Social class, disability and the lessons of psychiatric deinstitutionalisation for prison abolition:

An Interview with sociologist Neil Gong

Interviewed by Rory Randall

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Abstract

Consumer academic Rory Randall interviewed sociologist Neil Gong about his research on social class and mental health care in the United States. They discuss Neil's analysis of the differing models of client choice and freedom in public safety-net services and in elite private clinics, and what this means for service users. They also discuss Neil's political writings on psychiatric deinstitutionalisation and the lessons that history holds for movements to reform or abolish police and prison systems.

Key words: mental health care; class; race; prison; abolitionism; deinstitutionalisation; United States; Australia

Rory: Could you talk about your current work briefly? What brought you to be so interested in how class intersects with systems of mental health care?

Neil: It's a pleasure to discuss these things in *IJNTCW*, Rory, so thanks for inviting me. My current work investigates inequality in community-based mental health care by comparing a Los Angeles public safety-net treatment team with a boutique private team and related services for wealthy people. Each is a variation on the assertive community treatment model that sprung up after psychiatric deinstitutionalisation to provide 'hospitals without walls'. I came to the research after working on a treatment team myself as a case manager in New York City, where I noticed that providers were basically filling in the gaps of the US welfare state. For instance, we worked on finding housing and getting people out of the justice system. There were seemingly very progressive elements like harm reduction and honouring people's choices about meds. All of it seemed good given how dire the situations were, but I didn't see much treatment or therapy, and I wondered what higher-end care looked like. Thus when I decided to become a social researcher rather than clinician, I plotted out a comparative study to illuminate those differences.

My methods were ethnographic – that is, I shadowed or interviewed workers, services users, families and various other stakeholders, and tried to understand what shaped individual and organisational behaviour. To summarise what I've seen: the public team in LA, like the one I worked on, has the goal of keeping people housed and not in jail, while the rich one is different: it is about making people into respectable upper-middle-class subjects.

This is because each treatment program is part of a different governance project: one deals with psychiatric disability in the context of urban poverty governance, with overlapping issues around homelessness and incarceration, while the other deals with what I call family systems governance – that is, addressing the needs of the paying relatives, usually parents.

Given the weakness of the US welfare state, the public treatment team functions as much as a housing agency as a mental health centre. They focus on getting people off the street or out of jail and into either independent apartments (the housing first model) or into board and care homes (basically psychiatric flophouses).

The elite private team doesn't have to worry about things like homelessness, and on the rare occasion a client gets in trouble with the law, the families have money to keep them out of prison. So, case managers are working to help craft people a respectable future. The team may work with clients who are coming out of residential programs and perhaps live in a high-end sober-living home or with family. They focus on things like getting people back to school, developing purpose in life and the like. This can be quite wonderful in that there are resources for helping people achieve their goals. Yet it can also be normalising and controlling in a way that is simply not possible in under-resourced clinics for the poor.

My argument is that, because of differences in resources and who is the shadow client (city elites who want 'clean streets' or rich families who want 'respectable' futures for their relatives), these places also have very different logics of care and control. At the public program, they engage in what I call tolerant containment: they accept a fair amount of 'noncompliance' and continued drug use so long as people don't make too much trouble. The goal is keeping people 'contained' and out of sight.

This has partial roots in radical traditions of harm reduction, but is also a simple product of lacking staff and resources to check up on people. At a more macro-level, it may be driven as much by the politics of gentrification as any interest in care. Despite some progressive aspects, then, it presents some ethical dilemmas. For instance, a person might be free to be psychotic and high in their own apartment. Is that client choice or abandonment? Even in the board and care flophouses, there is a pseudo-tolerance: people are expected to take meds, but other than that, there is no monitoring to enforce rules or programming, again because of lack of capacity. I've been in these places at midnight and people are openly getting high, despite the rules. It is

only one step up from abandonment, so there is an obvious downside, but there is a kind of freedom in that there is no one trying to 'fix' the clientele. This differs from the predictions of some scholars in the Foucauldian tradition, who would expect the state to discipline the poor or try to make them self-governing. My finding is that in this model, there is no investment in people's subjectivity because who they are as a person doesn't matter for the goals at hand, and there is insufficient therapeutic capacity anyway. What matters to the system is that clients are housed and not in jail or the hospital.

At the high-end clinic, they do what I call concerted constraint. It's akin to upper-middle-class parenting, where families invest a lot of money in activities and scheduling, for example soccer, then karate, then tutoring. I derived the term as an extension of what the sociologist Annette Lareau (2003) named the 'concerted cultivation' approach to parenting. In the case of psychiatric services, that cultivation and control might come to mean a visit to upscale residential treatment, an intensive outpatient program, then a sober-living home that does yoga on the beach. Here we see that expectation of surveillance and control versus 'freedom' flipped on its head, for it is actually the wealthy who are subject to transformative efforts. Access to good care precisely means a lot of surveillance – that is what the wealthy are paying for. Again, this goes against theories that simplistically predict that wealth means freedom to do as one pleases. And far from being abandoned and 'free', as in the poor clinic I studied, people are expected to behave in more respectable ways. It's not acceptable here to be psychotic and high. You get investment in being a person, but you have to be a person according to someone else's definition.

Rory: It was interesting to read your double storying of the care types you have examined (Gong, 2019). It seems like people are offered different kinds of freedom. For people who have been relegated to these 'flophouses', the aura of freedom comes with abandonment (with social ostracism and lack of access to resources). For the boutique private care clients, freedoms exist within the kinds of person they are allowed to model. It seems like both types of mental health service responses, whether for rich or poor, serve to maintain class structures. From your perspective and reading, what do you see the role of class being when trying to create new ideas for the future? Do you have ideas about what concepts we might seek to gather around that are not degrading but re-grading? Or do you see all forms of division and heuristics as potentially harmful?

Neil: Maintaining class structures is such an interesting issue here, because it's not the typical reproduction story of the young achieving the class status of their parents. In both cases there may be downward social mobility, but of varying degrees. Sometimes people who have fallen through the cracks and ended up in the public safety-net services came from middle-class backgrounds. It is not likely they will have a return to the middle class, but instead they may have life as a person on disability benefits. This may become permanent in part because starting to work could threaten access to benefits. These benefits are small, however, and many people are only a step away from homelessness. The upper-class families paying for private services are precisely trying to avoid loved ones ending up in that other situation. The person in question may not become a lawyer or what have you (although this certainly can happen), but the goal will still be completion of school, work or at least class-respectable activities, so the person achieves class expectations to some degree.

As to 're-grading' and normatively what we should aim for, the question for me is how to offer people robust possibilities without imposing values that could inadvertently shame them or lead to inappropriate demands for work productivity.

What I mean is this: if a person decides they'd like to work or attend higher education, for instance, I want everyone to have this option. At the same time, not everyone desires those particular accomplishments or is suited to those environments. There is a problematic version of 'recovery' discourse that imposes middle-class values and resembles neoliberal 'welfare reform': it defines a person's value and their recovery primarily in terms of work and productivity. For some people, it may be that their role as a loving friend, peer, relative or interdependent community member will be what brings their life meaning and value.

Ideally, everyone should have access to what we might call a middle-class standard of living, but their access to those resources shouldn't be predicated on fulfilling middle-class expectations. That's my hope for a re-grading versus degrading approach.

Rory: It was fantastic to come across you and your work during the recent Institute for the Development of Human Arts (IDHA) webinar 'Decarcerating care'. It is so exciting to see these conversations about decarceration and police and prison abolition springing up around the world. In Australia, we have difficulty even getting folks to consider ideas of police and prison reform, let alone complete systemic transformation. I wanted to hear your thoughts on why this may be in Australia. I think it may be because we have something of a welfare state: our needs are met just enough to make it seem risky to push back. What do you think has enabled the fertile ground for so much conversation on these concerns in the US?

Neil: That's a great question about Australia! Perhaps that is a part of it – there seems to be enough of a welfare state that no one wants to rock the boat, although I'm really not an expert on the Australian case. What I'm more comfortable speaking about is the United States.

In the US there is, as you imply, a weak welfare state and thus significant need. Social movements of various stripes have long tried to address this. There is also a tradition of Black radical thought that focuses on how police and prisons oppress racial minorities in particular and disadvantaged people in general. Some of the racial components are tied to US history, such as the fact that police in the south have partial roots in slave patrols. I can't speak to the specifics of how that compares with the racist colonial history in Australia, but there certainly are similarities that are worth exploring.

The other big component in the US is that mass incarceration is just so staggering here – around 655 people per 100,000. That means a massive human toll on the incarcerated, their families and communities, and significant expense for taxpayers. For that latter reason, even conservatives have come to see it as an issue worth tackling. Australia, on the other hand, has an incarceration rate of about 170 people per 100,000. That's still unacceptable, but it is far less than in the US.

Rory: Although the overall Australian incarceration rate is lower than that in the US, the rate for Aboriginal Australians is a shocking 2325 per 100,000, and for Aboriginal men it's even worse: 4252 per 100,000 in 2020 – the highest rate in the world.

Neil: Wow, I hadn't realised that. The African American male rate at the peak of US mass incarceration was 2261 per 100,000 in 2006. The effects of mass incarceration are so unequally distributed along racial and gender lines in both my country and your country. That certainly complicates any simple idea of Australia having a restrained penal system, and I can't help but wonder if there would be more discussion of reform or abolition if other groups were similarly impacted.

Another complication is hybrid treatment and punishment models that achieve social control via welfare-state functions; these are also applied differently in different countries. Let's consider this in relation to mental health crisis. It is unconscionable that so many Americans experiencing psychiatric disabilities are incarcerated. Yet welfare-oriented interventions may at times also be shaped by punitive logics.

One thing I have really struggled with when talking with people about international models for the US to learn from is that it seems that countries with strong welfare states are often more paternalistic. For instance, my sense is that in Australia there are more community treatment orders and assisted outpatient treatment–type programs, and hospitalisation at lower thresholds. Similarly, my collaborator Alex Barnard is a sociologist who has studied French mental health care and finds that they have more resources in their robust welfare state, but rely on institutionalising people at a higher degree than the US, and at a lower threshold. Now compare this with what I saw in Los Angeles, where there are very few hospital beds, a major homelessness crisis and a very high threshold before anyone gets hospitalised. That means community freedom of a sort. But you see people lying on the street, vulnerable, ignored until they cause a problem, maybe go to jail. Then if they're lucky enough to

get 'treatment' they experience this 'tolerant containment' I've described, in which they are given a kind of freedom that sometimes resembles abandonment. This is American libertarianism in action.

The big question is: how do we imagine a strong welfare state that creates excellent care that remains voluntary and empowering, and allows for psychic difference without sliding into abandonment like in LA?

Rory: Recently in a piece for *Los Angeles Review of Books* (Gong, 2020), you reflected on learnings from the economic motivations for psychiatric deinstitutionalisation and the consequences of not providing the meaningful alternatives required at these moments of drastic change. You mentioned the idea of pushing for true abolitionist thinking that calls for articulated blueprints for doing all sorts of things differently, not just a vision of shutting one malfunctioning aspect of a system. Can you think of any stories or lessons from your direct practice work, or from looking into the history of deinstitutionalisation, that might point us towards some 'clues' or where might we start developing these 'blueprints' from?

Neil: One of the beautiful ideas in abolitionist thinking about police and prisons is that the goal is not simple defunding or destruction; *the goal is creating societal conditions such that prisons and punishment are not needed.* This is the vision from thinkers like Angela Davis (2011) and Ruth Wilson Gilmore (2007) that we need to hold in our minds. Getting there, however, is extremely complicated. It is a generational project, in the sense that it will require enormous work over a long period, and it requires replacing simple 'solutions' to social problems (like incarceration in prisons or state hospitals) with encompassing changes to society. My reference to 'blueprints' concerns the fact that some emphasise the 'grand vision' at the expense of figuring out the technical ways in which we will actually achieve that vision. We need concrete plans, humility about the fact that we are experimenting and to keep an eye on the larger, generational prize.

This is where the analogy between the state psychiatric hospital and the prison is instructive. I draw on the US history since it's what I know best. What we learn from psychiatric deinstitutionalisation is that abolition based on facility closure is easier to accomplish than reinvestment, and that the work it takes to help people thrive in the community often exceeds the expectations of reformers. In many cases, people were released before things like housing and basic survival resources were available in the community. That was vision without a blueprint. We are in a position to learn from those mistakes.

The approach has to be two pronged. First, we must fight for the kinds of social democratic policies that allow all people to live securely, otherwise getting people out of lockup may simply mean them suffering on the outside. In the US right now, that means addressing housing and food insecurity, ensuring health care access, and creating meaningful work or activities for people to contribute to their communities. As you've noted, places like Australia have more welfare than the US, but it is still an insufficient welfare state. Some of this is about movement building and politics that is not explicitly about mental health or penal issues directly but will impact them. One of the routes will likely require taxing the wealthy at substantially higher rates. Right now, the idea of defunding police and prisons risks becoming a call for austerity. With the United States' libertarian tradition, it seems we have latched on to the idea of even more neoliberal cuts to the state. Instead, we must get out of a 'tax–neutral' framework, assuming our only option is taking resources from the 'bad' and moving them to the 'good'. No, there is abundance, even during a pandemic, via existing wealth and profit that can be redistributed. As the sociologist Adaner Usmani (2020) has argued, even if we reappropriated the entirety of local police budgets, it would not be enough to transform communities. We need to tax the wealthy. It is unconscionable that Jeff Bezos, a single man, has nearly 200 billion dollars. Again, these social movements and taxation issues appear not to be about mental health or penal issues directly, but it will nonetheless be fundamental to making a world where prisons or institutional mental health warehousing aren't necessary.

The second prong is looking at what we can do to develop concrete alternatives to

oppressive penal practices, without simply replacing them with oppressive 'mental health' practices. This will require working both within and outside of the system. I was extremely gratified to be on the recent webinar with IDHA precisely because they had representatives from CAHOOTS, a Portland, Oregon–based model for diverting 911 calls from police to a behavioural health team, and Mental Health First, which presents a model that is separate from 911, based on volunteers. Both the within-systems change and the true alternatives that they represent are necessary.

Another key component is the voice of peers and people with lived experience, whether that is the experience of incarceration or the mental health system. Many such peers have ideas based on little pockets of the system that worked for them or might work under different circumstances. We have to find these seeds and try to help them blossom, and keep what works as we transition to something radically new. It is simultaneously important for reformers and abolitionists to be humble here about solutions. We are entering into new territory. We often have promising anecdotal evidence about things like restorative justice circles, various forms of harm reduction, court diversion and such, but not robust evaluations. It's the same in mental health with open dialogue and some exciting other alternatives to the medical model as usual. We still have limited research, and must consider that some of these approaches may require tremendous changes to transfer from, say, Scandinavian contexts to places like the US.

My belief is that we must also avoid one-size-fits-all thinking, and avoid dogmatism. Many abolitionists are highly critical of court-mandated drug rehabilitation, for instance, as it brings penal logics into spaces of healing. This is a fair critique. As noted above, I'm very wary of welfare interventions that are coercive. And yet, some people find that court-ordered rehab, or at least some form of leverage and pressure, is what initially helps them get started. For others, it will be a gradualist or harm reduction approach that is entirely self-directed. Even the same person may find that different tools work at different times. We want to expand options, not simply contract them, and be willing to consider things that seem anathema to 'purist' abolitionist thinking.

To connect these two prongs again, remember that innovative programs may fail when we lack adequate community support, but succeed when people have access to good housing, meaningful work, et cetera. Simply releasing people from jails or prisons or hospitals without a place to go and plans for a future is not viable. We may not know precisely what will be the 'solutions' to everything, but we must be at least attuned to some of the possible negatives and do our best to craft wise policy responses.

Rory: I have really appreciated the consideration of the mycelium network of things we need to be growing to move towards spaces where there is enough flexibility and abundance for people to be supported in ways that resonate with their particular lived experience. I also appreciate the emphasis on many paths and avoiding dogmatism. I have concerns sometimes that the critical thinking that leads us to consider new systems of living can invite folks into dividing practices in the form of expelling those who fall short of some ideal lauded as the only way forward. Looking forward to continuing this conversation!

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