

Between Tolerant Containment and Concerted Constraint: Managing Madness for the City and the Privileged Family

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Abstract

How do public safety net and elite private mental health providers cope with a key dilemma since psychiatric deinstitutionalization—managing madness when people have the right to refuse care? I observed two approaches to voluntary community-based services, one that tolerates “non-compliance” and deviant choices, and another that attempts to therapeutically discipline clientele. The puzzle, given theories of the paternalistic governance of poverty, is that select poor patients are given autonomy while the privileged are micro-managed. Drawing on comparative fieldwork in Los Angeles, I show how contrasting ecological pressures and resource bases shape divergent practices. In the context of urban poverty governance, mental health care and low-barrier housing offer a way to remove problem people from public space. This “tolerant containment” is linked to limited therapeutic capacity and the construction of clients as beyond transformation. In the context of family systems governance, elite private mental health care is a project to reform wayward relatives and equip them with respectable futures. A “concerted constraint” of deviance, akin to Lareau’s theory of privileged childrearing, is reserved for those who can afford rehabilitation and conceivably recover. Using these cases, I contribute to theories of social control and inequality in advanced liberal societies.

Keywords

mental health, inequality, social control, urban poverty, family systems

The mid-twentieth-century closing of the United States’ mental asylums simultaneously advanced patient civil liberties and eroded a major social welfare function. Whereas liberal societies once had a clear response to psychiatric disability—hospital confinement justified by the state’s paternal powers—the loss of the “total institution” (Goffman 1961) and civil libertarian transformation of mental health law left a gaping hole in patient care and social control (Scull [1977] 1984). Far from reformers’ utopian visions of community-based services that would improve clinical outcomes and save money, the inadequately funded community centers offloaded costs and left many ex-patients destitute.

Instead of long-term care and confinement, a new generation was subject to brief emergency hospitalizations (Rhodes 1991) and an “institutional circuit” (Hopper et al. 1997) of clinics, shelters, and penal facilities.

Beyond the infrastructural crisis of reduced hospital beds, the civil libertarian turn fundamentally shifted authority over serious

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mental illness from the state and the medical profession to patients. For classical liberal thinkers madness had been the limit case in the expansion of rights. As Locke ([1690] 1980:350) put it, “lunatics and ideots are never set free from the governance of their parents.” Mill ([1869] 2010:10) similarly argued that liberty was “to apply only to human beings in the maturity of their faculties,” and “good despots” remained necessary for those who could not be educated into responsible freedom. The new restrictions on civil commitment and insanity pleas, however, generated new dilemmas surrounding rights and responsibilities. Rather than coerced in total institutions, people would be “governed through freedom” and choices (Rose 1999:72) in community settings, with robust rights to refuse treatment.

One legacy of the 1960s upheaval is that the very terminology surrounding mental health remains fraught with debates over rights, roles, and the nature of unusual psychic states. Throughout this article, I use the language of “madness” alongside “mental illness” to acknowledge competing perspectives, such as historical researchers skeptical of projecting psychiatric frameworks across time and place (e.g., Foucault 1965) and ex-patient activists who claim “mad pride” as part of a political identity (Schrader, Jones, and Shattell 2013). For contemporary reflections on the analytic importance of the term “madness,” see Menzies, LeFrançois, and Reaume (2013) and Scull (2015:11–15).

After deinstitutionalization, social scientists have focused on the consequences of serious mental illness for the public sphere, such as psychotic homeless people in urban centers, overburdened social services, and transinstitutionalization to the penal system. For instance, the sociology of mental health has studied the ex-patient empowered to reject psychiatric care on the street (Luhmann 2008; Rowe 1999), and the marginalized former patient arrested and held responsible in criminal court (e.g., Pogrebin and Poole 1987).

Such a focus on public institutions has limited our theorizing to the state or state-funded agencies, ignoring other projects of

social control with different stakeholders and capacities. Neglecting the private sector risks conflating state projects with control more generally. Whether public or private, rich or poor, deinstitutionalization produced a common dilemma: the management of serious mental illness when people have the right to refuse or shape care and otherwise make choices about daily life. How do public safety net and elite private providers govern psychiatric patients through their choices in voluntary outpatient services?

This article explores these regimes through a comparative ethnography of community mental health care in Los Angeles. In Downtown Skid Row, the public safety net and nonprofit agencies serve indigent and homeless clientele, while West LA and Malibu private agencies treat privileged patients. I compare two case management teams with shared roots in the 1970s movement to create “hospitals without walls,” each oriented toward voluntary care in community settings. Such teams treat a small number of people who are formally coerced via guardianships or court orders, but most clientele do not meet legal thresholds for forcible care. Although each clinical regime invokes notions of “client choice,” I find divergent ways of implementing choice. In the social service ghetto of Downtown Los Angeles, the public providers offer some “difficult” clients a surprising level of freedom to refuse medication, continue substance use, or act in socially deviant ways. In the elite treatment ecology, in contrast, workers act warmly but firmly to discipline wealthy clientele and leverage resources to generate compliance with elaborate therapeutic regimens.

This complicates typical associations of poverty with constraint and wealth with freedom, as well as recent theories of neoliberal governance. A wide literature observes the disciplining of the poor, who must comply with therapeutics to avoid arrest (Stuart 2016), work to receive welfare (Soss, Fording, and Schram 2011), and become responsible self-governing subjects in a larger context of hyperincarceration (Wacquant 2009). Comparative research across class echoes the intuitive

domination of the poor and a tolerance of the rich. In addiction services, for instance, McKim (2017) finds that the poor are subject to intensive surveillance and discipline via criminal justice rehab, whereas the better off receive less invasive care and avoid stigmatized “addict identities” in private insurance programs. Similarly, the literature on white-collar crime shows the “kid gloves” treatment that class privileged and highly educated individuals receive (Madden et al. 2012).

Why does tolerance emerge amid the material constraint of poverty, whereas disciplinary power manifests with the material freedom of wealth? My answer is that these forms of governance are dialectically related to clients’ experiences of constraint and indulgence. The clinical regimes are embedded in social ecologies that have markedly different goals and resources to achieve them, and thus different practices. Although there are shared historical roots and some overlapping dilemmas, the teams are engaged in different projects that correspond to the two respective social institutions responsible for madness after deinstitutionalization: municipal governments and the family. In these contexts, with different classed expectations, resource bases, and expertise, providers have developed different tools and ideals for community care.

In the context of *urban poverty governance*, the public safety net team engages in *tolerant containment* of deviant behavior. Rather than surveillance and the transformation of subjects via disciplinary tactics (Foucault 1977), the team aims for basic management of harm. With a key goal of housing homeless clients and ending the institutional circuit, providers concede a degree of medication “non-compliance,” continued substance use, and idleness as inevitable. In the context of *family systems governance*, the private treatment team engages in *concerted constraint* of clients’ behavior to transform them into responsible adults. Here I bring the social control scholarship into dialogue with the literature on family class socialization. Drawing on Lareau’s (2011) notion of “concerted cultivation” of privileged children,

which emphasizes scheduling of activities, surveillance, and development of individual capabilities, I theorize *concerted constraint* as the mobilization of therapeutic resources to cultivate and control adult-children.

MANAGING MADNESS IN MODERNITY

The Asylum and Its Critics

With the nineteenth-century rise of the coercive asylum, caretakers deployed strategies from brute restraint to moral treatment in an effort to manage and normalize the mad alongside other deviants unmoored during early capitalist development (see Foucault 1965; Porter 2003). From small-scale private operations where privileged families could send difficult members to large-scale state-sponsored institutions for the poor, orphaned, insane, or otherwise non-productive masses, the asylum proliferated as a purportedly humane alternative to prison or indigence. The emergence of physical institutions like the asylum and prison served as paradigmatic instances of disciplinary power (Foucault 1977, 2008), which attempted to render their charges simultaneously docile and productive. Rather than simple exertions of domination, discipline would help people internalize external norms and the self-governance required by liberalism.

In the mid-twentieth-century, criticism of the asylum’s social control function found a public and policy ear. Ethnographers like Goffman (1961) documented the differential ward system, physical discipline, and various forms of control in even well-regarded hospital settings.¹ This criticism dovetailed with increasing awareness that the hospital system was financially unsustainable. As Scull ([1977] 1984) argued, the fiscal crisis of the Western welfare state created a strong structural pull alongside the cultural forces of the 1960s. An unlikely coalition of leftists and fiscal conservatives pushed for the destruction of a presumed abusive and neglectful system that housed, fed, and organized the

days of over half a million people (Sedgwick 1981). With the development of new medications and new social security measures like SSI and Medicare, clinicians and policymakers expressed hope that former patients would be able to self-manage in the community.

Model legislation like California's Lanterman Petris Short (LPS) Act of 1967 granted patients considerable new rights to decision-making and essentially ended long-term state hospitalization outside of forensic trajectories. New federal funding mechanisms gave states incentives to prioritize community care, and state hospital bed numbers fell rapidly. Some ex-patients transitioned smoothly to the community, yet many struggled. Promised community mental health centers were never adequately funded (see Grob 2005), and advocates began calling attention to ex-patients falling into poverty and homelessness. Critics of the new civil liberties claimed people were in fact "dying with their rights on" (Treffert 1973). And yet, this liberation was not a false one: in a very literal sense, people were released from long-term confinement. Instead, they would be "governed through freedom" (Rose 1999:72), with choice and responsibility now integral and unavoidable components of care provision. Psychiatric control would be less concerned with managing the patient through *coercion*, and reoriented to a patient-directed *compliance* with a somatic or psychosocial treatment regimen (see Gong 2017).

Community Care and its Discontents

A wealth of ethnographic research collected from the 1970s onward illuminates the fate of patients in a transformed institutional landscape. Estroff's (1981) classic study of a pioneering community treatment team details the struggles of ex-patients to live independently, tolerate medications with significant side effects and ambiguous efficacy, and avoid returning to the hospital. Rhodes' (1991) work on emergency hospital settings shows how organizational demands push staff to simply "empty beds," rapidly discharging patients with

little in the way of concrete care. Hopper and colleagues (1997) note that many psychiatric patients rotate through jail stints, emergency hospitalization, and homeless shelters. More recent government statistics paint a dismal picture: of the country's 552,830 point-in-time count of people experiencing homelessness, approximately 111,000 were classified as severely mentally ill (U.S. Department of Housing and Urban Development 2018), and 33 percent of prisoners and 44 percent of jail inmates had "history of a mental health problem" (Bronson and Berzofsky 2017).²

The 2000s saw a shift toward a "recovery" approach, initially developed by patient activists, which brought renewed commitment to ideals of client independence and the possibility of full recovery from illness (see Davidson, Rakfeldt, and Strauss 2011; Deegan 1988). Yet as Myers (2015) found in her study in a nonprofit mental health center, empowerment amid material deprivation is elusive. For instance, client goals of employment or connecting with people outside the treatment center rarely come to fruition. As Braslow (2013) argues, such rhetoric of "independence" merely echoes the earlier wave of deinstitutionalization and might indicate further neoliberal attacks on welfare state functions. Similarly, recent journalistic exposés of programs to move institutional patients into independent apartments have found evidence of gross neglect (Sapien and Jennings 2018). Disability studies scholars further argue that efforts to foster individual "resilience" in recovery may de-politicize the social determinants of health (see Howell and Voronka 2012). Thus, the meaning of "recovery" and "independence" remain fraught, with proponents continuing to push against the paternalism of treatment-as-usual, and critics warning that it provides ideological cover for retrenchment of support.

Trends in Urban Poverty Governance

Beyond mental health care proper, scholars have examined people with psychiatric disabilities alongside other marginalized urban

populations, in such contexts as street encampments, shelters, and jails. They document a profound disciplinary turn in the U.S. management of urban poverty, characterized by work requirements rather than cash disbursement, punitive sanctioning, and “therapeutic policing” (Stuart 2016) that pushes people toward social services under threat of arrest. Within such services, providers discipline the poor into making “better” choices, such as going to therapy, taking prescribed medications, and compliance with recommendations before accessing basic resources. When service providers medicalize homelessness as a sign of pathology (Snow et al 1986), individuals with and without significant psychiatric disability become subject to therapeutic case management (Gowan 2010; Lyon-Callo 2008).

Other scholars note that much contemporary social control lacks the transformational aspirations of earlier disciplinary institutions—that is, it can be punitive without being disciplinary in the Foucauldian sense (on parole, see Feeley and Simon 1992). On the streets, cities use “post-disciplinary” forms of spatial exclusion, such as “bum proof” benches or trespass laws that do not aim at correction so much as at keeping people away (Beckett and Herbert 2008; Merry 2001).³ Cities may ignore homeless encampments so long as they remain secluded in undesirable areas (Herring 2014). In some situations, emergency services merely “burden shuffle” people between different state agencies (Seim 2017). For the incarcerated, prison warehousing “neutralizes” social problems through “punitive containment” rather than any attempts at correction (Wacquant 2009:296). Thus, the disciplining of individual behavior and a post-disciplinary spatial exclusion of marginal populations can often work together.

In the 2000s, however, federal and municipal governments embraced the use of “Housing First,” or subsidized apartments without preconditions of medication compliance or sobriety. The clinical rationale is that mental health and addiction needs cannot be addressed without safe housing (see Tsemberis, Gulcur, and Nakae 2004). Researchers

found that a small number of “chronically” homeless people, typically with serious psychiatric disabilities and addiction, consume a disproportionate amount of shelter and emergency services (Culhane et al. 2002). This discovery provided an economic rationale for low-barrier housing, as targeting permanent supportive housing at this subpopulation offered the possibility for major cost savings. Critics argue that this is merely a re-prioritization of scarce resources, non-costly populations will be left out (Willse 2010), and seemingly progressive care has “an alignment with street clearance policies” in gentrifying areas (Baker and Evans 2016:31). Whatever the impact in the larger politics of homelessness, the concern here is with clinical interaction on the ground. Such a policy means that, in certain forms of subsidized housing, patient compliance with treatment can be deprioritized. Some groups are eligible for housing with few preconditions, whereas others deemed neither sufficiently vulnerable nor costly remain subject to higher behavioral expectations for resource access.

Social Class and the Family

Most ethnographic literature on mental health care in the United States is an account of public and nonprofit services for the poor, with remarkably little known about care targeting other populations. More privileged mental patients have escaped social scientific attention, perhaps because they are not a publicly visible social problem like the homeless expatient. And yet, they and their families also faced a transformed institutional landscape as confinement gave way to community care and brief emergency hospitalization. The transfer of the burden of care from state to municipal governments, and the subsequent stresses on public settings, tells only one half of the story of deinstitutionalization. Beyond the city, the major social institution tasked with management of madness was *the family*. Stripped of legal power and with few resources from the state, a burgeoning family member social movement sought greater

influence in civil commitment procedure and treatment planning, often at odds with patient rights movements for self-determination (McLean 2000). The majority of individual families must turn to the poorly funded public system, where they may be cut out of care when patients reject their involvement (Padwa et al. 2016). Families with greater resources, however, have recourse to an alternative system in which *they* are the clients (see also Abramson 2009).

To make sense of the governance of privileged patients requires dialogue with the sociology of family, class, and socialization. Sociologists have long investigated the family as a site of social control, whether at the level of gender role socialization (Lorber 1994) or as an ideological state apparatus (Althusser 2006). How might community mental health care function when oriented toward the needs of wealthy families? Recall classical liberals like Locke argued that “lunatics” were to forever remain “under the governance of their parents.” Here the childrearing literature might offer insight into how class-based familial logics function.

Lareau’s (2002, 2011) classic comparative ethnography of social class and parenting offers the clearest account of differential logics of raising children. Working-class and poor families engage in an “accomplishment of natural growth” model of parenting, believing “as long as they provide love, food, and safety, their children will grow and thrive” (Lareau 2002:749); there is little structured activity, and less emphasis on talk. Lareau’s (2011:238, 748) middle- and upper-middle-class families, in contrast, engage in a “concerted cultivation” to develop talents and capacity in individual children, “a deliberate and sustained effort to stimulate children’s development,” which requires “organized activities that dominate family life and create enormous labor.” Furthermore, these parents attempt to reason with children, using talking as their preferred method of discipline.

These styles are rooted in part in material class factors, as only the wealthier can afford to pay for things like violin and karate lessons.

Yet they are also linked to different ideals, such as middle-class parents seeing their children as “projects,” or a working-class parent’s criticism of forcing a child to play piano. Lareau (2011) argues that these forms of socialization reproduce class advantage through differentially rewarded dispositions—the poorer children lack tools for navigating middle-class institutions like school, and the more privileged children begin to feel entitled to resources or speaking with authority figures, such as doctors or teachers. Recent extensions, such as Sherman’s (2017) work with elite parents, find a concern that too much material privilege may spoil a child morally. Thus, properly cultivating a child may also require retraction of goods or “symbolic deprivation” (Pugh 2009:9–10) to ensure proper moral characteristics.

This concerted cultivation, with emphasis on scheduling, achievement, highly verbal interactions, and the development of individual talents and interests, offers a possible hypothesis for how childrearing logics might arise in clinical care oriented toward the privileged family. Will community treatment providers attempt to schedule the time of the “adult-children,” cultivate their interests into productive talents, and expect therapeutic achievement? When put into dialogue with the social control literature, we begin to see intriguing parallels unexplored by Lareau. Most notably for the following analysis is the intersection between concerted cultivation and the techniques of Foucauldian (1977) disciplinary power. With each aiming to develop self-efficacious subjects for participation in modern social institutions, and sharing such tools as surveillance, the time schedule, and controlled activity, we may find that reading Lareau alongside Foucault offers tools for theorizing governance far beyond childhood.⁴

This study speaks to three tension points at the intersection of these literatures. First is the social control of madness and deviance in a neoliberal age. If scholars have largely focused on the public sphere through state institutions or the regulation of urban space, how do private circuits of control—such as those oriented

toward families with resources—inform our existing theories? Second is the way social class inequality affects the formation of subjectivity and life chances. If sociologists note profound consequences to bifurcated strategies in “unequal childhoods” (e.g., Lareau 2011) and job sorting (e.g., Willis 1981), what is the effect of “unequal illnesses” and trajectories through vastly different forms of mental health care? Third is the political and bioethical significance of stratified mental health services in an era of empowerment. Given disability activists’ critique of both paternalistic normalization and the co-optation of “patient rights” as justification for abandonment, what is the significance of care infrastructures that “govern through freedom”?

METHODOLOGY AND THE LOGIC OF COMPARISON

To investigate how resource and institutional variation affect community psychiatric treatment, I engaged in more than four years of comparative field research with public safety net and elite private providers. I centered on two case management teams as focal access points for the larger ecologies of care, as the teams collaborate with medical providers, service agencies, family support groups, and other relevant actors. Each treatment team has historical antecedents in the Assertive Community Treatment (ACT) model, or the “hospital without walls,” widely accepted as the “gold standard” in intensive outpatient care for people diagnosed with serious mental illness (Brodwin 2013; Dixon 2000). Rather than a statistical logic requiring the clinics and their ecologies to offer a representative sample of public versus private care, I use critical cases that crystallize issues under examination (Yin 2003) and “represent with special clarity phenomena that exist widely but in more diluted form elsewhere” (Katz 2012:259).

Los Angeles presents a useful location for studying legally empowered service-users and resource variation for two reasons. First, California’s LPS laws put significant limits on coercion into treatment, such as emergency detention and commitment criteria

based primarily on “dangerousness” rather than “need-for-treatment” standards. Second, Los Angeles is home to two iconic service locations severely stratified by wealth: the “recovery zone” (Stuart 2016) of Downtown Skid Row, for the down and out, and the “treatment destination” of West LA and Malibu, where local and global elites seek private psychiatric and addiction care. The advantage of comparing critical cases is that theoretically relevant differences are rendered in stark relief.

Such an interpretive approach to comparison aims to “clarify particularities through contrasts” (Skocpol 1984:371) and let cases “form a kind of commentary on one another’s character” (Geertz 1971:4). Here complex variation is leveraged for comparative understanding rather than fully controlled for. For instance, despite similarities in historical background, organizational form of the clinical settings, and diagnostic categories,⁵ the respective *client* populations have differences. Relative to the county treatment team, the elite agency’s clientele skew younger, whiter, and more connected to family. These elements are associated with the focal class comparison and help shed light on the regimes of care and control.

Beginning with an initial case study of public psychiatric services in Downtown Los Angeles from 2013 to 2015, I noticed the way resource constraints, patient social networks, and the local politics of homelessness affected treatment and everyday matters of “client choice.” Upon learning of a private psychiatric case management treatment team on the other side of town, I decided to investigate the care infrastructure across the proverbial tracks. I conducted the second case study between 2015 and 2017, occasionally returning to Downtown for follow up. Although I initially envisioned the comparison as one of social class, I came to see it was also about psychiatric disability as a problem of the city versus of the family. As a volunteer at the Department of Mental Health (DMH) clinic, I weekly observed team meetings, client-provider interaction at the clinic, home visits, and group activities. During this time, I spent

one more intensive year volunteering multiple times a week with DMH's homeless outreach, which brought me in contact with new clients, potential clients who were screened out, and other agencies doing street work. Through a recurring "homeless task force," I observed meetings between business owners and local government officials, as they debated the proper tactics for the removal of a homeless encampment.

As an intern with the pseudonymous "Actualization Clinic," I observed weekly case conferences, co-ran a social group, attended group therapy, and participated in events for private agencies in a referral network. Due to privacy concerns, I was rarely able to accompany on home or community visits. To triangulate case conference discussion, I observed the field services of a private-practice case manager who had once been an Actualization client and was now affiliated with the clinic. I visited the dual-diagnosis (mental illness and chemical addiction) rehabs, transitional and sober living homes, and residential treatment centers that Actualization worked with, to observe daily life and speak with clients and staff.

During field observations I took "jottings" and later elaborated these into narrative notes (Emerson, Fretz, and Shaw 2011), took real-time notes during meetings and some group therapies, and conducted semi-structured interviews with clinicians, clients, and collateral contacts. I represent audiotaped or real-time notated statements as direct quotations, and I paraphrase dialogue from field note observations, where brief quoted phrases should be understood as key phrases captured in jottings. I approached data collection with "the broadest theoretical base possible" (Timmermans and Tavory 2012:180), systematically generating codes by reading my empirical materials in dialogue with the sociology of mental illness, social control, urban sociology, and the family. Emerging conceptualizations were "brought back" to the field, allowing me to iteratively refine them as theoretical categories. The research project received IRB approval from UCLA and the LA County

Department of Mental Health, all quoted participants were guaranteed confidentiality, and all names of people and non-state agencies are pseudonyms. Informed by evolving discussions of the ethics of studying psychiatric settings (e.g., Dubois, Bante, and Hadley 2011; Skultans 2005), I took cues from service users and clinicians to minimize disruption and prevent potential research-related harms.

CLINICS IN THEIR ECOLOGIES

County Clinic: Mental Health Care in Urban Poverty Governance

The DMH community treatment team serves approximately 180 clients at a time in Downtown Los Angeles. Funded by the 2004 California Mental Health Services Act, such teams were designed to find unserved or underserved clients diagnosed with a serious psychiatric disorder who were homeless, recently incarcerated, or high utilizers of hospitals. The model was largely derived from the ACT approach developed in the wake of deinstitutionalization. Structurally, the team consisted of a clinical social worker and PhD psychologist in supervisory roles, a psychiatrist, two field-based social workers, a nurse, a licensed practical nurse, and four "community workers," with a client to staff ratio not to exceed 15 to 1. With their California state funding, such teams could perform services not typically billable to Medicaid or Medicare. The team I observed focused on adults between the ages of 26 and 65.

The ecology of Downtown LA, with gentrifying neighborhoods and the infamous Skid Row social service ghetto, influences the tasks at hand. Clients are drawn from homeless outreach, hospital and jail referrals, and other clinics. Despite laws against "homeless dumping," hospitals in the surrounding area are known to drop indigent psychiatric patients off in Skid Row (Kloczko 2016). The overlap with the criminal justice system is visible in the clinic, where a county sheriff and private security guard keep watch. Homelessness and incarceration are omnipresent

concerns. Indeed, in the county report for fiscal year 2011 to 2012, just prior to my fieldwork, the first description of the treatment teams notes “programs have demonstrated a 67 percent decrease in homelessness, a 35 percent decrease in jail days, and a 15 percent decrease in hospital days” (Los Angeles County Department of Mental Health 2011:15).

The Actualization Clinic: Mental Health Care in Family Systems Governance

The Actualization Clinic began as a small hospital discharge service in the 1970s, emerging in the same deinstitutionalization milieu as the ACT team model that became common practice in the public sector. Working as a “reintegration program” for wealthy adult patients released from hospitals, Actualization built up a case management team with some slight variations from public models. Structurally, a clinical social worker and a PhD psychologist lead the team, with nine other master’s-level clinicians, typically marriage and family therapists. They collaborate with psychiatrists whom patients see privately. Serving up to 90 clients, and thus with a client to staff ratio of around 8 to 1, case managers see considerably fewer individuals than in public services. The only client classification requirement is that the person is 18 or older and they or their family can pay. Along with people diagnosed with serious mental illness, the team also serves people struggling with more general problems of living. Drawing on the logic of family therapy, the team treats both the “identified patient” brought in for care and the whole *family system*, in some cases identifying the family dynamics as a contributor to the focused illness of the individual patient.

The Actualization Clinic operates in a broader ecology of exclusive services that we might call an *elite institutional circuit*: boutique residential treatment programs, exclusive rehabs in Malibu, private hospitals, therapeutic farms, high-end sober living homes, and wilderness camps for troubled

youth. Collaborating with family members, they work to create a highly customized array of services. Outpatient services cost approximately 5,000 dollars for 12 home-visits a month and are generally paid privately rather than via insurance. The Intensive Outpatient Program therapy groups are sometimes covered by insurance, but insurance companies will not typically pay for psychosocial services deemed “non-medical.” Payments nearly always come from affluent family members, rather than clients themselves. Private cash-pay services are not subject to the audits required of programs that take DMH funds, Medicaid, or other insurance plans.

Rather than being accountable to city politicians or bureaucratic insurance companies, Actualization is oriented primarily toward the family. Richard, the owner, explained,

Every few weeks I’ve got to send a millionaire dad running a major company a bill for a few thousand bucks and he wants to know why is he paying it. The reason he’s paying it is cause he’s talked to me several times. He’s talked to the doctor. He’s talked to the son and he feels really lucky to be able to pay the bill. I get audited every two weeks by everybody.

Getting “audited” by the families introduces a key dynamic at Actualization: the family members are the paying customer, not the individual patient. Clients sign HIPAA release forms for communication with the paying family member, who is entitled to case updates, and the team typically will not “hold secrets” from the person paying the bill.

Consider Richard’s description of a patient in this milieu: “A manic or psychotic person with resources and connections can do so much damage, you wouldn’t believe it. To their family business, to their community.” Rather than an eyesore on a gentrifying street corner, here the patient might be a liability for the family’s material and social standing in the community. Beyond issues of protecting reputation, the team orients to family separation and strife. Promotional materials link substantive improvement for clients to the

Table 1. Tolerant Containment and Concerted Constraint

	County DMH	Actualization Clinic
Governance Project ^a	<i>Urban Poverty Governance</i>	<i>Family Systems Governance</i>
Practical Goal and Tools	<i>Neutralization</i> of public nuisance through medication, housing, and disability benefits for the homeless or formerly incarcerated mad person.	<i>Normalization</i> of wealthy patient and strained family relations through medication, specialized psychotherapy, and rehabilitative activity.
Logic of Care and Control	<i>Tolerant containment</i> (e.g., contra Foucault [1977] on disciplinary power) of deviant behaviors, such as non-compliance, substance use, and idleness.	<i>Concerted constraint</i> (e.g., Lareau [2011] on privileged childrearing) of deviant behaviors, leveraging resources and therapeutically reforming wayward adult-children.

^aA note on the “governance projects”: marginalized urban patients may have family involvement, and rich patients may occasionally create problems in public space for the city. My analytic separation of *urban poverty governance* and *family systems governance* points to the way the overarching clinical logics are linked to these broader organizational and institutional dynamics.

resolution of familial difficulties: “Actualization has helped thousands of patients return to meaningful, satisfying lives and has been reuniting families for 35 years.” This emphasis on *meaningful lives* and *reuniting families*, in a context of familial wealth, sets forth a specific set of tasks and possibilities. Table 1 summarizes the overarching logics in the two clinical settings.

TOLERANT CONTAINMENT AT DMH

Housing the Homeless Mad Person

Public psychiatric services in Downtown LA respond to a particular yet not uncommon context: urban redevelopment of a gentrifying area and the need to clear problematic people from the street via either policing or services. In contrast to but also in conjunction with the “zero tolerance” policing of street corners (Stuart 2016), mental health and housing providers work to move people into apartments or Board and Care homes. This approach is oriented toward madness as an urban problem: the management of people who are homeless, recently discharged, or at risk of being a disturbance in public. Its goal is *neutralization* of problematic public behavior, not by incapacitating people via incarceration, but by

bringing people indoors and manipulating environments such that behaviors that cannot be fully changed can be tolerated or redirected while contained in housing.

As a form of social control, this “tolerant containment” is characterized by an acceptance that rehabilitation is unlikely, eschewing attempts to create the docile and productive subjects that Foucault (1977) theorized in the prison and asylum or the responsible consumer of neoliberalism (Rose 1999). Yet unlike post-disciplinary strategies that would simply exclude problem people from public spaces, this “post-disciplinary tolerance” creates spaces for people to be deviant. It focuses on “harm reduction” in the broadest sense, from codified and concrete strategies regarding medication and substance use, to minor alterations of problematic behaviors such that they do not lead to client eviction and arrest. Put simply, tolerant containment is more than neglect or social abandonment, but less than robust care and treatment.

Lowering Behavioral Requirements to Get People Off the Street

The first step of a tolerant containment approach to managing empowered madness is to relax behavioral expectations. In line with a broader movement toward low-barrier

housing, DMH placed homeless people in hotels or special shelters and applied for vouchers for permanent supportive housing. The quickest route to stable housing is typically placement in a Board and Care home, with shared rooms, medication monitoring, and onsite staff who cook and clean. Yet it was precisely the “difficult” clients who refused or were refused by Board and Care homes who might get permanent apartments, because specialized vouchers were tied to length of homelessness and “vulnerability” scores. Thus, one way to govern through seemingly irrational or pathological choices was to simply accept behaviors that were previously unacceptable.

Clients deemed too difficult for other agencies or who had done poorly in structured settings were offered independence, and a surprising freedom to engage in ostensibly problematic behaviors. For individuals who had been booted from stricter settings outside of DMH, the team’s relative tolerance was remarkable. As John, an African American man in his early-50s said to me upon first entering his subsidized apartment, “Am I dreaming? I can’t believe this.” He explained he had been in and out of prison, kicked out of a Board and Care home for drug and alcohol use, lost an apartment, and lived on the streets and in a shelter. Although constrained by poverty, he could now make everyday choices in his subsidized unit. As Laura, the team leader, put it later with a smile and shrug, “He’s still housed, still drinking, and still defying gravity!” Given that he was alive and indoors, his alcohol consumption was tolerated.

To see the key features of this practical logic, consider a debate over the appropriateness of such housing placements. Melena, a licensed practical nurse who had previously worked in hospital settings, broached this at one morning meeting: “We know they were sick. Why did we put them in these apartments?” She relayed her latest contact with a woman who glared menacingly and intentionally broke the key to the door. The team debated whether the woman could stay in structured settings. Laura concluded, “They

were this way on the street. At least they are safe. People like them are not gonna do what we want. But what can we do? These are the behaviors that kept them in the streets.” Notice the disjuncture between Melena’s suggestion that people who are “sick” do not belong in independent living, and Laura’s high tolerance of the woman’s behavior. With the belief that people will not “do what we want,” Laura prioritizes the basic *safety* that comes with a roof and a locked door.

Here the clinician’s aim of keeping people away from the dangers of street life dovetails with the urban development need to bring the most disruptive homeless people out of public sight. Neutralized as a problem of visible disorder, behaviors could then be tolerated until reaching a point of “danger.”

“Sitting Back” and Keeping People in Place

With clients having the legal right to refuse care unless “dangerous” or “gravely disabled,” workers were often *laissez faire* until a person became “hold-able.” For the DMH psychiatrist Dr. Wong, ideas like harm reduction and rapid housing made sense in terms of engagement, but he found some people continued to refuse his treatment after they had safety. Having worked in hospitals and prisons, he was used to greater control than in community care. He was frustrated that little could be done coercively until a person crossed a “danger to self or others” threshold:

Gone are the days where we tie them [mental patients] to a post and beat them. . . . But now we’re too far over to the other side, the pendulum swung over. Now they’re saying my job is to educate a person about their mental illness, and their options, and you have to sit back and hope that the person chooses the right choice. . . . Until something bad happens.

When the team hospitalized people, they prepared for a quick release. Yet rapid discharges did not result in a completely passive “sitting

back,” as Dr. Wong put it. Instead, there were different interventions related to voluntary care and the continual evaluation of risk. Consider the following representative instance of rapid assessment paired with an offer of voluntary medication.

I accompanied a social worker and a nurse to see Hugo, a Cuban American man in his mid-20s diagnosed with schizophrenia. After living on the streets of Hollywood, Hugo received a subsidized apartment and took in homeless youth in the area. He said he could hear men think about harming his female friends, and the team believed this was an auditory hallucination that might lead him to an altercation. Yet Hugo said he knew not to attack anyone until they physically assaulted him or a woman. The nurse decided he had “said the right thing” to avoid a hospitalization, so she turned to the voluntary option. “Hugo,” she said, “would you like a medication appointment?” He refused, explaining, “I’d rather have my friends than be zonked out on meds.” We all laughed, and the team members said he needed to clean the house.

The team would continue to monitor Hugo and others like him, honoring the right to refuse treatment until clients either tried voluntary care or could be hospitalized. This form of surveillance does not aim at the deep internalization of norms, as in a Foucauldian model. It is driven primarily by the dynamics of legal liability, as workers must both try to prevent danger and avoid violating patient rights. Some people indeed became more open to medication or addressing substance use once safely housed, but such “natural growth” was sometimes secondary to the main goal of getting people indoors.

This emphasis on keeping people housed meant workers might simply “lay eyes” on a person to see if they were staying in place. This is illustrated by a routine visit to an older man living in a Board and Care home. When the client decided he did not want to talk that day, the nurse, Vic, said this was fine. As we left, Vic said to me, “Well, we made eye contact, so we can bill for it. Last week he didn’t even want to come back to stay here, so hey.”

For a model oriented toward urban poverty governance, keeping people in place was a victory. In the potential clash between empowerment and paternalistic care logics (Dobransky 2014), the worker here embraces the client’s stated choice to be left alone unless in crisis. Vic could have sought to draw out another discussion of choice—the client’s apparent interest in living elsewhere—but that would have created a problem where there temporarily was none.

Redirecting Behaviors to Prevent Eviction

When a person was symptomatic, or seemed to replicate elements of street life, the team worked to redirect problematic behaviors. People might be relatively stable and safe yet disruptive to the broader public. Thus, the treatment team frequently responded to landlords, with intervention aimed to prevent eviction. Consider the way apparent symptoms and deviant behavior were not eliminated, but creatively redirected when a client was disturbing her neighbors. Sandy, a white woman in her 40s, had been found on the streets and placed in a women’s center before coming to the treatment team and getting her own apartment. Diagnosed with schizophrenia, she refused medication and repetitively banged her head against the wall.

I went with Beth, a social worker, to check up on Sandy, who had been housed in a new apartment outside of Downtown. Her building manager called to say she had angered her adjacent neighbor by banging her head against the wall shared between their apartments. We first spoke to the building manager, who also wanted to make sure the unit was cleaned. Although landlords may generate or embellish accusations to evict undesirable tenants (Desmond 2016), the DMH workers initially took the manager at her word. When we went to Sandy’s room, Beth gave her a series of instructions that would be necessary to keep living in that building. The plan was for Sandy to clean the apartment more, and to bang her head on the *other wall* that went out to the street.

Rather than seek the internalization of norms through therapy, or attempt to fully eliminate problem behaviors, this approach redirects behaviors so as to minimize the harm to clientele and the nuisance to the public. The team's highly creative plan honored Sandy's compulsion to bang her head, while keeping her housed. Soon the team came to believe that the building manager was exaggerating Sandy's troublemaking, and they worried that an eviction was imminent. Sandy liked the area, but an eviction could jeopardize her housing access in the future, so they convinced her to move to a building Downtown that would be more accepting of such behavior. This highlights the fact that tolerant containment is not only a feature of the treatment team but of particular ecologies.

Reducing Harm and Delaying Death

When a person was unlikely to get sober, workers suggested moderate use or choosing some drugs over others. Bobby, a white man in his 50s who enjoyed uppers and refused medication for his bipolar disorder diagnosis, relayed how Beth had instructed him to "smoke crack [cocaine] instead of injecting crystal [meth]" because there had been some fake methamphetamine floating around Downtown. He failed to follow her advice, and showed me an infection in his legs seemingly due to the bad product. Theorists of harm reduction note that it can function as a disciplinary project to turn drug users into docile patients (see Bourgois and Schonberg 2009). Beth's approach, however, was practical. Bobby would go on to lose his subsidized apartment, get arrested, and end up in a locked rehab before coming back to the team, who helped him enter another subsidized unit. Choosing "crack over crystal" was simply about survival in the meantime.

In other cases, this harm reduction approach was seen as delaying the inevitable. Consider Roxanne, an African American woman in her 50s and long-term street drinker. Diagnosed with major depressive disorder, she was housed in collaboration with a nonprofit agency, and I accompanied

her case manager Carlos to check in. After making sure she had food, Carlos would remind her that the doctors said more drinking could kill her, which Roxanne acknowledged. One day Carlos confided in me that they had wanted to schedule her for more visits, to try and connect with her and encourage her to drink less. Yet with other "fires" to put out, and with the departure of some staff members who had yet to be replaced, they were reduced to seeing her every two weeks. Carlos feared he would find her dead, and indeed, a year after my fieldwork they found her unresponsive.

As a visiting psychiatrist stated regarding another client's passing from alcoholism, "You're dealing with a societal group where premature death is enormous. And you're pushing it in the other direction." Keeping people alive for the time being, housed, and away from the most dangerous drugs was a significant task unto itself, and it required a different set of expectations.

The Limits of Social Services as Treatment

The DMH team's low-barrier approach to engagement, and their commitment to honoring non-dangerous choice, meant clients who were deemed "resistant" in other programs could be served effectively. Yet when a client was "compliant" and doing well in terms of medication, housing, and survival, the team had less to offer. Laura, the team leader, explained they were good at getting people stable, and getting them into housing, "but not so good at the rehabilitative side." "It's no one's fault," she said to me, "It's just once we've covered the basics with one person we have to move on to the next person to get them housed."

Consider the case of a Jamaican man in his early 30s who had been psychotic and homeless in Downtown Los Angeles. I first met Jeremiah on the team's initial outreach response near a courthouse, where he stood drawing messages in the dirt. He was given a hotel room, and then hospitalized, responding well to an

antipsychotic. Scared of a return to the street, Jeremiah decided to stay in the Board and Care until he felt stable enough for an apartment. As one social worker later said, “That’s what hope looks like.” Yet Jeremiah noted that his treatment opportunities remained limited:

You get housing, which is good. I think that’s a very good thing. Housing, food, clothes. That is a big plus, but I think it can be more too. It should be more too, right? . . . When Laura took care of my Green Card that was a big plus too. . . . I think a big part of it is like when you’ve gotten the persons on the meds and they’re doing fine, you want to get them to the point where they’re working and it makes more sense instead of just not having anything to do or feeling that you can’t do anything, you know?

Note that the things offered here besides medication are basic provisions of the welfare state and help with immigration. Jeremiah was hesitant to criticize the program given how much they had helped him, but he also believed there “should be more.” From an urban governance perspective, however, Jeremiah was already a success story: he had been neutralized as a public disturbance. No longer psychotic on the street, he was indoors and not bothering anybody.

The other limit to tolerance was when team members suspected clients were addicts taking resources away from the “truly ill.” For instance, I watched Gary, a middle-aged white client, ask why the team was not doing more to appeal his failed SSI claim. A supervisor later told me that Gary’s psychiatric hospitalizations were related to his heroin addiction and they had mistakenly enrolled him. He might have a formal psychiatric label, but the workers informally labeled him as not-seriously-ill and therefore less deserving (see Dobransky 2014). When I visited Gary at his new single-room-occupancy unit, he complained that he had to fill out the housing paperwork without help from the staff. Ironically, such institutional competence might affirm the team’s suspicion that they

need not prioritize his case. Like Jeremiah, Gary was now housed and relatively stable, allowing workers to move on to the next client.

In short, in the logic of *tolerant containment*, care and control were exercised by relaxing behavioral expectations. This tolerance coexists alongside zero-tolerance policing and other forms of intensive social control. If the housed client fails to meet the most basic forms of behavioral compartmentment, the treatment team and authorities like landlords can still attempt to invoke the coercive power of the state via eviction, psychiatric holds, and incarceration. Neighbors may engage in “third-party policing” (see Desmond and Valdez 2013; Stuart 2016), and when evicted from independent housing a person might return to intolerant settings like shelters. Yet within the clinical regime, everyday treatment was marked by the expectation and partial acceptance of deviance and compromised choices.

What the team does *not* do is equally important and worth highlighting. For clients who retain their legal rights, the team does not demand medication compliance or sobriety.⁶ The team rarely utilizes formal talk therapy, and generally does not push idle clients to be more active and find meaningful roles in the community. When clients lived with family, the team could mediate conflict, hospitalize, or facilitate moving to a Board and Care home or to supportive housing. They were not, however, positioned for therapeutic interventions.

CONCERTED CONSTRAINT AT THE ACTUALIZATION CLINIC

Re-parenting the Adult-Child

Whereas the logic of tolerant containment frames interactions between clients and service providers on Skid Row, the logic of “concerted constraint” organizes treatment relations in wealthy private psychiatric settings. This care and control style is characterized by a belief that clients have the potential to improve clinically, engage in activities in

the community, and achieve sobriety, requiring both positive and negative incentives. Practices unfold in a project of family systems governance: an intervention to reform “identified patients” and their relationships with kin. Deirdre, the clinical director of Actualization, described much of the clinic’s work as “re-parenting.” She noted that some clients were at a far younger developmental stage than their actual chronological age, often due to privilege and overindulgent families. Therapeutic work is tied to a larger project of teaching people how to be adults. Rather than intervening into problems of urban poverty, like removing the mad homeless person from a business district, Actualization works with families to alter relations and long-standing dynamics.

Akin to Lareau’s (2011) privileged parenting style of “concerted cultivation,” this psychiatric rehabilitation strategy utilizes surveillance, scheduling, and a variety of therapies to create self-efficacious individuals and stimulate their hidden talents and desires. It is “concerted” in that it requires resources and energy, engaging in costly rehabilitative services. It is “constraining” of choice, but not coercive per se—instead, it creates webs of incentives to *normalize* behavior. Dev, a former Actualization client who now collaborates on cases as a social worker and “peer coach,” explained the approach: “In the private mental health system you can create situations in which the individual is likely to comply as a result of the work you do with the family.” Whereas tolerant containment creates space for impoverished patients poorly served by a cruel environment, concerted constraint seeks to generate conditions of compliance for those whose mental illness has been “enabled” by privilege.

Leveraging Resources to Motivate Compliance

A key dynamic in Actualization’s concerted constraint of a “non-compliant” patient was *leveraging* resources, which could both positively and negatively influence behavior. In contrast to DMH’s immense struggle to secure

housing vouchers or qualify clients for benefits, the Actualization workers had to coach well-off families on how to restrict resources. Cash was seen not only as an asset but also as a liability. Flush with money, clients had little incentive to engage in treatment. A different set of difficulties arose when families had long funded destructive lifestyles, and the very privilege that bought access to elite care could constitute an obstacle when a person did not respond to the team’s friendly overtures. As Richard, the owner, put it, “Would you rather try to deal with someone that’s psychotic, but homeless and broke and desperate, or someone that’s psychotic and got a lot of money in the bank?” He explained that families often enabled problematic behavior, as they did not know what to do besides giving more. This made it difficult to motivate people, because they “didn’t have a problem.” Actualization thus tried to help families learn to leverage their financial resources into both a carrot and a stick.⁷

During a team meeting to address a young man who refused an antipsychotic medication, Richard said, “I don’t care how disorganized you are [psychologically]. When you see it [budget] in black and white, you’ll get on board.” Here we see a clear formulation of governing through choices: in the absence of coercion, even psychotic people understood the meaning of money and would comport their choices appropriately. This meant creating a gradated set of incentives, with cash attached to “healthy” behaviors that might be internalized over time. The team called this *contributions and expectations*, where team members would mediate a deal between families and adult-children. These tactics are distinguished from simple coercion, encouraging rather than forcing compliance and engagement.

The positive leverage provided by disposable income is illustrated in the following example. Vanessa, a white woman in her 50s diagnosed with psychiatric and developmental disabilities, did not want to take her assortment of medications. The treatment team worked with her elderly mother to develop an allowance system, paying her to take pills and engage

in healthy behaviors. For instance, she received a dollar for every minute she walked outside. In some cases, the team would propose paying people extra money to take antipsychotics. The carrot can easily become a stick, if providers threaten non-compliant people with retraction of money and social support.

Steven, an Asian American and Jewish man in his mid-20s, told me he had previously resisted going to treatment to address his psychosis and drug use. After being released from the hospital, he refused to attend a residential program, and he was within his rights to do so. He planned to continue using drugs and even thought he could make it as a homeless person, until he learned what this might mean: "When I was using, and my mom really wanted me to stop because I found out I had schizophrenia, my case manager took me down to Skid Row and was like, 'This could easily be you.'" Steven had never seen such poverty, and he agreed to treatment. If providers could work with families to leverage resources, the money and support that was previously "enabling" could become a disciplinary tool.

Such leveraging could easily backfire, however, generating the kinds of crises families were hoping to avoid. For instance, one man reacted by signing up for General Relief from the city, selling his plasma, and using the money to live out of his car. He soon drove off to Texas in a psychotic episode, where he was arrested for marijuana possession. When a different man in his late 20s diagnosed with schizophrenia went off antipsychotic medication and refused to come back to treatment, the clinic recommended that his family threaten to evict him as leverage. In response, the man set the family guesthouse on fire and was arrested for felony arson of an inhabited building.

Thus, teaching these privileged adults a lesson was a tightrope walk. The point was not to make their clients suffer, but to create enough of a threat to constrain behavior and encourage participation. Whereas for poorer people, the world had already generated difficulties, and being kicked out of the family

home might simply mean homelessness, here leverage backed by significant resources could facilitate myriad possibilities of care. This external control in the concerted constraint model aimed to get people into treatment, where medication, specialized therapies, and scheduled activity might generate the internal control needed for self-governance.

Controlling the Environment in the "Bubble" Sober Living

At the Actualization Clinic, it would be wasting a therapeutic opportunity for a symptomatic or substance abusing person to live in an unstructured setting, contrasting markedly with the harm reduction model for the formerly homeless patients at DMH. According to an Actualization therapist who had once worked in nonprofit services for the poor, "Harm reduction is all the county *can* do. They can't control the environment like we can." This meant keeping people in the right housing situations and away from the wrong people, in relatively closed environments. As a step-down from such total institutions as private residential therapy centers or rehab, the team sought placements that offered surveillance but also community activity. Actualization worked with a series of dual-diagnosis sober living and transitional homes, preferring residences that had a great deal of programming and structure. They introduced me to one they considered exemplary, Namaste Gardens, a Buddhist-themed house near the beach.

Namaste served men in their 20s, 30s, and occasionally 40s. It boasted a highly regimented schedule with daily therapeutics, exercise, a meatless diet, multiple urine tests a week, and 12-step meetings. Residents spent the first six months attending an Intensive Outpatient Program (IOP) at a nearby center—in some cases this might be Actualization's mental health IOP or the adjacent addiction facility. This treatment was paid for by insurance, but the sober homes themselves usually required cash.⁸ Residents told me that Namaste was a "bubble" sober living home, structured and semi-removed from the real

world, in contrast to the “flophouse” sober livings attended by poor people.

Geoffrey, the owner of Namaste Gardens, contrasted the intensive scheduling of healthy activities with two poles of treatment: settings that let people choose idleness, and those that used shame-based control inappropriate for mental illness:

[Some residences] allow the person to just take their meds, sleep in . . . kind of shuffle through life. That’s not going to happen here, I’m not going to want it . . . we’re doing so much together, meditating every day, surfing every day, going to the gym every day. . . . I feel like those bipolar and the schizoaffective clients, they can’t handle any kind of confrontation or stress. It exacerbates it, but they flourish in a healthy rhythm.

Neither allowing people to “shuffle through life” nor relying on punitive “confrontation,” Geoffrey delivered the “healthy rhythm” of scheduled time, therapies, and an active California lifestyle.

Justin, in his early 30s and diagnosed with schizophrenia, illustrates how this can nonetheless be experienced as excessive control. Justin was on a large dose of Clozaril, a powerful antipsychotic that quieted the voices but left him tired. When I would see him at Actualization’s IOP therapy in the mornings, he would begin dozing and ask to lie down. He participated in terms of medication, trying to stay sober, and meeting with his Actualization case manager who was “like family,” but he resisted the intensive schedule and lack of privacy. Justin believed he was ready for more autonomy, but the Namaste Gardens house manager confided in me that he was worried Justin could end up as a psychotic street person, and they would not allow him to transition to more privileges.

I observed Justin’s request in front of the 11 other residents, three of whom also had a schizophrenia diagnosis, for the ability to walk around alone and call his mother without staff listening in. When he asked the

house manager for “a leap of faith,” the man said, “We can’t take a leap of faith with people’s lives.” Justin sat down against a wall, crying silently. That night he ran away and got high on the beach. He was later found by the police and hospitalized when he said he felt suicidal. He returned to Namaste Gardens, beginning his cycle toward privileges over again. When I later accompanied him to do volunteer work, he said with resignation, “You kinda can’t get out of Namaste.” Although a voluntary residence, he believed himself trapped.

Such settings offer a level of surveillance and scheduled activity otherwise difficult to achieve in the community. Unlike the Board and Care system or the “flophouse” sober livings for the poor, which left residents unmonitored or idle through the day, “bubble” residences like Namaste sought to cultivate participants. Although the providers questioned whether someone like Justin could indeed live on his own, the rehabilitative machinery of Actualization and Namaste kept him safe and engaged in activities oriented toward recovery.

Internalizing Control through Techniques of Self-Management

I next turn to the kinds of therapeutic work at Actualization’s IOP and the goals of self-control and self-efficacy. Unlike the urban safety net clinic whose time is dominated by addressing homelessness and mitigating basic harms, Actualization could focus on specialized psychiatric, psychological, and behavioral treatment. Clients were often disposed to doing therapy, having attended university clinics, therapeutic farms, psychoanalytic residential facilities, or individual psychotherapists.

Actualization’s on-site curriculum consisted of cognitive behavioral (CBT) and dialectical behavioral (DBT) therapies with workbooks and homework assignments, alongside art and experiential groups. The psychotherapies, broadly concerned with “self-management,” are industry standards for mental health and addiction and not restricted to the wealthy. Yet the emphasis

stands out when contrasted with its relative absence among the county team. During a session, the IOP director explained, “At Actualization we do the ‘opposite action.’ So if you feel like staying in bed, you should go to the gym.” Clients’ thinking was considered disordered yet open to rational reflection and change. By learning to name emotions, rate them, and work on being “mindful” through difficult experiences, clients could hope to have greater choosing capacity. This required symptom rating, as the inscription of such ratings would allow tracking of emotions and cognitions. The director elaborated, “When we look at things [e.g., anxiety] and rate them on scales, they tend to go down after a while.”

Similarly, Dawn, the DBT therapist, implored clients to “name it to tame it.” By this she meant that articulating emotions and bodily states allowed people to “know what they’re working with.” This was different than tapping into unconscious psychodynamics. For many clients, these “practical” therapies were useful and complementary, as they often saw more process- or meaning-oriented therapists individually. Dawn emphasized the melding of “emotional mind” with “rational mind” to get at what DBT practitioners call the “wise mind.”

Consider this exchange with Tom, a man in his mid-20s who had recently come out of the hospital after a period of mania and psychosis. An aspiring entrepreneur, he hoped to make it big in Bitcoin and other tech ventures in Silicon Valley. He explained how DBT had helped him remain calm through an argument with his father, who doubted Tom’s business ideas and wanted him to do something else:

Tom: [In the past] he’d say I was full of shit. I’d say f-you dad. But I stayed mindful during the trigger and he gave me the best advice—I don’t have to be an entrepreneur to be happy. I could do other things and be just as happy.

Therapist: You’re so much more open.

Tom: Yes, more growthful. DBT gave me the skills to choose.

Another group member: Choose what?

Therapist: The choice to remain calm and present. What did “emotional mind” say?

Tom: He’s going to judge the last two years of my life.

Therapist: You’re making assumptions.

Tom: Yes I felt afraid. Fear and hurt.

Therapist: “Rational mind” said what?

Tom: Maybe I should listen to my dad, he pays my bills.

Therapist: “Wise mind” is a melding of the emotional and rational.

The therapy presented Tom with a new way of conducting himself in relation to his father and the ability to choose his actions. Whether he truly believed in this, or was merely performing for the therapist, it demonstrates the logic of self-management and growth at play.

Here we see a chief feature of concerted constraint: the emphasis on cultivating self-control, as learning to stay “mindful” through fear and anger can generate new forms of choice. It is *concerted* in that it is focused and takes considerable time and money. Its *constraint* is about tempering emotional reaction with rational reflection, eventually enabling participants to make “wise” decisions. The issue of listening to one’s father, who pays the bills, links back to the governance of family systems. Such cultivation was not necessarily effective, for clients might come to associate expensive therapies and facilities with external control. Tom, for instance, told me he was fed up with Western medicine, therapeutic groups, and being told what to do. He declared he was only coming to Actualization so his parents would support him, and he soon disengaged, went off medication, became psychotic, and returned to the hospital and then a psychoanalytic residential treatment center.

“Get-Well Jobs” and Meaningful Activity

The Actualization team worked to schedule client lives with non-clinical activity. Far from mere safety checks or redirecting someone to bang their head on a different wall, Actualization insisted on getting people busy in the community. Because there was little concern with basic survival, home visits could be oriented to different goals.

Behaviors that would be low priority at DMH, like idleness and staying at home, became a site of clinical intervention.

Deirdre, Actualization's clinical director, explained that it was doing people a disservice to give them too much choice in what to do. Janice, a case manager, had asked for clinical advice on how to engage Roy, a white man in his late-30s diagnosed with schizophrenia. His father had brought him to the clinic because he spent all day reading comics and watching TV. Although Roy took an antipsychotic and was not experiencing positive symptoms of psychosis like hallucination, he had purportedly exhibited negative symptoms such as flat affect and self-isolation in the past. When Janice asked what he wanted to work on, Roy was resistant to new activities, suggesting a potentially pathological withdrawal. Deirdre said Janice was giving too much choice, and she revealed her logic drawn from parenting:

We don't want to infantilize our clients. But it's like with my kids: if I ask them what they want to do, they want to be on their phone. "You want a bike ride or get something to eat?" If they want something else, "Sorry that's not an option."

Deirdre warns against infantilizing clientele, but then suggests reducing their choices like one would treat a child. Yet by narrowing the range of activities, Roy would have choice among acceptable options. Janice soon began taking him to busy restaurants in an attempt to increase his tolerance for discomfort. Roy would later tell me this work, although difficult, was "better than any medication" he received, and he soon began to pursue more daily activities by himself.

As people reduced treatment days in the therapy groups or home visits, Actualization insisted they go to school, work, or volunteer. In some cases, this required enormous support. One woman in her 30s, diagnosed alternately with bipolar and borderline personality disorder, received multi-day-a-week psychoanalytic treatment as well as Actualization case

management. As Richard put it with a grin, she was getting "\$1,000 of therapy to keep a \$500 job" at a bookstore. Although he used a humorous tone, the point was that the work was psychosocial care—rather than a means to make a living, it served as a "get-well job." With such resources at the family's disposal, privileged clients could pursue employment activity without the fear poorer disabled people had of work affecting benefit provision (see Estroff 1981; Padwa et al. 2016).

In some cases, however, the pursuit of meaningful activity meant insisting on community engagement even when it terrified clients. Kayvon was a Persian man in his early 60s who lived at home with his mother. Diagnosed with schizophrenia, he had been in various forms of treatment since his 20s, and he now saw Dev, a caseworker, on weekends. I sat with them one morning in Starbucks after playing soccer, an activity Kayvon previously believed would cause a catastrophic event in his brain. Now Dev was insisting on additional activities, but Kayvon was scared a new destructive event was imminent:

Kayvon: Dev, I'm not going to risk my sanity for doing things that I know—

Dev: I would never put you at risk. You know that.

After some back and forth, with Kayvon relaying his fear of a brain malfunction, Dev finally put his foot down and said, "It would be a disservice if I allowed this to continue, because it impacts the quality of your life."

Later that day, Dev explained his reasoning, and linked it to differences between private and public sector services and ideals of client choice. In most public settings, they would accept Kayvon's refusal and apparent delusion as a form of choice:

With the private [sector], I don't know if the right word is *you can get away with more*, but for instance, with Kayvon, we push through things, do things. But in the public [sector] I might not be able to do that. They could think that *that's not ethical*. [emphasis added]

For Dev, on the other hand, it was unethical to allow people to live small lives, sitting at home and doing nothing all day. He was hired by Kayvon's family to give him a wider array of activities and improve his quality of life.

The Limits of Leverage Based on Resource Control

I earlier noted situations where resource "leverage" resulted in crises, such as a person running away or setting the house on fire when threatened with homelessness. In other cases, adults who retain control of their own money may subvert concerted constraint by simply refusing to comply. The reliance on families can also become a weakness, as when "non-compliant families" agree to leverage but then recant and disrupt the incentive structure. I now consider two cases where Actualization had to reorient the trajectory of care when their resource control strategies were inoperative.

Will was a white man in his 40s diagnosed with bipolar disorder and alcohol dependence. He was successful in the movie industry, so although his parents were involved in treatment, he was not financially beholden to anyone. Will saw the team's favored psychiatrist, enlisted two Actualization case managers, and hired "sober companions" to accompany him throughout the day. Notably, he used these people precisely to constrain his own behavior when he felt he could not do it on his own. Yet Will soon decided to drink again and fired his treatment team.

After an alcohol-related health scare sent him to the hospital, his psychiatrist reached out to the team. Will would be coming out of a residential rehab program and would need community-based support. Yet Deirdre declined to take him on again as a client. She pointed out that "he has his own money," and therefore would be immune to the team's attempts to leverage him into sobriety. When she saw him on television some months later, she remarked, "I can't believe that guy is still alive." Unlike a safety net clinic that might support a client with risk of death due to

serious addiction, Actualization can refuse the person as inappropriate for their form of care. This reveals how concerted constraint can be rendered inoperable without leverage dynamics, and private settings are less obliged to tolerate certain forms of risk.

Consider next an unusual but revealing case in which a homeless woman briefly received services at Actualization. Carolyn, in her 40s, was diagnosed with schizophrenia and heroin dependence. From a well-off family, she had been cut off and fallen through the cracks, going through a series of psychiatric hospitalizations before homelessness. Her brother, however, was paying for high-quality insurance. In the wake of the Affordable Care Act, which brought previously uncovered people with preexisting conditions into private insurance, a behavioral health insurer reached out to Actualization to gauge whether community case management would be cost-effective for their high service utilizers. Carolyn was one of the initial test cases.

Put simply, Actualization did not know what to do with Carolyn. They struggled to get her housed, for the insurer would not pay for non-medical housing and her brother would not assist. Spending hours at court hearings, and finding her when she disappeared, the treatment team could not implement their therapeutic procedures. In the end, Deirdre decided they were unable to help the woman and requested that the insurance company not send them any more homeless people. This case reveals how concerted constraint is reliant on a baseline of financial resources and family involvement, and elite therapeutic expertise may not translate without that structure in place.

In summary, in the logic of *concerted constraint*, providers exercise care and control via resource leverage with extensive treatment to transform clientele. These forms of therapeutic discipline aim to avoid excessive choice, on the one hand, and punitive confrontation, on the other. Far beyond simple offers of medication and housing, the providers mobilize a variety of therapies and social activities to cultivate a client's self and design a new life. In cases where a person does not

“recover” to the point of independent living or employment, workers may still push for hobbies and the appearance of health over tolerance of idleness and socially deviant behavior. Should a person prove too self-destructive, immune to resource leverage, or lack the social and financial resources for treatment, however, the team may decline further work and refer them elsewhere.

DISCUSSION AND CONCLUSIONS

Given the need to govern clients through their choices rather than coercively, how do the DMH and Actualization treatment teams manage serious mental illness in voluntary community settings? I identified a series of techniques and tools oriented toward the respective practical problems of the two treatment ecologies. At county DMH, the response to clients who are poor, disposed to street life, and in some cases “non-compliant” is to reduce behavioral expectations, offer safe housing, redirect problem behaviors, and reduce harm. At the Actualization Clinic, the response to privileged adult patients who resist but are not dangerous is to leverage them, exposing them to positive incentives and graded material deprivation to generate treatment engagement, control the environment through luxurious and structured residences, rationalize emotions through psychotherapy, and guide people to healthy activities. Each of these findings—a kind of freedom for the materially constrained, and constraint for the materially privileged—complicates assumptions about social control and class. My analytic strategy to resolve this brought my study of mental health and governance into dialogue with urban sociology and the sociology of the family.

To make sense of the tolerance for indigent psychiatric service users, I have shown how shifts in urban poverty governance prioritized low-barrier housing for certain costly populations, and how limited therapeutic capacity relative to need alters the threshold at which behaviors are problematized. This can disrupt

the disciplinary aims of psychiatric services (Foucault 1977) and attempts to develop appropriate choices characteristic of neoliberal governance (Rose 1999). To analyze the behavioral constraint of the privileged, I looked outside the social control literature to a situation where highly directive and intensive socialization is a mark of prestige and class development. In the case of parenting, “concerted cultivation” is indeed only possible with considerable resources and is linked to values of social reproduction (see Lareau 2011). This style may be repurposed in therapeutic projects to keep the well off from downward mobility or entering other control institutions like penal settings.

Drawing these literatures together, I theorized these contrasting approaches as *tolerant containment* and *concerted constraint*: two concepts that help illuminate why the surprising elements are quite sensible in their respective environments. The former captures how spatially specific acceptance of deviance may serve as a release valve in a context of abandonment and punitive poverty management, and how the precarious freedom is marked less by robust inclusion than mere tolerance. The latter shows how the disciplinary elements of intensive therapeutic control can work alongside indulgence, serving as an investment in substantive change, self-efficacy, and respectability. As a caveat, the empirical findings and theoretical logics are drawn from critical cases and do not capture all forms of community-based psychiatric service. Various private insurance schemes, pilot public programs for “first episode psychosis,” rural community centers, and forensic treatment teams may differ in ways that limit the applicability of these models.⁹ Moreover, many people continue to receive no services at all. Still, these cases remain highly significant both theoretically and for people’s lives. Reflecting on the contrasting logics, this article makes three contributions.

First, I show that mental health recovery has different targets, mechanisms, and strategies depending on a person’s class situation and the institutional backdrop of care. Here I

draw inspiration from research on inequity in the production of subjectivity, social roles, and life chances. Whereas Goffman (1961) theorized hospitalized patient “careers” in the singular, a comparison of client community careers shows these to be as stratified as occupational ones. Like Lareau’s (2011) parenting styles or Willis’ (1981) schools, programs encounter and mold different kinds of patients-in-recovery. For DMH’s formerly abandoned or criminalized patient, a tolerant approach to housing and safety may relieve suffering and serve as a foundation for mental health improvement. Yet in this non-developmental project, some people will self-destruct, return to punitive circuits of social control, or sit idly in poverty. If there is freedom, it is freedom to be “mad” in ghettoized housing, and if there is “natural growth” it is largely incidental. Actualization’s approach, on the other hand, may act as an extension of concerted cultivation, especially given the younger age, financial resources, and general social advantage of its clientele. It is an explicitly developmental project that can generate resentment or even crisis, yet also facilitate meaningful social activities, therapeutic transformation, and class-respectable roles. Here discipline is not the opposite of freedom, but one of its conditions when coupled with material opportunity. In effect, the same diagnoses may be lived as radically different illness and recovery experiences.

Second, the theoretical categories can illuminate a range of governance projects in advanced liberal societies oriented toward “freedom.” Abstracted from the cases at hand, *tolerant containment* is a general strategy to stem costs and mitigate disruption when corrective social control is ineffective or too expensive. Elements may appear in such cases as safe injection sites, decriminalization, penal diversion programs without substantive treatment, sanctioned homeless encampments, universal basic income, or any situation where it becomes cheaper or politically expedient to accept or redefine previously problematic behavior. *Concerted constraint*, on the other hand, is a component of elite socialization to

ensure well-being and maintain privilege in private circuits. Rather than opposed to luxury, therapeutic discipline may be necessary for generating self-efficacy, reputation management, and respectability. This is a general strategy of reforming elite deviance rather than merely tolerating or punishing it. We might see this in boarding schools for problem children, wilderness programs for teenagers, residential sex therapy for disgraced celebrity harassers, and other efforts to keep privileged people from criminal responsibility or downward social mobility.

Third, the article points to some ironies for the bioethics and politics of mental health care. Disability studies scholars and activists have long criticized the “hegemony of normalcy” (Davis 1995) and disciplinary attempts to “fix” different bodies or psyches. Ironically, the local state’s tolerant containment may avoid this disciplinary normalization, precisely because it cannot afford therapeutic transformation. Yet a person’s “choice” to bang her head in a subsidized apartment, to drink himself into a stupor, or to sit idly might easily be reframed as the state’s abdication of responsibility for profound need and social defeat. This echoes the perspective of advocates wary of the way “independence” and “choice” rhetoric can justify inadequate support (e.g., Braslow 2013; Howell and Voronka 2012). Familial investment in concerted constraint, in turn, shows the way love, control, and opportunity may go hand in hand. Here class privilege and family expectation may bring a kind of normalization that the marginal urban patient avoids by default.

As a final note, and returning to the contemporary legacy of deinstitutionalization, we find fierce struggles to reform civil commitment law and even “bring back the asylum” (Sisti, Segal, and Emanuel 2015) to address the criminalization and social abandonment of mental illness. In California, current efforts to reform the definition of “grave disability” may lead to an uptick in legal guardianships, should resources be made available to back it up. Yet even if such thresholds change, many care decisions will

still take place in community settings where choice is both legally institutionalized and normatively valued. In Los Angeles, for instance, a recent homelessness bond measure authorized over a billion dollars toward tolerant interventions like harm reduction-oriented supportive housing. Thus, understanding the contemporary management of psychiatric disability means not only the political flashpoints of overriding choices, as in emergency hospitalization or criminalization, but also governing *through* choices when people do not present danger. Whether one sees tolerant containment as a civil libertarian achievement or neglect, and concerted constraint as loving treatment or familial control, each offers a form of liberal governance that cannot be reduced to questions of simple domination. Here a politics of coercion versus freedom may prove less useful than one that considers the material roots of unequal illnesses and stratified choice architectures.

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Notes

1. There was class variation in treatment provision, as in Hollingshead and Redlich's (1958) finding that poorer patients often received primarily custodial care.
2. The use of point-in-time counts for homelessness, the complexity of psychiatric diagnosis, and issues surrounding self-reporting render these numbers and percentages open to methodological criticism. The point here is simply that many people with psychiatric disability experience homelessness or incarceration.
3. According to neo-Foucauldian scholars, these are all indicative of a broader shift to "neoliberal governmentality," with individual self-governance and market logics becoming the primary form of population management. Although some analysts frame an epochal shift away from disciplinary power (equated with physical institutions) to governmentality or "control societies" (e.g., Castel 1991; Deleuze 1992), these in fact overlap greatly (see Rose 1999). State or nonprofit agencies attempting to foster autonomous and responsible citizens/consumers may use various disciplinary practices to render people self-governing. Yet what Rose's theory describes is a world where those who do not learn self-governance, such as deinstitutionalized mental patients, will be excluded via incarceration or simply abandoned to the streets. That is certainly part of the story, but it neglects the post-disciplinary tolerance addressed here, such as tolerant containment in subsidized housing with minimal rules.
4. The opportunity for theoretical synergy is considerable. Foucault's (2008) writings on the family in disciplinary societies, such as the surveillance of childhood masturbation, offer a rich and suggestive avenue for exploration. Yet as feminist scholars like Taylor (2012) point out, Foucault offered only "fragments" of a genealogy, alternately conceiving of the family as a sovereign or disciplinary institution, and he failed to theorize maternal power at all. Thus, empirical sociological works like Lareau (2011), with ethnographic observations and grounded theorization of actual familial governance practices, offer ripe material for contemporary Foucauldian theorists. When Foucault (2008) did address families of means and their management of deviant members, he addressed a historical era where the solution was long-term institutionalization—a different problematic than the one presented here.
5. There is a danger of taking mental illness categories for granted in a comparison such as this one. Classic labeling theory research argues that categories like "schizophrenia" are catchall descriptions of residual deviance—social constructions rather than medical diseases (see Scheff 1971). Others take a middle ground, such as modified labeling theorists who focus on how labels affect both stigma and treatment processes (Link et al 1989), and dynamic nominalists

who assume mental illnesses are real but subject to historical change (Hacking 1999). My comparison is oriented toward the clinical regimes and ecologies, and how they process a person diagnosed with particular mental illnesses. Whether everyone so diagnosed in fact has the same illness is unclear. Instead, I address how the providers and ecologies construct, problematize, and treat behavior that has been labeled, say, psychotic or a sign of major depression.

6. Even when the DMH team was a representative payee for a person's SSI, they did not take away funds based on lack of medication compliance or sobriety. In line with the general logic of tolerant containment, they often anticipated discretionary money would be spent on drugs or alcohol. This may vary regionally. Brodwin (2013), for instance, observed a Midwest urban clinic directly tie spending money to accepting psychiatric treatment and behavioral compliance. That city and region appeared to have a robust outpatient commitment system, whereas LA County only recently piloted such programs, so there may be larger differences in approaches to control.
7. In some cases it was not the family driving the middle-class values of concerted constraint, but the Actualization Clinic itself. Although upper-middle-class families seem primed for ideals of cultivation, productive living, and structure, the team reported that some very wealthy families did not necessarily have the same values as the middle- and upper-middle-class staff.
8. The for-profit addiction industry has come under heavy public scrutiny for unscrupulous business practices and outright insurance fraud (see John Oliver's 2018 HBO television special [Parise, Penolino, and Oliver 2018]). In some cases, outpatient providers will pay for sober living homes via insurance billing as a kickback for referrals. Actualization and their collaborators criticized such situations, and they were involved in attempts at behavioral health industry self-regulation and certification.
9. My fieldwork did not focus on middle-class treatment institutions, but I did encounter people of middle-class origin in both the safety net and elite settings. At county DMH, some people of higher SES experienced "social drift" after mental health crises, eventually coming to the public system and living on survival benefits. Given that private insurance rarely covers intensive case management-type services, I also learned of middle-class families that took adult-children off of private insurance in order to access those public resources. In the elite clinics, some middle-class families utilized private insurance for what it would cover, and then went into debt financing specialized services. Such families might sustain private-pay care for a short time. Future research should further address the degree to which the findings outlined here apply in various middle-class services.

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