streets and by correctional officers while incarcerated. When we met, she had recently been released from county jail and was staying in a transitional housing

		program until she could secure permanent housing in a city-run SRO. When she was released from jail, she was not using any drugs, however, she reinitiated heroin and crack-cocaine use and occasionally used methamphetamine and other prescription pills. Before moving to San Francisco, she had done sex work, however in San Francisco survived largely in the illicit economy through bartering or petty drug sales.
25	Stella	Stella is a Latina woman in her 40s who lived in the daily rate hotels. She had a hard time meeting her basic needs and often asked for referrals and support from the outreach team. She overheard the violent assault and eventual murder in the Astha hotel that I discuss in Chapter 3.
26	Stephanie**	Stephanie is a 43-year old white woman who lives in the daily-rate hotels. Service providers who also knew her described her as having borderline personality disorder, though Stephanie did not use this term to describe herself during interviews. Despite living in a daily-rate hotel, she had an arrangement with the management and was allowed to stay in her room for months at a time. She sometimes did informal work for the management, such as cleaning hallways and trash areas. Her primary drug used was methamphetamine.
27	Talia	Talia is a Latina woman in her 20s who I met in the daily-rate hotels after she was released from the County Jail. Upon her release she was not using drugs, but over the course of a few weeks, she reinitiated drug use and started doing sex work in order to pay the rent on her hotel room.
28	Timo**	Timo is a 44 year-old transgender African American male who lived in the daily-rate hotels. Though he did not use drugs at the time of my field work, he was immersed in the illicit drug economy in the daily-rate hotels because of his partner, who was a long-time heroin user. Timo and his partner eventually moved out of the daily-rate hotels and secured more stable housing in a cooperative at which time Timo joined the outreach team that I was a part of. Timo's partner suffered a violent assault during my field work, which a woman who lived in the hotels witnessed.
29	Valerie	Valerie is a white woman in her 30s who moved between daily-rate hotels. She was an active heroin user and frequently suffered from injection-related abscesses. During my fieldwork she had a severe case of cellulitis, which can result in acute and fatal complications, but did not desire to seek medical care.
30	Yulie	Yulie is a white woman in her late 40s who had been living in the daily-rate hotels for over a decade. She was one of most well-known figures around in the Mission corridor because she maintained a tough affect, but also because she was known

		for getting extremely high in the hotels. She had a long history of both drug use and sex work.

Police and Provider Cohort (n=10)
Semi-structured interviews with providers, criminal justice, and law enforcement

Agency	Interviewees
San Francisco Police Department	Semi-structured interviews with the following: -2 Homeless Outreach Team Officers in Mission District -2 Homeless Outreach Team Officers in Tenderloin District -Police Captain in Mission District -Police Captain in Tenderloin District -Previous Coordinator of Homeless Outreach Team
Forensic AIDS project	Interviewed provider for agency that coordinates care inside and outside of the county jail for men and women who are HIV positive
Public Defender's Office	Interviewed Assistant Public Defender who worked with SRO hotels residents regarding allegations of police misconduct in SRO hotels in San Francisco
San Francisco City Outreach Workers	Conducted a ride along and ethnographic interview with 2 city employed outreach workers whose role it is to interface with homeless populations and provide service referrals.
Community Justice Center	Semi-structured interview with coordinator of diversion program, which allows people to perform community service or participate in a program instead of face jail time for certain misdemeanor crimes.
San Francisco Homeless Coalition	Semi-structured interview with provider organization regarding how social service agencies interface with the San Francisco Police Department and the key issues facing unstably housed populations in San Francisco.

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