I worked with and studied case managers while they mobilized resources in a mental health organization to enable former hospital patients to continue living in communities. In this book I am primarily concerned with the ways managers use case management theory to produce apartment-dwelling consumers of mental health services. The policy is deinstitutionalization and the practice is case management. Sometimes called “continuum-of-care” or “community reintegration,” case management depends heavily on the policy emphasis given to short stays in hospitals. And successful programs are measured by their capacity to divert patients from hospitals to community resources.

Researchers, policy advocates, and practitioners persuasively argue that case management, the linchpin of deinstitutionalization, is effective in linking clients to social, mental, and medical services; it increases functioning, diminishes residential mobility, promotes independent living, and reduces hospitalizations. Practitioners are inundated with books and scholarly articles describing case management models and corresponding outcome and evaluation studies. Encouraged by this accumulation of knowledge, policymakers and scholars now talk about “best practices,” especially those shown to measure up to empirical scientific standards.1

I add to the case management literature by studying the work of a specific practice model, and when it fails I ask what the case manager faces. My study of case managers’ daily work explores not only how the policy of deinstitutionalization, community support service, and strengths case management
determines practice. I also examine how practitioners produce effects that are of their own making. Yet I am fully aware that policy influences social work practice. Managed care, for example, has transformed the nature of our practice, just as the politics and economics of liberal social welfare states shape practitioners’ actions (Chatterjee 1999; Handler and Hasenfeld 1991; Lipsky 1980). And the recent scholarly focus on the power to name, to classify, to survey, and to regulate behavior—what has been called discursive or disciplinary knowledge/power—reveals still more constraints on practice and practitioners (Chambon et al. 1999). The literature studying the conditions for practice raises significant theoretical, practical, and research questions about the moments where case managers take the products of policy, welfare states, and discursive knowledge and make or do something tactical, personal, and new with them (de Certeau 1984:xii). Although I found the conditions for case management to be immensely constraining, by comparing oral and written narratives, I show that case managers create in ways not determined by or reducible to those conditions. I utilize a unique methodology for studying and writing social work practice, a multimethod, interdisciplinary and critical-realist perspective that will challenge current mental health policymakers and practitioners.

THEORETICAL AND METHODOLOGICAL CONSIDERATIONS

Social workers are often seen as occupying two positions, that of the omnipotent state agent, enforcing policy, rules, and conventions, and that of the oppressed worker, acquiescing to more powerful state structures and agents. Indeed, the criticism and study of social workers fluctuates around these two poles. One practitioner is knowing and reflective, the other is dominated and at the same time dominating. I explore the practical and symbolic terrain between what Joel Handler once called the coercive social worker (1973) and Richard Cloward and Frances Fox Piven (1977) called the acquiescent one.

Influenced by anthropological, historical, and interdisciplinary studies, I am reversing the typical way of thinking about and studying social workers. Michel de Certeau (1984) argues, for example, that television programs do not absolutely determine consumers’ taste and opinion. Likewise, subjects of colonial governments and economies are not mere copies of the colonizer (Apter 1992), nor are peasant farmers uniformly pawns of landlords (Scott 1990). Bourgois, in his study of poverty and drugs in Harlem, shows how dealers are agents in their own right (Bourgois 1995), with a full understanding of
the economic logic that shapes their lives and that they in turn use to shape
their lives. Just as anthropologists, historians, and sociologists have recovered
agency for marginal or oppressed groups—factory workers, women, peasant
farmers, ethnic minorities, gays and lesbians, or drug dealers—I believe that
the study of social work practice must include the practitioners and account
for their agency. Thus we must carefully explore what effects managers pro-
duce that are outside the mere conditions of practice.

A variety of methodological and theoretical works during the last decade
have been aimed at the study of social workers. They examine the writings of
practitioners to show how social workers dominate through their unmedi-
ated applying of policy and disciplinary knowledge/power. In part, this new
interest in social work results from the availability of records; with the passage
of time sticky confidentiality questions are resolved, and scholars have access
to case records from the early decades of the last century. Moreover, social
workers are easy research targets as they are the authors of thousands of
progress and case notes, treatment plans, social histories, and assessments
(Prince 1996; Kagle 1991). Nothing is more seductive to the researcher or jour-
nalist than a professional paper trail; indeed, it is imagined that case records
reach deep like taproots into a social worker’s subjectivity.

For more than a generation now critics have argued that social workers
police the masses. The liberal welfare state, according to this view, is a proxy
for capitalists who use social workers to manipulate, control, and regulate the
unwanted workforce. For scholars critical or unsympathetic to the political-
economic argument, Michel Foucault offered a radical alternative account.
Foucault’s signature concept, biopower, provided a point of departure for the
more recent sociological, anthropological, and historical accounts of practice.
Government agents, the theory suggests, use biopower to regulate and rou-
tinize everyday social relations; typically, however, this is not accomplished
through techniques, knowledge, and classificatory schemes that give empha-
sis to the naked force of the state. In short, this is not simply power over.
Biopower refers, instead, to the myriad ways that dominant discourses on
gender, sexuality, ethnicity, and work, become taken for granted, normalized,
and internalized; the individual becomes the subject dictated by the domi-
nant discourse. And it is in this way that biopower includes practitioners’
“dividing practices” (e.g., assessment and diagnostic schemes) that work to
place clients either inside a normal circle of behavior or outside, among the
abnormal.

Influenced by Foucault, researchers use case records to interrogate the
malevolent worker; they produce the service recipient’s subjectivity: the
“patient,” the “client,” or the “case.” Consequently, to the earlier political and economic criticisms of practice a new one is added: the social worker as disciplinary agent. Armed with psychological, behavioral, and psychodynamic practice theories, helpers defend the therapeutic state (Polsky 1991), produce tales of wayward girls (Tice 1998), invent kindness to mask the evils of home visits (Margolin 1997), and construct delinquent daughters (Odem 1995) and unwed mothers (Kunzel 1993). Through disciplinary knowledge and power, social workers are figured as regulators of castaways and their everyday lives.

This generation of scholars has argued that the regulation of bodies—emotional, intellectual, and physical—in time and space is an effect of disciplinary knowledge/power (Foucault 1979; Chambon et al. 1999). Though Foucault rarely turned his gaze to the practices of social workers, about the generalized process of discipline and social regulation projecting outward from prisons, he wrote that “the second process is the growth of the disciplinary networks . . . as medicine, psychology, education, public assistance, and ‘social work’ assume an ever greater share of the powers of supervision and assessment” (Foucault 1979:306).3

In a recent application of Foucault to what many claim is the ever-widening sphere of social work, Leslie Margolin (1997) argues that social workers subversively use empathy and friendliness to gain entry into private homes and lives. In short, surveillance and disciplinary meetings, disguised as “home visits,” were “social work’s totem technique, corresponding to the psychometric test of the psychologist or the physician’s prescription” (Margolin 1997:26). I have argued that Margolin’s purblind use of written texts exaggerates the role of disciplinary knowledge in social work (Floersch 1999). About Margolin, Jerome Wakefield adds, “he eliminates from consideration what social workers actually say to one another or to themselves and focuses instead on examples presented in textbooks and articles, where social workers—as do other professionals—tend to present the most successful examples of practice” (Wakefield 1998:567).4

In this study, I avoid this by now conventional temptation to reduce social workers and their practices to the disciplinary power of theory (Kunzel 1993; Gordon 1994; Odem 1995; Tice 1998). Although theories and models of practice constitute a basic component of the conditions for practice, without individual actors there can be no practice (Collier 1994). In short, by arguing that case managers make a difference—not as minions of disciplinary knowledge—in the everyday work that produces the effects of deinstitutionalization, I offer a corrective to accounts of social work that reduce practice to theory or disciplinary knowledge/power. I follow the work of those who have
argued that the ideas, cognitive processes, meanings, and experience of social workers generate specific practices (Berlin and Marsh 1993:11).

I started with Michel Foucault’s concepts of biopower and disciplinary schemes and looked at how scholars apply them to the study of social work. The result was my use of the concept disciplinary knowledge/power, which refers in this study to strengths case management. This I did in order to highlight that strengths theory has an inherent quality to produce helping effects; its property to produce effects is denoted by placing a forward slash (/) between knowledge and power (i.e., strengths disciplinary knowledge/power). Most Foucauldian studies of social workers see disciplinary knowledge/power as regulating, controlling, and shaping the behavior and thoughts of clients (i.e., the making of a “case” of mental illness). In order to avoid reducing all practice effects to the disciplinary knowledge/power, I needed a companion concept to capture the case manager’s specific, contextual, or strategic efforts. In this search, I found Foucault’s discussion of the “specific” intellectual potentially useful (Rabinow 1984:67–75). Similar to Antonio Gramsci’s organic intellectual, Foucault’s specific intellectual identifies the knowledge of the particular; that is, knowledge that is grounded in everyday action and is not mediated by a dominant theory or ideology or, in my case, strengths case management.

However, in addition to Foucault’s idea of the specific intellectual, I trace my adoption of situated knowledge/power to a further synthesis of several professional and scholarly works. First, there is the cognitive and learning literature on situated learning; here, learning is contextual, intersubjective, relational, and specific, not the single or direct extension of intrinsic capacity or teaching theory (Lave 1988; Lave and Chaiklin 1993; Rogoff 1990). Second, professional literature has used the following concepts to denote a practice reality that is separate from theory: practice wisdom (Klein and Bloom 1995); tacit knowledge (Zeira and Rosen 2000; Sternberg and Horvath 1999; Imre 1985); personal practice models (Mullen 1983); reflective practitioner (Berlin and Marsh 1993; Schön 1983), deliberative practitioner (Forester 1999), and practitioner-researcher (Hess and Mullen 1995). And third, anthropologists use the terms “local knowledge” (Geertz 1983) and “situated lives” (Lamphere et al. 1997) to refer to particular cultural knowledge, and the feminist philosopher Donna Haraway (1988) calls for an understanding of women’s situated knowledge. Examining how these conceptualizations variously name personal knowledge, I saw agreement that situated knowledge/power pointed to realities disciplinary knowledge/power could not capture or represent; that is, practitioners produce local, specific, contextual, or situated knowledge in practice. Moreover, in contradistinction to the a priori disciplinary knowl-
edge, these various conceptualizations see situated knowledge as dependent on activities or as knowledge in action.

I have not operationalized, according to positivist methods, the terms disciplinary and situated knowledge/power. Like others, I am using these in a heuristic description of the holistic work of practicing professionals. Nor am I referring with these concepts to a strict polarity between two powers, theories, or logics; instead, I show that case managers use both types of knowledge/power. I use historical data in chapter 3 to argue that an early form of case managers’ situated knowledge was absorbed by the scientific community and then transformed into strengths case management disciplinary knowledge. Thus, disciplinary and situated practices are often integrally related.

It is in this manner that I show that case managers can be viewed as Foucauldian “specific” and “universal” intellectuals (Rabinow 1984:67–75). By using ethnographic methods, I demonstrate that Foucault’s specific intellectual uses situated knowledge/power, while the universal employs the disciplinary. And most important, I show that situated knowledge/power is found in the oral narratives of case managers. I will show that while disciplinary knowledge/power tends to absorb indeterminacy into universal categories, social workers also use situated knowledge/power. Moreover, the multiple (and often indeterminate) causes of mental illness make responses to it continually negotiable. Situated practices may complement disciplinary ones, or it may resist them; it may be consciously or unconsciously deployed; alternatively, it may be subsumed by the disciplinary. Situated and disciplinary practices are both constraining and productive forces, controlling and also caring (Wakefield 1998). I show not only how these combined knowledge/power systems produce the same controlling and caring outcome. I also show their distinct conceptual significance and usefulness.

None of the effects of disciplinary or situated practices, however, can be known a priori (Apter 1992:213–226). Situated knowledge/power must be empirically studied; it could be different from and contrary to the disciplinary—in this case it might resist the desired outcome. Or it could be different from but complementary to the disciplinary—in this case it has a neutral or supporting influence upon the desired outcome. A third possibility is that situated knowledge/power could be a copy of the disciplinary—in this case both work together to achieve the desired outcome, that is, where policies, organizations, and the disciplinary practice produce all desired effects, practitioners have no reason to create or invent. I will show that case managers used situated knowledge/power and acted in the manner of the second possibility.

The study of situated knowledge has been overshadowed by sole interest in the Foucauldian idea of an omnipotent disciplinary gaze. Yet, even the hospi-
tal nurse, psychiatrist, and social worker were incapable of finding a single standpoint (the panopticon) that provided absolute insight, monitoring, and assessment. Susanna Kaysen, in *Girl Interrupted*, nicely illustrates how she acted as an adolescent patient to checkmate the gaze of the nurse. She writes, “We were sitting on the floor in front of the nursing station having a smoke. We liked sitting there. We could keep an eye on the nurses that way” (1993:65). Patients secretly passed notes and hid medications in the cheeks of their mouths. Similarly, social workers escape the gaze of the administration, policy, and disciplinary knowledge/power. I show that when strengths case management fails to produce effects, situated practices make up for the model’s limitations. Scholars, neglecting to see the obscured oral narrative, the empirical site of situated knowledge/power, miss its significance by studying only the written texts, the empirical site of the disciplinary knowledge/power. I will show that oral situated practices are not just a shadow of the written disciplinary powers, and although situated practices are difficult to research, they have unique powers with corresponding effects.

In sum, I use a variety of qualitative methods and a critical-realist perspective to show that case managers use two types of practice power: disciplinary and situated. Together they form a totality of practice. I challenge scholars of practice to calibrate their conclusions to both the readily seen (written text) and the less visible (oral narrative) facets of social work power. I have placed the disciplinary practices of case managers within social fields; this provides for a more nuanced treatment of the systemic cultural and political features of strengths case management (see figure 1, appendix A).

**SOCIAL FIELD**

Knowledge/power schemes are not ahistorical, nor are they independent of society. I use Pierre Bourdieu’s concept of the social field to understand the history and sociological production of knowledge/power. Social work practice is inextricably connected to national, state, and local policy. Mental health policies create boundaries that constitute a field of practice that fills up with unique kinds of knowledge/power schemes. And the latter defines who the helpers and recipients will be. For example, the mental hospital was a unique social field formed with nineteenth-century understandings and policies. Accordingly, the medical model defined the power relationship between the psychiatrist and the patient (Braslow 1997). During the last forty years, however, a new social field gradually replaced the hospital: community support services (CSS). This field deploys case management as a knowledge/power
scheme and defines a new social relationship, that between case manager and consumer.

Although case managers are brought into the project of deinstitutionalization, it is not a project of their own choosing. A social field called CSS structures the conditions for case management. For Pierre Bourdieu, a field may be defined as a network, or a configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents, or institutions, by their present and potential situation (situs) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions.

(Bourdieu and Wacquant 1992:97)

Bourdieu identifies religious, artistic, educational, and economic social fields, among others. To this list I add community support services. The network of power relations that organize and reproduce community support services bind the disciplinary and situated practices of case managers; these relations have juridical force—in my study this force derives from the Kansas 1990 Mental Health Act—and they are also administratively determined by the mandated use of strengths case management.

The CSS field is filled with practice theories (disciplinary) as well as with local (situated) meaning and experience. Here I am cautious not to use social field as a conceptual receptacle for the purpose of reducing disciplinary and situated practices, that is, these practices have relative autonomy from a social field’s policy and administrative power. The relationship between case managers and service recipients is thus configured by national and state mental health networks that name the problem (e.g., patients’ dependency on hospitals), create systems of organizations, and employ specific kinds of workers. Case managers’ practices only make sense—and can only be made sense of—when placed in a sociohistorical relation to the CSS social field. I argue that state mental hospitals and community support services uniquely combined six elements of helping social fields; in table 1.1, I compare these elements.

Spatially, hospitals were organized as laboratories; in the clinical environment patients were confined, studied, diagnosed, and, one hopes, cured (Foucault 1973). Here, as Foucault describes in regard to prisons, there is “uninterrupted, constant coercion, supervising the processes of the activity rather than its result and it is exercised according to a codification that partitions as
closely as possible time, space, and movement” (Foucault 1979:137). Indeed, hospitals were designed to remove patients from the pathologies and stresses of urban life or the hazards of living in communities (Grob 1994). In the hospital space, a closed therapeutic environment, patients moved through institutional time, not personal or private time. Moreover, patients gained access to daily necessities—shelter, food, and medicines—through a centralized, socialized, hospital economy, where needs were met at a single and unified site. Medical and psychiatric knowledge was aimed at underlying pathologies; the helper was named doctor and the service recipient was known as patient.

In the CSS social field, space, time, mobility, and economics were so radically reorganized and reconstituted that new disciplinary knowledge and practitioners became necessary. Deinstitutionalization loosened the patient’s ties to the closed system of the hospital, and policy advocates believed that the open system of the community was good for personal growth. In addition, CSS advocates claimed that life regulated by personal time, as opposed to institutional time, was therapeutic. Once freed from the constraints of the hospital, former patients became “consumers” of commodities, including mental health services. And here was the rub: making patients into everyday consumers was not possible within the time frame of the fifty-minute, clinic-based, psychotherapeutic hour. Many of the former patients required continual monitoring and assistance with paying bills, shopping for groceries, taking medications, and socializing. In this new and open environment practitioners, former patients, and families experienced the commodity and social service

<table>
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<tr>
<th>ELEMENTS</th>
<th>MENTAL HOSPITAL SOCIAL FIELD</th>
<th>COMMUNITY SUPPORT SERVICES SOCIAL FIELD</th>
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</thead>
<tbody>
<tr>
<td>1. Space</td>
<td>Closed clinic</td>
<td>Open community</td>
</tr>
<tr>
<td>2. Time</td>
<td>Institutional</td>
<td>Personal and private</td>
</tr>
<tr>
<td>3. Mobility</td>
<td>Bodies fixed</td>
<td>Bodies in motion</td>
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<td>4. Economic</td>
<td>Socialized economy</td>
<td>Commodity, market economy</td>
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<tr>
<td>5. Disciplinary knowledge</td>
<td>Medical/psychiatric</td>
<td>Pharmacological-medical and strengths case management</td>
</tr>
<tr>
<td>6. Helper and service recipient</td>
<td>Doctor and patient</td>
<td>Case manager and consumer</td>
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economies as fragmented, and by the end of the 1970s, together with the National Institute of Mental Health, all reached the same conclusion: a new practitioner and disciplinary knowledge was needed to screen, link, and monitor the consumers as they moved through the open systems of community life. With this sociological and historical understanding, I began my ethnographic study of case managers.

THE SETTING

High County Mental Health Center\(^6\) is located near the crossroads of the Oak Springs branch of the historic Santa Fe Trail and Fort Harrison and Fort Smith roads. In 1856 Oak Springs was renamed Oaklawn. Community Support Services (CSS), a branch of High County Mental Health Center, is located one mile south of Oaklawn, Kansas. The mission of CSS is

to support and teach individuals in developing the skills and resources they need to be successful in the living, learning, working, and social environments they choose. The desires, goals, and aspirations of the people we serve are of paramount importance in guiding this process.

(High County Mental Health Center 1997)

The mentally ill, put in motion by a policy called deinstitutionalization, negotiate the exurban world near the old Santa Fe Trail, from the state hospital to High County Community Support Services, then outward to homes, apartments, and center-operated residential facilities. Each client, with an assigned case manager, is linked to food, apartments, transportation, and health care. Advocates of deinstitutionalization claim that the journey from the hospital to the sprawling exurban spaces of High County is about the realization of unfulfilled dreams. At the national level, critics of the policy accuse it of having produced a lost population of underserved, neglected, jailed, and often homeless individuals (for a recent discussion, see Torrey 1997).

Yet despite its detractors, deinstitutionalization in Kansas and most states is a reality. Indeed, on May 16, 1997, the Kansas Topeka State Hospital closed its doors, and the region’s only remaining state-run hospital allocated only fifteen beds for the 400,000 residents of High County. Hospital closure and downsizing required Herculean efforts: 400 CSS clients, along with their thirty-five case managers, travel nearly 750,000 miles annually—thirty revolutions around the earth—to and from CSS, apartments, grocery stores, banks, welfare offices, and numerous other suburban locations. Little did the
architects of deinstitutionalization realize that resettling the suburban mentally ill would become, de facto, a transportation policy.

In the early 1980s Kansas community mental health centers provided few services for the “chronically mentally ill.” While High County Mental Health Center had a program for such clients, it was clearly peripheral. For example, in 1981 the center employed no case managers, it lacked a housing program, and psychosocial services amounted to little more than a few afternoon “talk groups.”

High County made its first serious overture to the ex-hospital population during the early Reagan years, when federal monies were sent directly to state treasuries via block grants. For ideological and political reasons, state administrators acknowledged that services to the most seriously mentally ill were underfunded and subordinate to “worried well” clinical services. Thus, Kansas officials initiated pilot projects aimed at expanding the scope of community support services philosophy and practice. As a result, by 1987 High County had fifteen case managers, had allocated office space for services, and had established a rudimentary psychosocial program.

Structural change was forthcoming in the form of the 1990 Kansas Mental Health Act. The latter mandated community support services, reoriented funding to assure its implementation, and empowered street-level workers. The new law, for example, gave social workers with master’s degrees along with psychiatrists authority over involuntary commitment procedures, something formerly granted only to psychiatrists.

By 1997 High County had nearly 300 employees distributed among three programs: clinical services, medical services, and community support services. An executive director, appointed by the county commissioners, was accountable to a board of directors. Each of the three divisions had a director, and within CSS there were several programs: case management, vocational, psychosocial (a residential care facility was phased out in 1994), and a crisis case management team. Subprograms of CSS were supervised by social workers with master’s degrees, and most case managers had bachelor’s degrees.

I chose High County Mental Health Center as the site for my research for two reasons. First, in Kansas and High County ample resources and political will provided an optimal environment for case management. For example, common wisdom suggests that it is desirable for case managers to have no more than fifteen clients. In High County, not only did the thirty-five CSS managers have the expected caseload, but their median salary ($35,000) was respectable enough to minimize burnout and discourage turnover. This assured that clients would have a continuous relationship, a variable considered crucial to successful case management (Axelrod and Wetzler 1989;
Bigelow and Young 1991; Chamberlain and Rapp 1991; Dietzen and Bond 1993). Moreover, of the mental health center’s overall 1997 budget, a robust 39 percent (five million dollars) of the total (thirteen million dollars) was spent on community support services; the center’s clinical services allocation was 30 percent (four million dollars). This marked a dramatic turnabout; advocates for the mentally ill had been critical of the national tendency to provide clinical services primarily to the “worried well” as opposed to those with chronic mental illness (Torrey 1988:228–232).

At High County the three requirements of successful case management were satisfied: (1) reasonable caseload, (2) staff continuity, and (3) adequate community resources. In this organizational environment, rich in resources and unhampered by contradictory funding policies, I did not have to concern myself with how an underfunded project constrained practitioners. In short, High County had produced optimal conditions for case management.

There was a second reason for my choice of this site. I had worked as an emergency crisis counselor and housing supervisor—from 1981 to 1994—in building crucial components of High County Community Support Services. In my work as a case manager I was enmeshed in the practices that shaped the everyday lives of workers. But perhaps most important, I was a familiar face; I had earned the respect of clients and staff; and mutual respect produced a curiosity about my research. For these reasons I was easily absorbed into the life at CSS.

DEVELOPMENT OF THE CSS SOCIAL FIELD

Displacing the hospital as a social field in Kansas and replacing it with community support services required top-down (national and state bureaucracies) and bottom-up (field practitioners) efforts. As policymaking goes, deinstitutionalization covers everything: from the idea to empty beds, from debate to agenda setting, from legislative action to implementation (Kingdon 1984). I do not, however, marshal historical data on CSS, Kansas, High County Mental Health Center, and the National Institute of Mental Health (NIMH) in chapters 2 and 3 to confirm or negate any particular theory about policymaking. In these chapters it is my purpose to show that once the CSS social field was formed, disciplinary knowledge necessarily followed. In chapter 2 I argue that the “principle of normalization” and the fragmentation of mental health services are among the primary historical roots of CSS and case managers’s roles.
RISE OF THE CASE MANAGER

Once CSS was conceptualized, NIMH and Kansas built organizational capacity. In chapter 3 I describe the bottom-up effort to build a viable county program, especially through the incremental rise of the case manager. Although the central figures of hospital care—the nurse and psychiatrist—were not altogether displaced in the new social field, their ruling and pivotal positions gave way to that of case managers and their advocates, policymakers, and related practitioners. In this chapter I describe how High County (in the 1980s) used office-based partial hospital program monies to surreptitiously support individual case management in the community. A “learning by doing” practice emerged; the first case managers were not trained in any specific disciplinary knowledge. And the early period marked the simultaneous use of “client” and “consumer” to name service recipients, a dualism that persists to the present day.

STRENGTHS CASE MANAGEMENT

Together with colleagues, Charles Rapp, a professor of social work at the University of Kansas, created a veritable cottage industry for the testing, formulation, and dissemination of strengths case management. Through scientific production processes, he coded the situated practices of case managers in the 1980s to produce a model of practice named strengths. The acceptance and legitimation of the strengths model is indicated today by numerous national and international conferences and workshops where it has been discussed. In 1984 High County became one of Rapp’s research sites. It proved a fruitful and enduring relationship. Of the case managers I studied, 90 percent had attended strengths workshops sponsored by the University of Kansas School of Social Welfare. Only recent employees had not attended. Indeed, training in strengths management was the only common element in the work and educational histories of the case managers I studied.

In chapter 4 I discuss strengths case management. Although in dozens of articles, research reports, and books (Rapp 1998) strengths management has been described and defended, none use ethnography to understand its application. Thus I began my research by attending a “Basic Strengths Workshop.” Here my aim was to develop from the outset an ethnographic understanding of the normative tenets and language of strengths management.
LANDSCAPE FOR A CASE MANAGER

Kansas state hospitals, like many, were bounded by pastoral grounds and tree-lined drives and had a central admission office, ward walls, corridors, and locked doors. Wards were locked to keep those inside from getting out. The use of space to segregate patients from communities was consistent with the nineteenth-century romantic notion that isolation from dirty, noisy, and crowded industrial landscapes fostered well-being (Grob 1994). Today, in a complete reversal, CSS’s doors are locked at night, not to keep consumers from getting out but to keep those outside from getting in. The use of suburban space now complements the idea that communities are healthy and that segregated hospitals foster dependency. In chapter 5 I describe case managers’ experiences with an eye toward understanding the unique configurations of time and space and the physicality of suburban High County.

With respect to studies of deinstitutionalization and, perhaps, social work practice more generally, I bring a novel perspective to the study of the work of helping. Discussions of space and landscapes—as opposed to the concept policy environment—are borrowed from recent literature in social geography and sociology of space (Soja 1996; Zukin 1991; Jackson 1984). In the production of space we reproduce social relations. Space, in short, is not a mere abstraction that we work around and through; indeed, spatial arrangements help define the nature of practice. Case managers must move in and out of suburban space in order to fulfill the mission of CSS and the strengths model to discover “naturally occurring resources.”

Negotiating space is also a source of irritation for the situated practitioner; by staying within the boundaries imposed by geopolitical landscapes, strengths management must absorb and define as “natural” what situated practice finds unnatural—the time it takes to drive (annually, nearly 12,000 miles per case manager) from home visit to grocery store to pharmacy to endless destinations. It is in this way that the suburban landscape uniquely marks case management.

MEDS, MONEY, AND MANNERS

To better understand the relationship between disciplinary and situated knowledge/power I draw in chapter 6 on the work of the anthropologist Victor Turner (1974). He argues that in moments of crisis social structure is revealed and social drama unfolds. When case management did not produce the hoped-for effects, I investigated the responses of practitioners. I present
an unfolding crisis and social drama in one intensive case study as an instance where medicine, CSS, and strengths case management fail to produce the desired effect of an independent, apartment-dwelling consumer. It is in crisis and social drama that the structure of the relationship between disciplinary and situated practice is most transparent.

Two types of data were used in chapter 6. First, I examine the written texts produced by case managers. Here, I explore the kind of textual subject produced in the recording of a case. Second, I use ethnography to capture the spoken language of the case managers. By combining the written and spoken narratives I produce a narrative that represents how case management is actually produced. And of this I asked: had one narrative been subtracted, what part of the analysis would have been silenced? In answering this question I point toward a critique of the sociological and historical literature that depends solely on the written texts of practitioners.

The strengths disciplinary scheme identifies seven primary functions of management—engagement, assessment, planning, implementation, collaboration, counseling, and graduated disengagement. In addition, situated practice functions to support three life domains: medications (meds), money, and manners. In chapters 7 (“Money”) and 8 (“Meds”) I describe how the social field and strengths bind case managers to service recipients. In the unending delivery and monitoring of medications and in the daily, weekly, and monthly supervision of spending, the case manager’s body is subject to the very same patterns of routinization and regularization as are the bodies of service recipients.

Strengths management, however, finds itself conspicuously empty-handed when medication does not work or consumers do not live within their financial means. It seems the situated knowledge/power is pressed into action when strengths case management is ineffective. Thus, the day-to-day particulars of taking and administering medications produce a situated practice I call “effect interpretation.” And with regard to money, a situated moral economy of case management works to produce “real” consumer identities, especially ones that recognize a good shopping bargain.

**THE HELPER HABITUS**

Strengths case management is derived from administrative mandates, state policy and law, and academic professionals. But what is the source of situated practice? Does the idea of a specific and situated practice mean that every case manager is unique in his or her practice? The specter of the independent
actor, voluntarism, or methodological individualism—actions without conditions for action—seems unavoidable. Contrariwise, in chapter 9 I will show that case managers shared a situated language and practice. I posit that a case manager helper habitus and the time and space constraints of the CSS social field account for their tactical language.

In chapter 9 I use Pierre Bourdieu’s mediating concept of habitus to revisit an old problem that the case managers situated practice posed: the “friendly visitor.” The earliest social work academicians appropriated the term “friendly visitor” from the precursors of nineteenth-century social workers. The term helped define the project of professional education by separating the untrained (family visitor) from the college-educated (Lubove 1965). The dispositions, or habitus, of the nineteenth-century friendly visitor—practical taxonomies, for example—are not unlike those of late twentieth-century case managers. Often, different epochs present unique helping projects that uniquely reconfigure the friendly visitor or helper habitus.

For Bourdieu, a habitus is an embodied set of dispositions produced in social fields. Most important, the dispositions, through the habitus, are transposable to other fields. Bourdieu writes that

the habitus continuously generates practical metaphors, or, more precisely, systematic transpositions required by the particular conditions in which the habitus is ‘put into practice’ (so that, for example, the ascetic ethos which might be expected always to express itself in saving may, in a given context, express itself in a particular way of using credit). The practices of the same agent, and, more generally, the practices of all agents of the same class, owe the stylistic affinity which makes them a metaphor of any of the others to the fact that they are the product of transfers of the same schemes of action from one field to another.

(Bourdieu 1984:173)

With interview data, I show that case managers transpose teacher/student and parent/child dispositions to the CSS field. Moreover, from their middle-class backgrounds and the surrounding suburban landscape, they transpose ideas of progress, goal-oriented achievement, and ideas about “living by the rules.” These concepts—habitus, disposition, and transposability—would not be so compelling to me if it had not been for Bourdieu’s understanding that through the habitus dispositions affect and are affected by the contexts where they are “put into practice” (Jenkins 1992:78). Practitioners make something new because the social field of community support services requires case managers to put helping theory into practice.