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Niching in Cities Under Pressure. Tracing the Reconfiguration of Community Psychiatric Care and the Housing Market in Berlin.

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Abstract

Community psychiatry services in Berlin are currently facing serious challenges providing care to their clients due to a strained housing market and a lack of housing for people with low income or on welfare. Rather than using the word precarity to describe the effect of cuts in welfare state benefits and investments, we grasp precarity ethnographically as a situated, processual condition that emerges in urban assemblages. Based on long-term ethnographic fieldwork in community psychiatry and with people with a psychiatric diagnosis in Berlin, we elaborate on the entanglement of housing market development, gentrification processes and mental health care provision. Community psychiatry professionals especially face challenges securing decent housing for their clients in the inner-city; as a result they pressure them to keep disturbances to a minimum and keep inconspicuous clients in the mental health care system. We argue that precarity is contingently produced by the coming-together of urban developments and community psychiatry principles. As such, precarity itself is generative of shifts in mental health care practices, produces visible tensions within community psychiatry and unfolds in the everyday struggles of mental health care clients, resulting in ambiguous outcomes. To provide a relational analysis of precarity as lived experience and a condition of urban life, we introduce the notion of niching as a middle-range concept connecting conditions of precarity with what people make of it. This is complemented by an analysis of the socio-material practices that produce urbanism.

Keywords:

mental health care; precarity, housing market; urban assemblages; ethnography; niching

1. *Introduction*

In 1994, five years after German reunification, a policy paper discussing the current state of psychiatric health care services in Germany's capital Berlin spotlights a dramatic situation.[1] After defining housing as a "basic need" for people with mental health problems, the paper states: "The situation of the housing market has escalated since 1988 in such a way that general and specific measures for providing housing to all population groups are imperative." Citing the Senator for Building and Housing, the report further emphasises prevailing problems providing even those with an "officially recognised urgent need for housing" with appropriate accommodation. This was considered the result "of a scarcity in housing in Berlin's housing market which exceeds any known dimensions, and which cannot be solved in the short-term" (Senatsverwaltung für Gesundheit, Soziales und Frauen 1994: 49). 25 years later, one could make very similar statements: housing in the German capital is again scarce and continues to be a vital political issue (Holm, 2016b; Lompscher, 2017; Vogelpohl et al., 2017). And again, it is especially a problem for those who are among the most vulnerable of the city's population: people living with a psychiatric diagnosis[2].

In this paper, our starting point is these precarious living conditions which are usually analysed as effects of the transformation of the housing market in Berlin, characterised by a lack of sufficient housing, rapid increases in rent and the resultant difficulties in finding affordable

[1] First and foremost we would like to thank all the people who took part in our research, especially those who allowed us to investigate their private lives. There are also a number of colleagues whom we wish to thank for enhancing the quality of this paper: Jörg Niewöhner for constructive comments on various versions of this paper; Michele Lancione for productive guidance; Ruzana Liburkina for spontaneous corrections; Simran Sodhi for a thorough proofreading; Milena Bister and Janine Hauer for ongoing engagement with our work; Ola Söderström for generative intellectual exchange; Ignacio Farías and Tomás Sánchez Criado for provocative discussions; Hester Parr for her comments on the very first draft of this paper. Last but not least we wish to thank the Geoforum Editor Julie MacLeavy and the three anonymous reviewers for their helpful suggestions and support.

2 We wish to acknowledge the historically contingent nature of medical categories (Hacking 1995; Young 1995) and their performative effects on subjective experiences and institutional practices (Hacking 2007; Martin 2007). However, we also want to emphasise the severeness of mental health problems (Luhrmann 2000) and the fact that the people we worked with are embedded in the mental health care system. Therefore, we use the terms "people with a psychiatric diagnosis", "clients of mental health care" and "people with mental health problems" throughout our paper.

apartments for people with low income or on state benefits. Currently, the term "austerity urbanism" (Peck, 2012) is widely used to describe how urban governance primarily operates through budget cuts for public services and thereby especially deprivileges already marginalised actors. This has framed analyses of the neglect of social housing in Berlin (Schönig, 2018). Our analysis builds on this critique but also differs slightly from it because mental health care expenditure in Berlin has actually increased over the last eight years – although surely within a wider context of cuts through new public management.[3] Therefore, we conceptualise precarity not in its conventional use as a sociological category describing the effects of the reduction of welfare state benefits and investments (Han, 2018), but as a situated, processual condition (Lancione, this issue) that emerges in urban assemblages.

Our empirical case represents the assemblage of housing market development, gentrification processes and mental health care provision. We will argue that precarity is not only characterised by the absence of economic and social resources or affordable housing opportunities but is contingently produced by the coming-together of urban developments and community psychiatry principles. As such, precarity itself is also generative of shifts in mental health care practices, produces visible tensions within community psychiatry and unfolds in the everyday struggles of mental health care clients, resulting in ambiguous outcomes.

To argue our case, we link two analytical concepts that are epistemologically consistent but differ in analytical mode: the notion of niching describes the processes by which people living with a psychiatric diagnosis engage in rendering the urban environment habitable (Bister et al., 2016), while the notion of urban cosmopolitics (Farías & Blok, 2016) goes beyond the

3 According to an internal report of the city-wide branch of public administration in which Patrick Bieler undertook participant observation, the number of clients doubled from nearly 5000 in 2011 to about 10.000 in 2016. Moreover, the expenditures on integration measures for people with disabilities increased from 626.115 € in 2011 to 811.918 € in 2016 (Amt für Statistik Berlin-Brandenburg, 2017). Most of this increase went into mental health care.

individual efforts made by mental health care clients and focuses on the condition-setting practices for niching.

In the following, we will first elaborate on the theoretical basis of our analysis more thoroughly (section 2). After having introduced our empirical material and ethnographic methods (section 3), we will provide brief insights into recent community psychiatry developments and some broader transformations in urban life in Berlin (section 4) that are of importance in order to understand the present precarious condition. In the remaining part of the paper (section 5), we will describe how care for people with mental health problems is provided through the coming-together of housing market developments, gentrification processes and community psychiatry principles: we will analyse how community psychiatry professionals act to secure decent housing for their clients by pressuring them to avoid behaviour that disturbs neighbours and landlords and by keeping potentially independent clients in the mental health care system. Moreover, we will trace how these shifting conditions affect everyday practices of mental health care clients.

2. *Urban Precarity as Practice*

2.1. *Niching: Precarity in Urban Everyday Life*

The urban environment is considered central in the organisation of the everyday lives of people living with a psychiatric diagnosis (Bister et al., 2016). Cities, as places that are both intense and dense, offer a variety of resources, but also entail a variety of "impositions" and "risk factors" for mental health, including social, financial, infrastructural and environmental aspects (Duff, 2014, 2016; McFarlane, 2011b; Schillmeier, 2010; Söderström et al., 2017). Hence, people with a psychiatric diagnosis develop specific capabilities to navigate the city. They avoid certain terrains and places in their neighbourhood or in the city more generally, because of the corresponding physical affordances, the unavoidability of social interactions or the availability

of resources; the potentials or impositions entailed by engaging in public life; and the physical and mental limitations which shape people's radius of movement in the city (Desjarlais, 1994; Lovell, 1997). They render the city habitable for themselves and put various efforts into developing a mode of dwelling in urban space that is bearable, if only ever momentarily. We refer to these practices as 'niching', emphasising the never-finished ambivalent processes of creating a precarious comfort zone in urban space (Bister et al., 2016). Niching as a concept is not reducible to subjective experience or the practice of an individual, but rather highlights the manifold relations of people living with a psychiatric diagnosis with urban environments, mental health care infrastructures, bureaucratic routines and urban governance. Based on our research, we have so far elaborated four different modes of niching, describing certain patterns of practice which are generated within the assemblage of care infrastructures, experiences of mental health problems, urban environments and various other aspects (Bieler & Klausner, in press):

- *Taming the urban* describes how people use the city as a 'therapeutic landscape' (Laws, 2009), how they actively build social contacts in their neighbourhoods and how they appropriate specific places;
- *Arranging the urban* describes how people handle the manifold resources of urban life, how they choose between therapeutic and non-therapeutic opportunities of participation and how they gain control over their own lives;
- *Drifting along the urban* describes how people passively react to the impositions of urban life and how they adapt to the demands of institutions and sociality;
- *Avoiding the urban* describes how people adapt their everyday routines to the rhythm of urban life and how they avoid certain places in order to reduce stress.

As such, niching is a relational anthropological concept (Beck, 2008) focusing on the co-constitution of human-beings and their environments (Ingold, 2000). It is based on an

understanding that the biology of the body is temporally, spatially and socially situated (Bieler & Niewöhner, 2018; Lancione & McFarlane, 2016; Niewöhner & Lock, 2018).[4] At the same time, it foregrounds how these everyday lives are partially connected to infrastructures of psychiatric care, administrative routines and urban governance. These, however, are undergoing rapid transformations themselves. As niching mediates between wider urban transformations and individual livelihoods, capturing it requires the detailed ethnographic analysis of everyday lives of people with a psychiatric diagnosis to be intimately related with an analysis of the socio-spatial conditions of urban existence. Whereas niching sensitises us to the processes through which precarity unfolds in the everyday efforts of people with a psychiatric diagnosis as a way of being-in-the-world (Ingold, 2000; Niewöhner et al., 2016), we also aim at an analysis of the broader socio-material distributions that produce urbanism.

2.2. *Urban Cosmopolitics: Precarity as a Condition of Urban Life*

Assemblage thinking is a productive way of analysing space as a gathering, thereby pronouncing the contingent and processual nature of constructing urban space (DeLanda, 2006; Farías, 2010). From this theoretical perspective, overlapping and shifting social relations and power hierarchies are understood as situated and practiced. Developing a 'cosmopolitical approach' to assemblage thinking, Farías and Blok (2016) more explicitly point to political questions in the negotiation of urban life, bringing "into view how urban worlds are always in the process of being subtly transformed, destabilized, decentered, questioned, criticized or even destroyed" (Farías & Blok, 2016, 2). This approach overlaps with work on urban infrastructures and their effects on urban environments and vulnerable populations (Gandy, 2006; Lancione,

4 While in a prevalent popular understanding of the term, the niche is mainly considered as the specific space and place of a certain population, we use the verb niching to denote the reciprocal and highly dynamic process of the mutual shaping of environments and organisms (Downey, 2016). For a more differentiated discussion of the genealogies of the concept of „niche-construction/niching", e.g. in Chicago School of Urban Sociology or Urban Ecology, see the original paper by Bister et al. (2016) and Beck (2015).

2013; Lancione & McFarlane, 2016). The notion of "infrastructural violence" (Rodgers & O'Neill, 2012) especially highlights the distributed nature of practices and regimes of exclusion and the production of inequalities and suffering. Such a framing is complementary to the classic approaches of political economy[5], yet its different empirical focus spotlights processes, actors and nuances that otherwise might go unnoticed.

Critical human geographers have analysed in depth how urban space is continually socially constructed by powerful capitalist forces exerted by specific actors and institutions leading to patterns of exclusion (Brenner & Theodore, 2005; Harvey, 1996) and how these affect different social groups in distinctive ways (Massey, 1994). For Berlin, political economy approaches plausibly demonstrate that "[t]he government's privatisation initiative […] created processes of gentrification, displacing long-term tenants and excluding low-income households from moving into newly renovated housing" (Fields & Uffer, 2016, 1495). More specifically for our purposes, there are numerous studies in mental health geography from the UK and the US that point to political-economic processes and socio-spatial urban dynamics that affect mental health care (cf. Wolch & Philo, 2000 for a thorough review). They demonstrate how the rollback of the welfare state shifts the responsibility for care on to the voluntary sector (Wolch, 1990; Milligan, 1998), how budget cuts due to a 'fiscal crisis' endanger the provision of care for those people most in need of it (Smith, 1987) and how privatisation changes the demand and supply of mental health services (Laws, 1988). These accounts demonstrate that mental health care planning is highly dependent on state resources. They have provided an important critique of the state's passing on of the obligation to provide mental health care, while increasing the exertion of social control over mental health care practices and the lives of mental health care clients.

5 In a recent Special Issue on the financialisation of urban production in the journal Urban Studies, Halbert and Attuyer (2016) emphasise the situatedness, openness and processuality of capital markets, but do not engage with the notion of assemblage.

We build on these insights and extend the analysis to include a focus on the practical effects produced by the entanglement of mental health care and the housing market. Precarity, we argue, is neither necessarily the effect of the (complete) absence of support nor clearly attributable to the actions of single actors, institutions, political or financial processes but rather emerges as an unintended side effect of changing urban assemblages. In processual terms, precarity is generative of shifts in urban life as well as in its mediating infrastructures and is experienced in everyday life. Understanding the urban condition in terms of assemblage thinking, especially focusing on the politics of these assemblages, allows "conceiving neoliberalism not as a universal and coherent project, or even as a generalised hegemonic process characterised by local contingencies, but as a loose collection of urban logics and processes that may or may not structure urban change in different places" (McFarlane, 2011a, 209). In our analysis, we foreground how urban developments, such as increases in rent and gentrification processes, are entangled with community psychiatry principles such as community-based care and the advocacy of patients' rights, and how this assemblage is productive.

Concept	**Intellectual History**	**Analytical Vantage Point**	**Questions**	**Analysis**
Niching (Bister et al., 2016)	Being-in-the-world as practice (Ingold, 2000; Niewöhner et al., 2016): relational, processual, socio-material gathering	Individual-in-its-environment (as co-constitution)	How do people with a psychiatric diagnosis render urban environments habitable? How is their everyday life related to urban development and psychiatric infrastructures?	Vignettes of Olaf Mattes, Mr. Hartmann, Angelika Siebert: Stabilisation and tensions in adapting practices & keeping clients in place Positive and negative effects of gentrified neighbourhood 'atmosphere'
Urban cosmopolitics (Farías & Blok, 2016)	Assemblage urbanism (DeLanda, 2006; Farías, 2010; McFarlane, 2011a): relational, processual, socio-material gathering	Mental health care infrastructure as entangled with urban development (housing market/gentrification)	How is mental health care affected by the precarious housing market situation? How do mental health care professionals deal with urban development? What	Adaptation pressure on individual clients' dwelling practices Keeping clients in mental health care infrastructure

			are the specific problems posed by urban development?	Visible frictions in the entanglement of mental health care principles with the housing market

Table 1: Summary of Epistemology

A relational approach brings into fruitful discussion urban precarity as lived experience with urban precarity as urban condition. Both are assembled. Niching is a middle-range attempt to connect conditions of precarity with what people make of it.

3. *Methods and Empirical Material*

The empirical data we rely on here was taken from two consecutive ethnographic projects[6] in community psychiatry in Berlin, spanning over a period of eight years in total. Our research was primarily located in one specific district in Berlin, which is rated poorly in terms of the concentration of social problems. Central for our conceptual work was the opportunity to work symmetrically with two groups of people in the field of mental health care: people living with a psychiatric diagnosis on the one hand, and people who are professionals in the field of mental health care, on the other hand. We consider both "groups" experts in the field of mental health care – some by experience, some by training.

Ethnographic research on the experiences of people with mental health problems has, amongst other things, demonstrated how people with mental health problems find and actively build 'safe havens' in communities (Pinfold, 2000), how they search for social interaction and simultaneously withdraw from it (Corin, 1990), how stigmatisation of people with mental health

6 Patrick Bieler carried out his PhD research on the relation of mental health problems, urban environments and mental health care infrastructures in Berlin, funded by a grant of Heinrich-Böll Stiftung from 2016-2019; Martina Klausner was part of the research project „Die Produktion von Chronizität im Alltag psychiatrischer Versorgung und Forschung in Berlin" ("The Production of Chronicity in everyday Psychiatric Care and Research in Berlin"), funded by Deutsche Forschungsgemeinschaft from 2010-2016.

problems persists despite recovery (Jenkins & Carpenter-Song, 2008) and how their everyday lives are related to processes of inclusion and exclusion (Parr, 2008). These analyses are based on long-term ethnographic fieldwork engaging with people with mental health problems in and beyond institutionalised care settings. Following this strand of research, our fieldwork with people with a psychiatric diagnosis was based on long-term participant observation of individuals' everyday lives and thus resulted in the development of close personal relationships (cf. Biehl, 2005). Martina Klausner collected in-depth, individual-based ethnographic material for five persons she met as patients in acute psychiatric care, whom she accompanied in their private lives outside the hospital over the course of two to four years. Patrick Bieler has taken up this line of research with a slightly different methodological focus. Over the course of 18 months, he undertook altogether 45 go-alongs (Carpiano, 2009; Kusenbach, 2003) with ten individuals. This method is currently applied in interdisciplinary ethnographic research to understand how mental health trajectories relate to urban environments, directly focusing on people's use of urban space (Söderström et al., 2016 Codeluppi, 2017).

The clients of community psychiatry or the patients in the hospital we met, are long-term clients of the psychiatric health care system, diagnosed with severe symptoms of psychosis, schizophrenia or depression and, in most cases, on medication that produces side effects. Due to our long-term contact with these people, we were able to discuss their medical history with them, capture their illness narratives and explanatory models (Kleinman, 1988; Good, 1977).

Our fieldwork in different health care settings consisted of recurrent participant observation spanning from six weeks to four months in two psychiatric hospitals and facilities of community psychiatry (Klausner, 2015), six months of participant observation in the city-wide branch of public health administration, ten weeks of participant observation in the district's case management (within the social services department)[7], ten semi-structured interviews with

7 The case management receives applications from people in need of mental health care and after an initial diagnosis and assessment of the potential client by the local health care administration, decides on the sum of

mental health care professionals and public administration officials and ongoing participant observation in a project on inclusive housing and living for people with mental distress (under the direction of a nationally active welfare organisation[8]) since October 2016. In addition, both authors analysed policy papers and official reports and included quantitative data on the district of interest.[9] Fieldwork in the mental health care infrastructure was designed in a co-laborative mode (Niewöhner, 2016) treating clinicians etc. as epistemic partners (Holmes & Marcus, 2005; Estalella & Sánchez Criado, 2018).[10] This comprised joint colloquia, reading groups and joint publications.

This comprehensive research allowed us to discuss the diagnostic and therapeutic practices in classification practices and the notion of chronicity in mental health care (undertaken by Milena Bister, cf. Bister, 2018) and elaborate on the choreographies of clinical mental health care practices and on how notions of crisis, experience and stabilisation were generative within but also beyond institutionalised care (Klausner, 2015). While we have started with a focus on institutionalised care, Patrick Bieler's research developed a focus on the intricate entanglement of urban environments, care services and mental health issues.

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money granted to a mental health care service for their treatment. They continue to exert control over mental health care services by evaluating clients' health trajectories. Patrick Bieler worked as an apprentice at the case management and had access to clients' records, which he could discuss with the case managers, focusing on treatment decisions.

8 This specific project was chosen to analyse how community psychiatry professionals build cooperation with housing market actors and political stakeholders, which has been a strategy typical of mental health care services in Berlin. While the regional committee of psychiatric care in our research district had only discussed the possibility of this but not yet established actual forms and formats for this purpose until mid-2016, Patrick Bieler was able to carry out intensive participant observation in this project to capture these processes. One of the largest mental health care services in the district was part of the project team.

9 The empirical data was thoroughly analysed using a situational analysis approach (Clarke, 2005). All fieldnotes, interviews and analysed documents are originally in German, but have been translated by the authors for this paper. All names of persons have been pseudonymised. This is also true for the district of our research.

10 We emphasise this because too often claims are made about collaboration with people who are in a rather powerless position vis-à-vis academics, without explicating the principles and consequences of collaboration. Research collaboration requires some scientific training, which ultimately heightens the participation threshold. While we do not preclude the possibility of collaborating with experts-by-experience, in the mentioned projects the research design was framed differently for diverse reasons. For us it was most important to create situations where we could explicate our research and aims and allow the interests of our informants to shape our research relationship.

On the whole, this paper's theme, the entanglement of housing and care practices, had not been the starting point of the two research endeavours. But due to the in-depth and long-term scope of our research we were in a position to capture some of the transformations in community psychiatry as well as in urban development in Berlin. The increasing pressure exerted by the housing market and the shifts in mental health care became a relevant issue in the first research project and a major topic in the field during the consecutive research project. However, no specific event demonstrates this transformation. Rather we observed small shifts and changes in concerns, daily routines, expectations and policy rhetoric, which refer to those changes but never simply sum up.

To grasp these transformations we draw from statistical analyses and policy papers on relevant urban issues and on interviews with experienced health care professionals. Central to our analytic concern, moreover, are the vignettes of mental health care clients we have either directly worked with or encountered as cases in the documents of the case management. We use these vignettes strategically to account for how precarity, emerging in the assemblage of health care and urban developments, affects lived experience.[11] The individual informants in various paradigmatic situated moments of niching become knots through which his/her partial embeddedness within the networked processes that make the urban condition becomes graspable (cf. Breidenstein et al., 2015). Those vignettes allow for a relational analysis and blend the individual and the assemblage perspective.

11 The analysed transformations can also be found in the trajectories of other mental health care clients and also fit observations made by the public administration of the mental health care system, which provided access to the overall structure of mental health care in our research district. The presented excerpts of interviews and other statements made by mental health care professionals are typical of the practices and problems we encountered in interviews and participant observation.

4. *The Landscape of Community Psychiatry and Our Research District*

Many of the features which mark Germany's mental health care system today are rather recent. Compared to the reforms in other European and North American countries with similar histories of psychiatry and its institutions, West Germany's mental health care reform came relatively late.[12] The reforms were triggered by the so-called "Psychiatrie Enquête", the "Report on the Situation of Psychiatry in the Federal Republic of Germany", compiled by order of the German parliament in the first half of the 1970s which disclosed the disastrous state of mental health care at the time (Enquetekommission der Bundesregierung, 1975). In the following years the mental health care system in West Germany was fundamentally transformed from a system consisting mainly of large specialised mental institutions to one with a whole new range of community-based facilities and small psychiatric units at general hospitals. The call to dehospitalise[13] and (re)integrate psychiatric patients into the community was central, as this was considered to have positive effects on patients' mental well-being and potential recovery (Zaumseil et al., 2007; Klausner, 2015).[14] Berlin, given its specific geopolitical situation, was relatively late in realising the reforms as explicated by the Enquête. While there were various other earlier attempts, the reform of Berlin's mental health care system was finally pushed through with the "Psychiatry Development Program" (Senatsverwaltung für Gesundheit, 1994, 1997), implemented throughout the 1990s. Accordingly, Berlin's mental health care provision was decentralised and organised in so-called "regionalised care", ensuring smaller units (usually corresponding with a district) for the planning and governing of mental health care provision, and enabling treatment and care near clients' homes. Hence, clients/patients usually

12 As the district that we focus on in our research and in this article is located in former West Berlin, we leave out the history of reforms in the former GDR.

13 While this move was often called "de-institutionalisation", its development indicates it was instead a transition from one institution (hospital) to others (community care facilities).

14 Although we cannot link to a proper analysis or provide statistics for the German context, it must be noted that deinstitutionalisation processes were probably not put forward simply due to reasons of recovery and morality but also served in favour of saving costs. This has been analysed for a different context by Dear & Wittman (1980).

remain within one district. In the last decades, there has also been an increasing emphasis on patients' rights in Germany, strengthening the principle of voluntariness against any form of constraint in psychiatric treatment (Heinz, 2014). The district hospital of our research area has been pioneering in its extension of the scope of voluntariness in the treatment of people with acute mental distress, for instance through an open-ward policy and a restriction of compulsory medication and treatment practices. Recently, debates on constraint in psychiatric care in Germany have been revived by the ratification of the UN CRPD, which has led to a critique of the German government's efforts towards the prevention of discrimination and of compulsory treatment of people living with a psychiatric diagnosis.[15] Questions of constraint and voluntariness in psychiatric care have been recurrent themes in our fieldwork.

At the same time, state-owned housing was heavily privatised in the 1990s. Berlin is currently facing a serious shortage of apartments due to a massive increase in the number of inhabitants and a lack of newly constructed houses. Similar, we should add, to the situation referred to 25 years ago at the beginning of this paper.[16] According to the Berlin Senate, Berlin's population increased by around 250.000 in the period 2011-2016. An estimated 77.000 new apartments would have been required for the period between 2013[17] and 2016 alone.[18] According to the sociologist Andrej Holm (2016b), an estimated 55.000 apartments for people on social welfare are missing. The strained housing market is characterised by rising prices for property (faced by housing companies) as well as increasing rents (faced by tenants). The district we focus on

15 See for example the official report of the German Institute for Human Rights, the National CRPD Monitoring Mechanism, in 2012 on a draft of guardianship law on regulating compulsory treatment, which voices general doubts on the conformity of the German legal regulation of constraint and human rights.

16 The strained housing market situation in the middle of the 1990s was slowly relieved by a negative population trend.

17 According to the statistics of the Berlin Senate, the vacancy rate of apartments fell below 3% in 2013. This is an economically decisive indicator for market volatility.

18 These data derive from the interim report of the 'Urban Development Concept Berlin 2030' (Stadtentwicklungsplan Wohnen 2030) which is currently being assessed and negotiated by the Department for Urban Development and Housing of the Berlin Senate (Senatsverwaltung für Stadtentwicklung und Wohnen, 2018).

in our research, has especially been affected by this development in prices in the last years.[19] Most of its community psychiatry facilities are located in the northern part of the district lying in the inner-city zone, while the hospital and two of three day clinics are located in the southern part. The southern part, lying outside the city centre, consists mainly of suburban homes, residential areas and commercial areas, with few care facilities and less social and street life. The northern part of the district in particular has had a bad reputation for years, considered to be one of the most "socially problematic" districts in Berlin. According to the Berlin Senate's regular monitoring reports, it has an alarmingly high percentage of unemployed persons, persons relying on welfare as well as number of children living in poverty (Senatsverwaltung für Stadtentwicklung und Umwelt, 2015). These numbers are not only high compared to most parts of Berlin, but also compared to the rest of Germany. However, the northern part of the district in particular has seen a rapid transformation in the last ten years: It has become one of the new hot spots of Berlin.[20] Comparing the data on social structure from 2015 with that from 2006 demonstrates three important trends: Firstly, prices for recently rented apartments have doubled during this period. Secondly, the number of available rentable apartments has dramatically decreased. And thirdly, the percentage of unemployed persons has been cut by half – from almost 20 % in 2006 to around 10 %. All three are typical indications of gentrification processes that lead to an eviction of low-income households to the outskirts of the city and a replacement by middle-class and high-income new residents (e.g. Holm 2016a).

19 The size and population of the district is about the same as the 20th largest city in Germany.

20 This perception stems from several sources: empirical results of go-alongs with people with a psychiatric diagnosis during our research; both authors' experiences as long-term residents of this district; media reports; the portrayal of the district on the official website of Berlin: https://www.berlin.de (last access 31/03/2018; for purposes of pseudonymisation we do not cite the complete reference).

5. *Reconfigurations of Care and Housing*

5.1. *The Entanglement of Community Psychiatry and Urban Development*

At expert conferences and meetings as well as in interviews with community psychiatry professionals, providing adequate housing was identified as the major problem in community psychiatry currently. The housing market situation has put community psychiatry under pressure as their clientele is extremely threatened by price development, scarcity of housing and the change of population in inner-city districts. According to the local coordinator of psychiatric services and other mental health professionals, community psychiatry clients in our research district are increasingly likely to be victims of cancelled contracts and eviction compared to previous years. Moreover, the district's public administration receives a higher number of applications for community psychiatry services from homeless people – 80% of all applications in 2017 compared to 20% in 2007 as estimated by a social services employee in the district.[21] Three important factors are usually given as an explanation for this situation. As a psychiatrist in the district's department of health, who worked in a central coordinating position in the district for more than ten years, summarises:

> *Rents have rapidly increased in our district and they have consistently increased in Berlin in general. Hence, it becomes increasingly difficult to acquire affordable apartments for our clients who have often been confronted with eviction before, who have negative credit reports and so on and who are not particularly noted for positive behaviour. This used to be easier. […] Another [reason] is the change in the population structure of the district more generally. There are more middle-class people living here now. And another reason is surely that patients used to be treated in hospitals for much longer*

21 Official figures are not available as the districts are not required to collect these numbers.

> *periods and also more comprehensively. These days autonomy and patients' choice are more decisive factors. Consequently, we see many more terminations of treatment [by patients] […]. This is why we are now confronted with many more public incidents of disturbance caused by this new clientele. All these factors clash with each other and so we are now confronted with problems that we cannot really solve. (Interview with a psychiatrist, 25/01/2017; translation by the authors)*

Although her normative and biological perspective on the potentially disturbing behaviour of people with a psychiatric diagnosis is controversial, she points to an important concern shared by health care professionals in our field of research: The confrontation with normative demands of urban life – especially newly emerging shared understandings of what counts as a disturbance or nuisance – challenges the very basis of community psychiatry's treatment rationale after de-institutionalisation reforms. Rather than integrating treatment into the local community and fostering the interaction of patients with the local population, psychiatrists increasingly release patients into urban conditions that are not accommodating of a clientele that does not conform to an ever narrowing understanding of appropriate behaviour on the street and particularly within apartment buildings. Precarity, thus, emerges in the assemblage of housing market developments, gentrification and mental health care principles and shifts care practices and affects people's livelihoods – whether or not they have a psychiatric diagnosis. Conflicts arise and community psychiatry does not have the means to deal with the emergence of precarity.

For our further analysis, it is of vital interest to examine the ways in which precarity shifts care practices. All professionals in community psychiatry we talked to refer to two central challenges that arise from the district's development: on the one hand those clients who are perceived to be able to live independently and without mental health care remain within care infrastructures because they cannot find adequate and affordable housing, not even with the help of community

psychiatry staff. On the other hand, an increasing number of their clients are threatened with the possibility of cancelled rental contracts due to an increase in rents and decreasing tolerance towards their clients' potentially disturbing behaviours in a changed social milieu with a new demographic. These challenges are evoked by community psychiatry professionals to explain and legitimise the increasing pressure they are putting on their clients to dwell according to accepted norms, especially when it comes to the avoidance of noise (at night), littering and cursing, as well as the decisions to keep clients who are supposedly capable of living independently within the health care system.

In the following, we will describe the implications for mental health care clients' niching practices in more detail, focusing on the shifts in mental health care practices in the entanglement of community psychiatry and urban development. This is analytically important in order to highlight how the emergence of precarity practically changes mental health care practices and how it plays out as lived experience. For the latter, we will draw on vignettes portraying mental health care in practice. These vignettes show that changes in conditions do not determine the livelihoods of people with psychiatric diagnoses in a simple fashion. The notion of niching we introduced above helps us analyse the changing conditions as affordances to which people respond in different and often contradictory ways.

5.2. *Changing Urban Environments, Shifting Care Practices*

Under pressure of a strained housing market and of gentrification processes, having their clients adapt their dwelling practices becomes an important practice as community psychiatry professionals are afraid of their clients losing their apartments.[22] They attach importance to

22 This is not to imply that individual control of disturbing behaviour was not a part of community psychiatry before. The argument, however, is that the assemblage reconfigures these practices in the sense that the individual is spotlighted. The practices of adapting could be read from a governmentality perspective (Foucault, 1991, 1997a; Rose, 1998; Feliciantonio, 2016) in order to analyse subjectivation processes, or as a form of

meeting normative demands concerning the potential perception of disturbances by neighbours and landlords. Community psychiatry staff currently act as mediators between clients, landlords and neighbours. They not only support their clients when they have been injustly treated, but also try to interfere in their clients' everyday lives in order to minimise the actual and possible disturbances they cause neighbours. Littering, noise disturbances (like screaming at night, listening to loud music), threatening behaviour (for example cursing, talking to oneself, heavy doorknocking) are mostly the examples put forward by our informants. An interview with a social worker illustrates the extent to which adapting is a balancing act between meeting the normative demands of neighbours and landlords and their clients' needs and choices:

> *Often, we face the problem of so called 'messy' apartments. The question then is: whose problem is that? This is very difficult because on the one hand there are societal understandings around normal living. On the other hand, the clients have their own perspective, and say: 'I want it like this and I need it like this.' […] This is a balancing act that we need to engage in. I remember a client whose apartment was a potential danger, as it was full of electrical garbage. This was dangerous for him, but also a fire hazard. And then there were the usual problems of hygiene – for example the presence of mold, rodents and insects. He agreed to deal with this and we also communicated this to the social benefits provider. […] In the beginning my idea had been to dispose of all the garbage and clean up, so that he would have been able to*

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biopolitical control (Foucault, 1997b) of 'life as such' (Fassin, 2009), pointing to how health is a central object of intervention not only in medical discourse but among a vast range of actors. Yet, we conceptualise these attempts to make patients adapt as a normalising mode of ordering (Moser, 2005). This material-semiotic approach draws on Foucault's notion of discourse but "traces it in local, situated practices and a wide set of relations and arrangements […] that] stresses […] first, the material heterogeneity of the conditioning arrangements – the fact that these are neither simply discursive nor purely social; secondly, the emergent, precarious and recursive process of ordering; third, modesty in empirical scope and claim; and, fourth, the multiplicity of and relations between arrangements, productions and settings" (Moser, 2005, 669). Moreover, this does not necessarily imply that these practices negatively affect mental health care clients. As Desjarlais paraphrasing Foucault rightly pointed out: "sometimes the most humane forms of care are the ones most invested with power" (Desjarlais 1997, 209).

receive guests. However, this has not happened, which I also have to respect. It is a question of negotiation […]. (Interview with a social worker, 07/06/2017)

In the social service sector of the public administration records show that most clients are assisted in keeping order in their apartments. There were several cases of people considered to be 'messis', which describes people who collect all kinds of (useless) things. In such cases, money for the decluttering of a client's apartment by a professional company can be requested (approximately 1.500 €) by a community psychiatry service. This service can only be utilised once per client. Whereas there were numerous documented cases of clients posing serious challenges concerning orderliness in their apartments, our two informants from the case management only recollected two instances where they were confronted with such a request. When asked the reason for the low number, one of them said: "Usually, mental health care services prevent this problem. And it is also our task to remind them of their responsibilities." (Fieldnote 12/03/2017) One case that we discussed with a case manager is particularly insightful as it demonstrates the transformations of the milieu in the district, the loss of an apartment, the mediating practices of community psychiatry, the resultant pressure as well as its ambiguous impact on clients. We use this story in order to demonstrate how the current developments in the housing market exert pressure on mental health care professionals and on their dealings with clients whose dwelling practices do not meet neighbours' and landlords' expectations. This poses serious challenges to community psychiatry as their attempts to make clients adapt are clearly limited.

Mr. Hartmann, 50, is diagnosed with obsessive-compulsive disorder. He suffers from the so-called 'messi-syndrome', that is he collects objects and produces massive amounts of litter in his apartment. When he lost his apartment in 2010 (the exact reasons could not be clarified), his sister initiated contact with the local health authorities. However, Mr.

> Hartmann rejected any form of psychiatric assistance. After losing his apartment, Mr. Hartmann was offered another apartment in the same building. Aware of Mr. Hartmann's obsession with collecting things, his landlord offered him two more apartments without charging extra rent. In 2013, however, a property management firm took over the building. After a while, the new landlords wanted to rent out these two extra apartments. When they realised the dimensions of Mr. Hartmann's messiness, they forced their way into Mr. Hartmann's apartment. According to written documents, Mr. Hartmann had collected about 2000 bottles as well as magazines and newspapers from the last 25 years. His rental agreement was finally cancelled for April 2015. At risk of homelessness, he decided to accept psychiatric care, applied for financial support and an apartment in an assisted living program of one of the local mental health care services. The case management accepted his application. Thus, a mental health care service was found and Mr. Hartmann could move into assisted living in an apartment. His new flat, however, was on the ground floor. Mr. Hartmann was often troubled by children playing in the backyard and after some time he also lost interest in his assistance. He began to collect bottles and paper again. His health worsened, so that in April 2017 his legal guardian asked his case manager for financial support in order to declutter his flat. The case manager approved this application, but only under the condition that the mental health care service will ensure that this problem does not occur again. (Drawn from fieldnotes 05/03/2017 & 07/03/2017)

Despite his initial refusal of mental health care, Mr. Hartmann found his way into psychiatric care due to increasingly limited rental options. Whereas his 'messiness' could be contained with the generosity of his first landlord and Mr. Hartmann was able to lead a relatively stable life, his homelessness could only be prevented due to the mental health care service when his rental

situation changed. Mr. Hartmann's story might seem rather exceptional[23] as it portrays a very unusual form of generosity and tolerance on the part of his first landlord and his collections are indeed enormous; however, mental health professionals repeatedly emphasised that preventing homelessness as well as the integration of previously homeless clients into the mental health care system has become one of their main tasks. This was achieved by trying to help and force their clients to meet the normative demands of not causing any disturbances through their dwelling by increasing control, which was problematised as being in sharp contrast with community psychiatry principles. However, "the market forces us to abstain from the notion of inclusion", as a social worker at an expert conference summed up the perspective of mental health care clients. (Fieldnote 17/02/2017)

While Mr. Hartmann's story highlights the more drastic shifts of losing an apartment and confronting a changed housing market as well as meeting the demands of the care services, our research in the daily lives of people living with a psychiatric diagnosis sensitised us to the many small and sometimes rather subtle shifts in care practices and the increasing limitations and pressures clients and care-givers faced. The story of one of the persons living with a psychiatric diagnosis we worked with over a longer period of time, highlights these shifts.

> Olaf Mattes lives in the northern part of our research district and has been living with the diagnosis of schizophrenia for around twenty-five years. While his place of residence had been unappealing to most people for the last decades because of its proximity to Berlin's inner-city airport, the area turned into one of the hippest places in the city when the airport was closed and transformed into a large park, the "Tempelhofer Freiheit". This offers new resources to Olaf, as he now regularly collects empty deposit bottles in the park and earns some extra money. Yet, it has also increased pressure on

23 However, it illustrates well the extreme changes in our research district over the last ten years from an excess of housing to extreme housing scarcity.

his living situation. The social worker who visits him twice a week constantly urges him to get to grips with the "chaos" in his apartment. Olaf is a collector, as he calls himself. If he sees things on the street that might still be usable, he takes them home. Once in a while he loses control over the piles of things in his apartment and starts putting pieces in the hallway and on the stairs of the apartment building. The social worker has had to negotiate on his behalf several times with the landlord who had received complaints from annoyed neighbours. While the social worker would like to increase supervision for Olaf Mattes, because he fears he will lose the apartment, Olaf emphatically rejects this. His attitude towards the mental health care system is ambivalent. He only accepts assistance to some degree and for certain periods of time. For him, being in control of himself means being healthy. Still, recalling his medical history and talking to him about an acute episode of psychosis in the past, we can clearly say that Olaf Mattes' life fits very well into the narrative provided by the psychiatrist above. Regular self-determined termination of psychopharmaceutical treatment resulted in episodes of acute psychosis where others (friends, family, neighbours) were not necessarily physically harmed, but had to deal with irritating, even frightening, behaviour over extensive periods of time.

The stories of Olaf Mattes and Mr. Hartmann highlight the effort made by care service providers to prevent clients from losing their apartments and becoming homeless. However, as these stories also show, these attempts reach their limits when clients become unwilling or unable to cooperate or the social environment becomes less tolerant towards disturbances of different sorts. Care practices aiming to have people adapt to changing urban environments are constantly manoeuvring between different demands and expectations and their clients' rights to self-determination.

Urban development, however, neither exclusively nor unidirectionally increases pressure on clients to adapt their behaviour but also affects care practices and niching in other ways.

Another facet of the changing urban environment apparent in the story of Olaf Mattes emerges: the co-presence of a new social milieu and of people with a diagnosis changes daily routines of mental health care clients beyond community psychiatry care practices, which is partially experienced as positive as new free time and leisure activities emerge. Although some mental health care clients live a rather inconspicuous life and are thus not the targets of the described attempts to make clients adapt, they are affected by shifts in the entanglement of community psychiatry care and urban development: In a strained housing market, some mental health care clients are kept in place, although mental health care professionals portray them as being able to potentially live independently. Keeping them in place is legitimised by the absence of affordable housing into which clients could be released. According to an estimation made by the local coordinator of psychiatric services in the health administration, there are around 80-100 clients that fit this description in our research district. One of them is Angelika Siebert.

> Angelika Siebert has been living in a nursing home in the northern part of our research district for several years now. This is located in one of the "heavily upgraded" areas. She is ambivalent about the transformations in the area: while she enjoys the new shops, cafés and especially the spread of organic stores, she can hardly afford any of it. Angelika has 80€ per month for her personal expenditure. Buying food in an organic store or hot chocolate in one of the new vegan cafés is nearly impossible for her even though she personally identifies with these forms of food consumption. Rather, she spends hours with housemates at a little Turkish bakery around the corner where the tea is cheap and they can stay for hours without consuming much. Yet, such places have become fewer as rents have increased and new businesses targeting a different clientele have pushed into the area. Angelika's plan for the future is to move into her own apartment in her neighbourhood. However, it is clear that there is no reasonable chance that she or her care-givers will find a suitable apartment. Even though the welfare system would pay for her rent if she were to find an apartment, the limit for the housing allowance would not be high enough to cover

her rent as rents have more than doubled in this specific part of our research district. Hence Angelika needs to stay in the nursing home if she wants to stay in the area. Going by the judgment of her health care provider, however, Angelika is independent enough and completely capable of living on her own. Community psychiatry logic hence demands that she moves out and lives independently. However, community psychiatry also recognises the importance of stable social and material surroundings. Hence, a dilemma arises between living independently in a different part of the city, or staying within the district but living in dependence and in what is considered to be the 'wrong' kind of arrangement.

Keeping clients such as Angelika Siebert in forms of assisted living in their 'original' residential areas, although they may be able to live an independent life, creates a co-presence of mental health care clients and the drivers of gentrification in the district. Even though most mental health care clients report that they have little exchange with their new neighbours and that they usually do not visit the new shops, cafés and bars in their areas, most of them experience the changes in their neighbourhood as positive as well. Due to the livelier atmosphere they participate by simply walking the streets as there is much more activity in public spaces as compared to just a couple of years ago.

6. *Conclusion*

Precarity has been criticised as a negative effect of the strained housing market in Berlin for especially deprivileging already marginalised groups of people. Although the housing market in Berlin is without doubt problematic, and has affected many more than just the clientele of mental health care, our analysis is derived from a conceptualisation of precarity as a situated and processual condition that emerges in urban assemblages.

Based on long-term ethnographic fieldwork in community psychiatry and on the everyday lives of people with mental health problems in a central district in Berlin, we are interested in a relational analysis of precarity as lived experience and condition of urban life. In this article we have analysed how precarity is produced in the assemblage of mental health care principles, housing market development and gentrification that reconfigures what care consists of and how it can be delivered, especially in inner-city neighbourhoods. As such, precarity is generative of shifts in mental health care practices, makes visible tensions within community psychiatry and unfolds in the everyday struggles of mental health care clients, resulting in ambiguous outcomes. To grasp precarity ethnographically, we have introduced the notion of niching, which allows us to analyse how people with a psychiatric diagnosis struggle to live a bearable life that unfolds in urban assemblages. In order to study the socio-material distributions that produce urbanism, we have moreover engaged with assemblage thinking and its politics. Niching as a middle-range concept connects conditions of precarity with what people make of it.

Our empirical material demonstrates that mental health care professionals increase the pressure on clients to adapt their dwelling practices, in particular to have them reduce noise, stop littering and stop insulting people in the streets. This form of individual control of clients is legitimised as a prevention of homelessness as community psychiatry professionals perceive that their clients are in great danger of rent cancellations and eviction, which they ascribe to rising rents and gentrification processes which have resulted in a shift in the thinking of neighbours and landlords in the last ten years around what constitutes a disturbance.

Beyond understanding community psychiatry professionals' attempts to make their clients adapt merely as problematic forms of control and subjectification, these shifts in mental health care can be grasped as productive efforts to have people stay put in their apartments and original residential areas. The rationale of trying to prevent mental health care clients from becoming homeless seems sophisticated as ethnographic analyses (in the context of the US) have

demonstrated that uncoordinated and unregulated discharge of patients from hospitals due to dehospitalisation led to massive increases in homelessness rates among people with a psychiatric diagnosis (Dear & Wolch, 1987; Estroff, 1981). We have moreover shown that the strategy of keeping clients in their apartments is not limited to clients who are accused of disturbing neighbours or landlords: Clients who are supposedly capable of living independently sometimes remain in the mental health care system because they cannot be released into adequate and affordable housing.

In our research district these processes more or less exclusively occur in the inner-city part of the district. This is highly problematic as most community care facilities and homes of clients are located in this area. The findings are somewhat consistent, yet also decisively different from results of earlier studies of mental health geography (for example Hall & Joseph, 1988; Taylor, 1989): In these studies "'[a]ccepting' neighbourhoods were often found in inner-city areas occupied by poorer groupings unwise to the ways of urban politics or by younger professionals who were basically tolerant of their new neighbours, while 'rejecting' neighbourhoods were often found in more affluent, family-oriented suburban areas whose residents were suspicious of nonconformist behavior" (Wolch & Philo, 2000, 140-141). In our case, urban transformations seem to have changed inner-city neighbourhoods and created less tolerance towards unfamiliar forms of dwelling as performed and evaluated by members of the 'middle class'.

These kinds of precarious conditions make specific tensions in community psychiatry principles particularly visible. While policy-makers and patient advocacy groups focus on issues such as dehospitalisation, the minimisation of compulsory treatment, clients' choice and so on, the objectives of integrating people into their communities, of enabling patients to lead a 'normal' independent life – principles that were at the basis of the Enquête, the "Psychiatry Development Plan", as well as of the currently widely used notion of inclusion – are confronted with urban

development. The integration of people with mental health problems does not come about 'naturally' as the idea of caring for people in their 'familiar' environment suggests. It is this complex entanglement of mental health care reforms focusing on personal choice and integration into the community, a new generation of less well-adapted patients, a change in the district's demographics and businesses and an increase in rents with a simultaneous shortage of available apartments which generates challenges for community psychiatry services without political solutions at hand.

The analysed shifts in the assemblage of mental health care and urban development, however, do not simply result in negative effects for mental health care clients. While they complain about being controlled and, thus, not independent, they are enabled to stay in areas with good infrastructure and a lively atmosphere. They are exposed to ambivalent gentrification effects: to some degree places that were easily accessible and usable in various ways by our informants are vanishing, such as the cheap café and bakery around the corner that are now making way for shops and cafés targeting a very different clientele. However, those transformations are rarely so severe as to completely replace former facilities. Moreover, most of the clients experience the changes in their neighbourhood positively as well.

Long-term ethnographic work allowed us to analytically grasp how a new form of precarity was co-constituted in heterogeneous relations between community psychiatry, urban development and practices of niching. While it restricts and limits care-givers and recipients in many ways, it also generates new modes of being-in-the-city, hence reshaping urban life itself.

Bibliography

Amt für Statistik Berlin-Brandenburg (2017). Sozialhilfe im Land Berlin 2016. Ausgaben und Einnahmen. Statistischer Bericht K | 1 – j / 16. Potsdam: Amt für Statistik.

Beck, S. (2008). Natur|Kultur. Überlegungen zu einer relationalen Anthropologie. *Zeitschrift für Volkskunde, 104*(2), 166-199.

Beck, S. (2015). The Problem of Expertise: From Experience to Skilful Practices to Expertise. Ecological and Pragmatist Perspectives. *European Journal of Pragmatism and American Philosophy*, 7(1), 8-23.

Biehl, J. (2005). *Vita: Life in a Zone of Social Abandonment*. Berkeley: University of California Press.

Bieler, P. & J. Niewöhner (2018). Universal Biology, Local Society? Notes from Anthropology. In M. Meloni, J. Cromby, D. Fitzgerald and S. Lloyd (Eds.), *The Palgrave Handbook of Biology and Society* (pp. 641-662). Basingstoke, Hampshire: Palgrave Macmillan.

Bieler, P. & M. Klausner (in press). Iterative Go-alongs. Eine ethnografische Methode zur Erforschung des Zusammenspiels von psychischen Beeinträchtigungen und städtischer Umwelt. In S. Krumm, R. Kilian, H. Löwenstein (Eds.), *Qualitative Studien in der sozialpsychiatrischen Forschung. Hintergrund, Perspektiven und Praxisbeispiele* (pp.-pp.). Köln: Psychiatrie-Verlag.

Bister, M. (2018). The concept of chronicity in action: everyday classification practices and the shaping of mental health care. *Sociology of Health & Illness, 40(1)*, 38-52.

Bister, M., Klausner, M., Niewöhner, J. (2016). The cosmopolitics of 'niching'. Rendering the city habitable along infrastructures of mental health care. In A. Blok & I. Farías (Eds.), *Urban Cosmopolitics: Agencements, Assemblies, Atmospheres* (pp. 187-205). Abingdon, Oxon; New York: Routledge.

Breidenstein, G., Hirschauer, S., Kalthoff, H., Nieswand, B. (2015). *Ethnografie: Die Praxis der Feldforschung*. Konstanz; München: utb.

Brenner, N., & Theodore, N. (2005). Neoliberalism and the urban condition. *City, 9*(1), 101-107. doi:10.1080/13604810500092106

Carpiano, R. M. (2009). Come take a walk with me: The "Go-Along" interview as a novel method for studying the implications of place for health and well-being. *Health & Place, 15*(1), 263-272. doi:http://dx.doi.org/10.1016/j.healthplace.2008.05.003

Clarke, A. E. (2005). *Situational Analysis: Grounded Theory After The Postmodern Turn*. Thousand Oaks: Sage Publications.

Codeluppi, Z. (2017): Entre le plein et le vide : les espace–temps quotidiens des jeunes patients souffrant de troubles psychotiques à Lausanne. *GéoRegards, 9(9), numéro spécial, Mobilité des étudiants*, 119-134.

Corin, E. E. (1990). Facts and meaning in psychiatry: An anthropological approach to the lifeworld of schizophrenics. *Culture, Medicine and Psychiatry 14(2)*, 153-188.

Dear, M. & Wittman, I. (1980). Conflict over the location of mental health facilities. In D. Herbert & R. J. Johnston, R. J. (Eds.), *Geography and the Urban Environment, 3* (pp. 345-362). Chichester: Wiley.

Dear, M., & Wolch, J. (1987). *Landscapes of Despair: From Deinstitutionalization to Homelessness*. Princeton: Princeton Legacy Publishing.

DeLanda, M. (2006). *A New Philosophy of Society: Assemblage Theory and Social Complexity*. Edinburgh: Edinburgh University Press.

Desjarlais, R. (1994). Struggling Along: The Possibilities for Experience among the Homeless Mentally Ill. *American Anthropologist, 96*(4), 886-901. doi:10.1525/aa.1994.96.4.02a00090

Desjarlais, R. (1997). *Shelter Blues: Sanity and Selfhood Among the Homeless*. Philadelphia: University of Pennsylvania Press.

Downey, G. (2016). Being Human in Cities: Phenotypic Bias from Urban Niche Construction. *Current Anthropology, 57*(S13), S52-S64. doi:doi:10.1086/685710

Duff, C. (2014). *Assemblages of Health: Deleuze's Empiricism and the Ethology of Life*. Dordrecht: Springer.

Duff, C. (2016). Atmospheres of recovery: Assemblages of health. *Environment and Planning A 48(1)*, 58-74. doi:10.1177/0308518X15603222

Enquetekommission der Bundesregierung (1975). Bericht über die Lage der Psychiatrie in der Bundesrepublik Deutschland.

Estalella, A. & Sanchéz Criado, T. (2018). *Experimental Collaborations: Ethnography through Fieldwork Devices*. New York; Oxford: Berghahn Books.

Estroff, S. E. (1981). *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community*. Berkeley: University of California Press.

Farías, I. (2010). Introduction: Decentring the object of urban studies. In I. Farías & T. Bender (Eds.), *Urban Assemblages: How Actor-Network Theory Changes Urban Studies* (pp. 1-24). Abingdon, Oxon; New York: Routledge.

Farías, I., & Blok, A. (2016). Introducing urban cosmopolitics: Multiplicity and the search for a common world. In A. Blok & I. Farías (Eds.), *Urban Cosmopolitics: Agencements, Assemblies, Atmospheres* (pp. 1-22). Abingdon, Oxon; New York: Routledge.

Fassin, D. (2009). Another Politics of Life is Possible. *Theory, Culture & Society 26(5)*, 44-60.

Feliciantonio, C. D. (2016). Subjectification in Times of Indebtedness and Neoliberal/Austerity Urbanism. Antipode, 48(5), 1206-1227. doi: 10.1111/anti.12243

Fields, D., & Uffer, S. (2016). The financialisation of rental housing: A comparative analysis of New York City and Berlin. *Urban Studies, 53*(7), 1486-1502. doi:10.1177/0042098014543704

Foucault, Michel. (1991). Governmentality. In G. Burchell, C. Gordon & P Miller (Eds.), *The Foucault Effect. Studies in Governmentality* (pp. 87–104). Hemel Hempstead: Harvester Wheatsheaf.

Foucault, Michel. (1997a). Security, Territory, and Population, In P. Rabinow (Ed.), *Ethics: Subjectivity and Truth* (pp. 67-71) New York: The New Press.

Foucault, Michel. (1997b). The Birth of Biopolitics, In P. Rabinow (Ed.), *Ethics: Subjectivity and Truth* (pp. 73-79) New York: The New Press.

Gandy, M. (2006). Planning, anti-planning, and the infrastructure crisis facing metropolitan Lagos. *Urban Studies, 43*(2), 371–396.

Good, B. J. (1977). The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine and Psychiatry, 1*(1), 25-58.

Hacking, I. (1995). *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. Princeton, New Jersey; Chichester, West Sussex: Princeton University Press.

Hacking, I. (2007). Kinds of people: Moving targets. *Proceedings of the British Academy 151*, 285-318.

Halbert, L., & Attuyer, K. (2016). Introduction: The financialisation of urban production: Conditions, mediations and transformations. *Urban Studies, 53*(7), 1347-1361. doi:10.1177/0042098016635420

Hall, G.B. & Joseph, A.E. (1988). Group home location and host neighbourhood attributes: an ecological analysis. *Professional Geographer, 40(3)*, 297-306. doi: 10.1111/j.0033-0124.1988.00297.x

Han, C. (2018). Precarity, Precariousness, and Vulnerability. *Annual Review of Anthropology, 47(1)*, 331-343. doi: 10.1146/annurev-anthro-102116-041644

Harvey, D. (1996). *Justice, Nature and the Geography of Difference* (Vol. 468). Cambridge, Massachusetts: Blackwell Publishers.

Heinz, A. (2014). *Der Begriff der psychischen Krankheit*. Frankfurt/Main: Suhrkamp.

Holm, A. (2016a). Gentrification und das Ende der Berliner Mischung. In E. von Einem (Ed.), *Wohnen. Markt in Schieflage – Politik in Not* (pp. 191-231). Wiesbaden: Springer VS.

Holm, A. (2016b). *Sozialer Wohnraumversorgungsbedarf in Berlin*. Berlin: Die Linke.

Holmes, D. R. & Marcus, G. E. (2005). Cultures of Expertise and the Management of Globalization: Toward the Re-Functioning of Ethnography. In: A. Ong & S. J. Collier

(Eds.), *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems* (pp. 235-252). Malden, MA; Oxford: Blackwell Publishing Ltd.

Ingold, T. (2000). *The Perception of the Environment: Essays on livelihood, dwelling & skill*. London; New York: Routledge.

Jenkins, J. H. and E. A. Carpenter-Song (2008). Stigma Despite Recovery. *Medical Anthropology Quarterly 22(4)*, 381-409.

Klausner, M. (2015). *Choreografien psychiatrischer Praxis: Eine ethnografische Studie zum Alltag in der Psychiatrie*. Bielefeld: transcript.

Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Kusenbach, M. (2003). Street Phenomenology: The Go-Along as Ethnographic Research Tool *Ethnography, 4*(3), 455-485. doi:10.1177/146613810343007

Lancione, M. (2013). Homeless people and the city of abstract machines: Assemblage thinking and the performative approach to homelessness. *Area, 45*(3), 358-364. doi:10.1111/area.12045

Lancione, M. (2018). The politics of embodied urban precarity: Roma people and the fight for housing in Bucharest, Romania. *Geoforum*. doi:10.1016/j.geoforum. 2018.09.008. (this issue)

Lancione, M., & McFarlane, C. (2016). Infrastructural becoming. Sanitation, cosmopolitics, and the (un)making of urban life at the margins. In A. Blok & I. Farías (Eds.), *Urban Cosmopolitics: Agencements, Assemblies, Atmospheres* (pp. 45-62). Abingdon, Oxon; New York: Routledge.

Laws, G. (1988). Privatisation and the local welfare state. The case of Toronto's social services. *Transactions of the Institute of British Geographers, 13(4)*, 433-448. doi: 10.2307/622740

Laws, J. (2009). Reworking therapeutic landscapes: The spatiality of an ›alternative‹ self–help group. *Social Science & Medicine, 69(12)*, 1827–1833.

Lompscher, K. (2017). Vom Mietenvolksentscheid zum Wohnraumversorgungsgesetz – Antwort auf die Wohnungsfrage in Berlin? In B. Schönig, J. Kadi & S. Schipper (Eds.), *Wohnraum für Alle?! Perspektiven auf Planung, Politik und Architektur* (pp. 243-254). Bielefeld: transcript.

Lovell, A. M. (1997). "The City Is My Mother": Narratives of Schizophrenia and Homelessness. *American Anthropologist, 99*(2), 355-368.

Luhrmann, T. M. (2000). *Of Two Minds: The Growing Disorder in American Psychiatry*. New York: Alfred A. Knopf.

Martin, E. (2007). *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton, New Jersey; Woodstock, Oxfordshire: Princeton University Press.

Massey, D. (1994). *Space, Place and Gender*. Cambridge: Polity Press.

McFarlane, C. (2011a). Assemblage and critical urbanism. *City, 15*(2), 204-224. doi:10.1080/13604813.2011.568715

McFarlane, C. (2011b). *Learning the City: Knowledge and Translocal Assemblage* (1st ed.). Malden, MA; Oxford: Wiley-Blackwell.

Milligan, C. (1998). Pathways of dependency: the impact of health and welfare restructuring – the voluntary experience. *Social Science & Medicine, 46(6)*, 743-753. doi: 10.1016/S0277-9536(97)00172-X

Moser, I. (2005). ON BECOMING DISABLED AND ARTICULATING ALTERNATIVES. *Cultural Studies 19(6)*, 667-700.

Niewöhner, J. (2016). Co-laborative Anthropology: Crafting Reflexivities Experimentally. In: J. Jouhki & T. Steel (Eds.), *Ethnologinen tulkinta ja analyysi. Kohti avoimempaa tutkimusprosessia*. Helsinki: Ethnos (English translation of Finnish original).

Niewöhner, J., Bieler, P., Heibges, M., Klausner, M. (2016): Phenomenography: Relational Investigations into Modes of Being-in-the-World. *The Cyprus Review, 28(1)*, 67–84.

Niewöhner, J., & Lock, M. (2018). Situated Biologies: Anthropological Perspectives on Ceaseless Environment/Human Entanglements. *BioSocieties 13(4)*, 681-697. doi:10.1057/s41292-017-0089-5

Parr, H. (2008). *Mental Health and Social Space: Towards Inclusionary Geographies?* Malden, MA: Blackwell.

Peck, J. (2012). Austerity urbanism. *City, 16*(6), 626-655. doi:10.1080/13604813.2012.734071

Pinfold, V. (2000). 'Building up safe havens…all around the world': users' experiences of living in the community with mental health problems. *Health & Place 6(3)*, 201-212.

Rodgers, D., & O'Neill, B. (2012). Infrastructural violence: Introduction to the Special Issue. *Ethnography, 13*(4), 401-412. doi:10.1177/1466138111435738

Rose, N. (1998). Inventing our selves: Psychology, power, and personhood. Cambridge: Cambridge University Press.

Schillmeier, M. (2010). Assembling Money and the Senses: Revisiting Georg Simmel and the City. In I. Farías & T. Bender (Eds.), *Urban Assemblages: How Actor-Network Theory Changes Urban Studies* (pp. 221-256). Abingdon, Oxon; New York: Routledge.

Schönig, B. (2018). Sechs Thesen. Zur wieder mal >neuen< Wohnungsfrage – Plädoyer für ein interdisziplinäres Gespräch. In B. Schönig, J. Kadi & S. Schipper (Eds.), *Wohnraum für alle!? Perspektiven auf Planung, Politik und Architektur* (pp. 11-27). Bielefeld: transcript.

Senatsverwaltung für Gesundheit (1994). *PsychiatrieEntwicklungsProgramm. Psychiatrie-Bericht Berlin. Teil I: Strukturelle Rahmenplanung (Drucksache 12/3615)*. Berlin: Verwaltungsdruckerei Berlin.

Senatsverwaltung für Gesundheit (1997). *PsychiatrieEntwicklungsProgramm. Psychiatrie-Bericht Berlin. Teil III: Empfehlungen für eine sturkturierte Entwicklung der regionliaiserten psychiatrischen Versorgung (Drucksache 13/1521).* Berlin: Verwaltungsdruckerei Berlin.

Senatsverwaltung für Stadtentwicklung und Umwelt (2015). *Monitoring Soziale Stadtentwicklung 2015*.

Senatsverwaltung für Stadtentwicklung und Wohnen (2018). Zwischenbericht Stadtentwicklungsplan (StEP) Wohnen 2030. http://www.stadtentwicklung.berlin.de/planen/stadtentwicklungsplanung/de/wohnen/download/step_wohnen_2030_zwischenbericht.pdf (last access 31/03/2018)

Smith, Christopher J. (1987). Progress Report: Mental Health and the Fiscal Crisis: The Prospects for a Socially Conscious Urban Geography. *Urban Geography, 8(1)*, 55-64. doi: 10.2747/0272-3638.8.1.55

Söderström, O., Empson, L.A., Codeluppi, Z., Söderström, D., Baumann, P.S., Conus, P. (2016). Unpacking ›the City‹: An experience-based approach to the role of urban living in psychosis. *Health & Place, 42*, 104–110.

Söderström, O., Söderström, D., Codeluppi, Z., Empson, L. A., & Conus, P. (2017). Emplacing recovery: how persons diagnosed with psychosis handle stress in cities. *Psychosis, 9*(4), 322-329. doi:10.1080/17522439.2017.1344296

Taylor, S.M. (1989). Community Exclusion of the Mentally Ill. In J. Wolch & M. Dear (Eds.), *The Power of Geography: How Territory Shapes Social Life* (pp. 316-330). London: Unwin Hyman.

Vogelpohl, A., Vollmer, L., Vittu, E., Brecht, N. (2017). Die Repolitisierung des Wohnens. Städtische soziale Bewegungen für ein Recht auf Wohnen und auf Stadt in Hamburg, Berlin, Jena und Leipzig. In B. Schönig, J. Kadi & S. Schipper (Eds.), *Wohnraum für*

Alle?! Perspektiven auf Planung, Politik und Architektur (pp. 243-254). Bielefeld: transcript.

Wolch, J. (1990). *The Shadow State. Government and Voluntary Sector in Transition*. New York: The Foundation Centre.

Wolch, J., & Philo, C. (2000). From distributions of deviance to definitions of difference: past and future mental health geographies. *Health & Place, 6*(3), 137-157. doi:https://doi.org/10.1016/S1353-8292(00)00019-8

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. New Jersey: Princeton University Press.

Zaumseil, M., Vock, R., Zimmermann, R.-B., & Manderla, S. (2007). *Mit der Diagnose "chronisch psychisch krank" ins Pflegeheim? Eine Untersuchung der Situation in Berlin*. Frankfurt/Main: Mabuse-Verlag.