Episode 260: Exposing America's Mental Health Care Inequities

Lizzy Ghedi-Ehrlich: Hi, I'm Lizzy Ghedi-Ehrlich,

Lisa Hernandez: And I'm Lisa Hernandez.

Lizzy Ghedi-Ehrlich: We are your hosts for Scholar Strategy Networks, No Jargon. Each month we'll discuss an American policy problem with one of the nation's top researchers without jargon.

Lisa Hernandez: And to give you a little behind the scenes look into our podcast, we are recording this in a month of mental health awareness. So it—

Lizzy Ghedi-Ehrlich: Good to be aware

Lisa Hernandez: —it sure is.

And we are definitely going to be discussing a lot of mental health related policy in this episode. So it is timely for us and slightly timely for the listeners here.

Lizzy Ghedi-Ehrlich: I mean, we are experiencing a mental health crisis as it has been called for not just this month or last month, but for quite a while.

Lisa Hernandez: Every morning.

Lizzy Ghedi-Ehrlich: Right? For some of us, yes, for sure. I think the conversation that we're about to have in that, the facets of it that I'm most excited about is that mental health, as much as it is such a salient issue, this is something that policymakers are talking about, it's something that individual people and their families are talking about. After Covid, it became such an issue with children, with teenagers, but we treat it sometimes as this separate thing that if you have a mental health problem, mental health treatment is the solution. And I'm really interested in how mental health actually intersects with so many other issues that people experience and therefore so many other policy realms. It's complicated. It's not simply mental health awareness or mental health treatment, but what it means to be a person who is experiencing houselessness and mental health issues at the same time. And how we address that in so many ways. People who are having those experiences in public loom large in the public imagination. So there's multiple reasons why

we'd need to address them, but certainly for those people themselves. And there's a whole lot of opinions about how to do that.

Lisa Hernandez: It's almost like we are whole people who have intersecting issues and things can be addressed to meet the needs of people in a way that feels like you're addressing a whole person as well.

Lizzy Ghedi-Ehrlich: It almost is, Lisa. And hopefully, we'll learn a little bit more about that and see what is actually happening in the state of California and what that means for everybody else. In this month's episode, I spoke to Neil Gong, Assistant Professor of Sociology at the University of California San Diego, who studies psychiatric services homelessness and how communities seek to maintain social order.

His new book, "Sons, Daughters, and Sidewalk Psychotics Mental Illness and Homelessness in Los Angeles," compares public clinics and private psychiatric programs to understand inequality in mental health. Here's our conversation.

Lizzy Ghedi-Ehrlich: Hi, Professor Gong. Thanks so much for joining us.

Neil Gong: Well, thanks so much for having me. I'm excited for the conversation.

Lizzy Ghedi-Ehrlich: Yeah, same. And congrats on your new book. We actually wanted to meditate on the title for a minute because it was very arresting to us here at SSN. "Sons, Daughters and Sidewalk Psychotics." It's provocative, and maybe not what you chose, but either way, the title that it is, we just, we wanted to know if there's a story there, what that means to you in terms of the folks that you're talking about in the book.

Neil Gong: Yeah, absolutely. So it was a title that I chose, although I thought about it for a while, because as you said it's quite provocative, and I didn't want to offend people with what is indeed a very stigmatizing phrase, people as sidewalk psychotics. But the point is precisely, through my research that I found that our society treats some people as sons and daughters or other relatives who are in crisis, who deserve care, and we treat other people as kind of social problems essentially, so in this case, the sidewalk psychotic.

But what's so interesting, and I think a lot of us have this experience around serious mental illness, is that we have both sorts of sets of experiences, right? So we have people who we

might meet on the street and they're kind of an object of fear or pity, but we don't really engage with them as a human.

We also, for many of us, have somebody we're close to. It could be a relative, it could be a friend we lost track of, it could be ourselves during a crisis. And so, we often have these sort of dual experiences around serious mental illness, and depending on which frame we're looking at, we might actually approach policy issues differently.

Lizzy Ghedi-Ehrlich: And there's more than just that interpersonal framework. You also talk about how there are two different mental health systems that have evolved in this country that are very much separated by wealth.

So we have a system for people who can pay and a system for people who can't. And then those themselves evolved out of the asylum system that came before. So tell us a little bit about that history. What are we coming from and what is that duality that you're seeing now?

Neil Gong: So the asylum emerged in the US in the early 19th century with these grand hopes about caring for people with serious psychiatric disabilities.

In part, it's tied to the transition from an agrarian to an industrial society. So urbanization people are maybe less densely connected with families and small communities, and so people with more severe disabilities might end up kind of unmoored, floating around, homeless, perhaps jailed, right? In some ways, it sort of echoes perhaps our current moment.

The idea then was that there would be these new hospitals run by the States, which would provide a safe place. And it was, it was quite optimistic, so the idea was perhaps you would have 250 people in a pastoral setting with activities and communal living.

But these early optimistic days, they go awry pretty quickly. These new state hospitals get overwhelmed, not just with lots of people with what we would today see as serious mental illness, but also lots of elderly people who have dementia. In some cases you see cities trying to reclassify elderly people as mentally ill so they could ship them off to the asylums, and this is actually another sort of common part of the story we still see today of trying to shuffle around, costly people.

And so by the mid 20th century, many of these asylums that had initially started out kind of small scale, have thousands of inmates. And I say inmates because in many cases this is kind of what they are.They're people who do not wanna be there, who are there, by force and often in quite bad conditions.

We then start transitioning to this process that we talk about today with the word deinstitutionalization. So moving people from the asylums to the community setting.

So, ironically what was initially this reform, now that scene is the problem and the new reform is gonna be taking people back to the community. And there are a number of factors that end up driving this. So you have, on the one hand,

civil libertarians and social reformers who are arguing that these places are highly oppressive and depriving people of fundamental rights. There's a series of journalistic exposes, there are certainly social scientists who are also documenting terrible conditions. And then from the right you have fiscal conservatives who are saying, these state hospitals are very costly.

And so you kind of have this strange bedfellows coalition of the civil liberties folks and the fiscal conservatives, and there was also sort of promising moment where with the emergence of the first antipsychotic medications, there was hope that this would allow a lot of people to transition to life in the community more easily.

Although even at that time, the research was showing that many people were not responding particularly well to these medications, or in some cases they were, but the side effects were pretty awful. So you have this kind of cultural critique, this civil liberties element. You also have this economic angle that, oh, we can save money by closing the state hospitals.

And the idea was that we were gonna create a robust, federally funded community mental health system in its place. But this really never ends up getting set up properly. And so again, there are these moments where it seems like things are going in the right direction with the new Social Security Amendments, we have things like Medicaid that are gonna pay for people's community treatment.

We have new disability incomes that supposedly are gonna help people live independently. You also have the birth of these new municipal programs. But these systems too also get

overwhelmed quickly. So in the book, I actually quote an early director of the LA County Department of Mental Health who describes a meeting he had with then California Governor Reagan.

The idea was that they had a handshake over this, that there would be time to set up this new community system before too many hospital patients were released or before the state hospitals were closed. and so this director was actually quite bitter because his claim was that this timeline wasn't followed.

So suddenly they had all of these patients released from the state hospitals. It completely overwhelmed these new community systems that were being set up, in a sense, they've just been playing catch up ever since.

Lizzy Ghedi-Ehrlich: I was gonna say that sounds like what people, if you didn't name names in that story, if you didn't mention Reagan, I think people would assume that that's exactly what's happening today. That seems like an incredibly modern story of folks setting up an incredibly complex system and saying, okay, listen, this is the plan.

But then seeing the results of these correctly or incorrectly met timelines for taking care of people who they don't have personal relationships with and everyone's going, well, what the heck happened here? So I like that you're explaining a little bit of what is behind that, what this is, what the heck happened.

Neil Gong: Yeah. Yeah. And I think we see, we see analogs too with, outside of psychiatric policy, like if you're looking at things like attempts to decriminalize drugs and build up community-based addiction and rehab systems, very similar kinds of things that are very well intentioned. The logistics are incredibly difficult to do this well, especially if you're gonna rapidly decriminalize or rapidly release people from prisons. So we see these kinds of analogs with other social policy issues that have some similarities.

Lizzy Ghedi-Ehrlich: Yeah, I think that brings us nicely into the present. You started discussing your research in LA and that's what I wanna turn toward now, and I wanna start with the public mental health system that has evolved to serve people in poverty who end up on the streets.

And that's a lot of the work that you were doing in LA. Tell us about folks who were actually being served by the system or who the system was attempting to serve.

Neil Gong: You know a good way to get us into this, let me tell you the story of a guy I got to know named Jeremiah, or I call him Jeremiah, I should say in the book, who's a Jamaican man who had immigrated, with his wife, who was an American and he had a psychotic break. He was in Northern California.

He ended up somehow, sent on a bus, ended up in downtown LA and he's sort of emblematic of a lot of what, a place like the LA County Department of Mental Health is dealing with. I was with the outreach team, we met him on the street. He was gesticulating with his hands, he had a towel wrapped around his head. He didn't seem to really seem to have a clear narrative of what he was saying, and they managed to do quite a bit for him. What they did was they helped him get access to housing. At one point, he ends up in a short hospitalization. He finds that he's one of these people for whom antipsychotic medication does work really well.

He has significant weight gain, but overall, he thinks it's worth it . They also help him sort of fix some of his immigration status. He's very grateful. What he ends up communicating to me is that most of what they've ended up doing is kind of addressing the problems in the, kind of broken US welfare state.

So what they're really addressing for him, is not really therapeutic. It was all about helping him get off the street, he had some legal troubles, for some things he'd done while he was in an altered state. They helped him with straightening out his immigration 'cause he hadn't been in touch with authorities over this while he was sort of wandering around California, while in psychosis.

This is, I think, a way to understand what a lot of public mental health treatment programs are doing. It is that they're really trying to help people cope with all the gaps in our safety net and really coping with the problems of urban poverty as much as mental illness, so if we just jump back again for a little bit to think about this history.

So during the institutionalization, people are being released, this is happening in the seventies and eighties. A lot of this is dovetailing with some major changes in the US around low income housing. So disruption of low income housing stock, like single room occupancy, hotels in some cities, this investment in public housing, places like California, just sort of general constraints on affordable housing supply.

And so it's, it's not that there's something inevitable about people with mental illness becoming homeless, but when you do have this kind of transition to this community system at a time when the kind of new homelessness as it was called was expanding, you have that as well as the expansion of kind of, hypercriminalization and mass incarceration.

Lizzy Ghedi-Ehrlich: Yeah, so it's not just dental and mental health. It's like every agency at once, every domain of government coordinated, and that is a lot.

Neil Gong: Yes, yes. So in some ways it's heroic.

Jeremiah said he was very grateful to this treatment team. But ironically there's not as much focus on mental health and he was hoping to have more vocational training, perhaps return to work. He felt he still had something to contribute. He was only in his early thirties at the time, but he was kind of in this new life as a sort of professional mental patient.

We have concrete disincentives right around. People are scared to work too much 'cause they're worried they might lose their benefits. So he ended up, kind of, in this world where they were able to help him to a degree, but that's kind of where he got stuck.

Lizzy Ghedi-Ehrlich: Yeah. Yeah. And it sounds like that's still exactly what's happening. I wanna lay down some kind of key concepts first, this component of our current system, which we're calling the Housing First model.

That's a term that I think some folks are gonna be very familiar with, and there will be other people who have a lot of opinions about it, but we wanted to ask you, what does that term mean, how does that model work? How is it supposed to work? Is maybe more the leading question.

Neil Gong: So Housing First, is the idea that to help people, especially people who are long-term chronically homeless and have, perhaps co-occurring disabilities, psychiatric disabilities, perhaps also addiction. The best way to help them is actually to start with stable housing.

And so this was in reaction to earlier models of addressing homelessness where a person might have to prove sobriety and compliance with a doctor, say to take psychiatric

medication, to perhaps go through a shelter system and eventually make their way to independent housing. And the idea was that actually for many people, this would never happen, they needed the stability of permanent Housing First, hence the name Housing First. And then all of the follow-up services could be brought into place in a voluntary manner.

And the early research on Housing First was very positive and actually, the continued research is positive in the sense that if it's done robustly where people get access to housing and then they get all the support services they need. You have high housing retention rates, about 85% of people. And these, are not just, the average homeless person, but we're talking about 30% of people, of the overall homeless population that have a serious psychiatric disability and again, maybe co-occurring addiction.

So this was considered a huge advance in terms of housing stabilization and retention. The unfortunate thing is that in many cases, what gets called Housing First really does not resemble that original model that was developed by this agency, Pathways to Housing, in the nineties.

These studies that show this high level of success are doing it in this sort of gold standard model where it's subsidized housing, but paired with these kinds of community treatment teams, these community treatment teams actually come out of community psychiatry.

They're considered the gold standard of community psychiatry. And they would have an interdisciplinary team of nurses, social workers, psychologists, psychiatrists, and they could be potentially on call 24-7.

But realistically, most things that get called Housing First are really just, housing that doesn't have requirements around sobriety or, treatment compliance. In many cases, that means maybe it's a good first step, but then if you don't follow up with these kinds of services, I have unfortunately seen places where people are sort of placed in an apartment and then left there to self-destruct.

Lizzy Ghedi-Ehrlich: And that is actually a concept that you discussed, tolerant containment.

Tell us what is tolerant containment? How do the stories that you're kind of alluding to, with Housing First policies that don't quite go all the way to their promise, how is that reflected then in the reality that we're left with?

Neil Gong: Housing First, and I wanna be very clear 'cause there are a lot of critics of Housing First who I think are correct to criticize the poor implementation, but I actually think Housing First and then harm reduction another term, are incredibly important components of public health and mental health care. This is the idea of, okay, we get somebody into an apartment and it's a harm reduction model. We're not demanding sobriety, we're trying to figure out how to reduce the harm around substances. It's a low barrier to entry into the housing.

But unfortunately what it ends up becoming is what I hear call tolerant containment. So the containment element is that the key goal isn't necessarily helping people, it's getting them out of the way or it's containing social problems. So whether that's putting somebody in an apartment or if they're on the street, making sure that it's not in a main business district moving encampments and saying, well, you can camp just do it over here.

And that ends up being the mentality. I argue around a lot of issues. So there's the containment element, so it's spacial, it's about keeping things out of the way. But it is tolerant in the sense it's a bit different then many things in the past where we were hyper criminalization, drug use, drug possession, or somebody was having a psychiatric episode and they would get criminalized and taken to jail. A lot of cities have really done in some ways an admirable job of trying to move away from that. So we've seen this in terms of, trying not to arrest or incarcerate people simply for drug possession or to certainly recognize that if somebody's having a psychiatric episode, jail is gonna be the wrong place for them.

But rather than this kind of robust ideal of, Housing First, where there's the housing plus all of these services, it ends up becoming tolerantly containing people out of the way, which looks like progress, but in many cases it's not really helping it's just kind of kicking the can down the road, or moving people out of the way, without any investment either in, truly trying to help them through treatment and care, or through getting at some of the sort of root causes, of these bigger social problems.

Lizzy Ghedi-Ehrlich: Right. I mean it's, it's acting as if the problem is not anything that those people are experiencing, but that the problem is the experiences and perceptions of

people who are being served, who have homes, who have whatever psychiatric care they need and are using public spaces. I mean, I think that is, that's a story that I'm always interested in exploring how we define who public space is for, how we define who is the worthy public.

Neil Gong: Well, there were times when I was with the outreach teams and with the county mental health teams where they sort of begin this question of, who are the true clients in the sense that sometimes the outreach teams would be responding to business owners or they'd be responding to local government officials who were themselves responding to business owners or local people with a bit more social and political capital who were saying address this encampment or deal with this person.

There were clinicians who said sometimes they felt used, sometimes they felt like they were there to have the veneer of help, when, otherwise there might be policing or there might be just this bit of help. But really, again, about getting people out of the way versus really trying to address their broader needs.

Lizzy Ghedi-Ehrlich: So let's talk about some of the shortcomings that you point out. I mean, what do you think would be needed to fix maybe Housing First policies that are not living up to the potential of programs like that, or not fulfilling all the actual requirements outlined in the original design of a program like that?

What does it take and maybe what are the reasons why we aren't getting it? In the cases where those aims have been degraded, is it from other politicians? Is it groups with clout? Like those business owners? Is it just a public misperception of how they work? What's going on there?

Neil Gong: So, an unfortunate thing, I think, was that when Housing First was first being pitched, it was pitched as a cost saving mechanism. So the idea was that if we invest in this kind of permanent supportive housing with support services, we can actually save money by keeping homeless people with disabilities out of the ER, or perhaps they're being arrested fewer times and so we'll save on these other municipal expenditures. In the end, it'll be cheaper. This is true under some circumstances for some people with more serious disabilities, in certain areas. Also, depending on the kind of availability of housing in the area change how you calculate this.

But I think one problem was that, there was kind of this attempt to suggest that doing this well would not just be the right thing to do, but then it would be cheap. The truth is, if you actually wanna provide the care side, it's not gonna be cheap. If you wanna simply contain people, there are situations where you can argue that it's cost effective in that sense.

But if we wanna do right by people, we actually have to invest. That means more staff, so that you can actually have this kind of consistent home visits, or that people can be called upon 24/7. It means better trained staff. I think that we can also think about part of the crisis around mental health as a labor issue.

You have staff who are perhaps, undertrained for some of these patients with more severe needs. And then also if you have a really high case load, it will be very difficult to one, simply get the practical side of the job done, but then also to actually be empathetic and do kind of therapeutic work, it's kind of impossible when you have too many people, especially when people are in such kind of high need situations and, and many of whom are actually difficult sometimes to deal with because they've often been through a lot of traumatic stuff on the streets or while incarcerated or for a variety of reasons. So it's just incredibly taxing emotionally to do this work well. And so the people who end up doing it are often rather callous by the end.

So, to do it well we're gonna acquire a big investment in staff, in training. Also even in the quality of the housing, just in terms of, you go to some of these places and they're sort of broken down, and dilapidated.

Lizzy Ghedi-Ehrlich: Speaking of big investments, there's another side of the coin that we haven't been on yet. We haven't talked about the parallel system. For people who are wealthy and have access to care that they need, who can seek it out in a private setting? Can you tell us a little bit more about that? Who were the folks that you spoke to having that experience, and what was that experience like?

Neil Gong: This is really interesting 'cause I had focused on the public mental health system as I think a lot of people do, who are interested in social problems and the policy side of it. And then I found out, well actually there's this whole parallel world. In Los Angeles , within one city we have, downtown Skid Row, which is kind of famous as one of America's homeless capitals.

But we also have West LA and Malibu, which is kind of famous for wealthy people, going to seek mental health and addiction treatment. And so there's also a story of, of deinstitutionalization. Where families are suddenly responsible for loved ones with disabilities.

And for most families, that's going to mean going to a public clinic, in fact, for a lot of middle class families, you find out rather quickly that private insurance is not very useful when it comes to serious mental illness. They're kind of, maybe fighting you on, coverage or reimbursements. They're not really set up with these kinds of social work interventions.

They can be very helpful for stabilization, in part because some of these things don't appear particularly medical. So medical insurers don't cover them. So a lot of middle class people also end up in this public system. But if you have, If you have a lot of money, you can end up, going to these other kinds of private facilities, which are gonna have, better client to staff ratio, often, people with more experience, many of whom have actually worked in, public sector settings, but then have transitioned to the private sector after, say they've gotten licensed.

So to just sort of think through this. I'll go with another story here. So I'll tell you the story of a man I met in his thirties, who I call Justin, and Justin, had a psychotic break while in college. It's a very common age for this to happen, but unlike some of the other people I met Justin, came from a family with money.

Over the last decade, he had been through a series of private programs, residential programs, hospitalizations. And he was going to an intensive outpatient program. So that's three days a week of intensive group therapy. And then he was also getting case management services from a kind of private version of that kind of treatment team model that I was talking about with the Department of Mental Health, or that's the kind of flagship program for California.

And so in this private one, things look very different, right? So, they're not focused on things like finding him housing. Trying to get him benefits. He's instead in this kind of intensive program, where there's a lot of activities, in a sense it's kind of the inversion, of some of the things I was talking about with, Housing First, where a person, is kind of given a lot of client choice, but they're kind of left alone.

Now, for Justin, on the other hand, he felt like he was overwhelmed. He was doing all of this group therapy. He was also going to AA meetings. The days are very scheduled. It's nice.

It's very southern California. It's things like, you might go to the beach or go to the gym. You might do yoga.

Lizzy Ghedi-Ehrlich: Equine therapy

Neil Gong: Yeah.

Lizzy Ghedi-Ehrlich: Ride horses.

Neil Gong: Exactly. You have these kinds of centers with these varieties of therapies and they can be quite beautiful. I mean, I went to some facilities that had a farm to table organic food. I mean, it was pretty nice, but people can feel totally overwhelmed and it is his case.

One of the things that was very interesting was, he had a dream that he was going to become a movie director. And the various therapists and workers sort of played along with this, but they told me on the side that they thought if they weren't monitoring him, as they were and surveilling his every move, he could end up a psychotic street person. And so he eventually asked for a bit more privileges to walk around the beach town by himself. And they told him, well, we can't take chances with people's lives. So I was there for, that night he actually ran away. He was found by the police on the beach. He said he was suicidal.

He went to the hospital and then he was released back to this kind of high end place. And, he said to me later, we were doing volunteer work together 'cause this is kind of one of the healthy activities that they would do there. He told me, Neil, you kind of can't get out of this place.

And it was very interesting 'cause legally speaking. He wasn't in a conservatorship. He wasn't mandated to be there by a court. But it's where his family had sent him and he didn't really see another option. So this is kind of a different dilemma. It's sort of the inversion of this kind of Housing First that sometimes looks like abandonment as I would see in these high-end private settings, very good care. But I could also see patients who felt like they were overwhelmed by the treatment demands or by their family's expectations of them. So a very different world.

Lizzy Ghedi-Ehrlich: Yeah. Yeah. A fancy asylum is still an asylum to the person who's in it. And then it's also so striking to me your description of Justin. With Jeremiah before him, these are two people who have a lot in common and really just one main critical difference, which is the amount of resources that they and their immediate family had to be able to address whatever their needs were.

And another difference that I think that you point out between the two systems that you've discussed here is kind of how they measure success. So now we're getting to the part where it's like, how do, what do we even say when? What does it mean when something's working? What is the correct policy prescription and the right amount of time and money and implementation that goes well?

What does that actually look like? How do the two systems that we've discussed so far measure success and how is it different?

Neil Gong: I saw this when I was first starting field work, I was looking at a county outcome data report. And the first thing they were saying about these programs, the intensive treatment programs, which is the most intensive treatment option for the public mental health system in California, is called these full service partnership teams.

The first line describing it in the outcome data report was, we've reduced days homeless this year compared to last year by this much, we've reduced days in jail by this much. And these are no doubt reasonable goals to orient to, right?

But what was really striking to me was that that was what the focus was. You could imagine focusing on different sorts of quality of life indicators, mental health indicators. But it kind of dovetails again, with what I was saying about, the goal being tolerant containment.

And I don't mean to suggest that all the people who are working at the county departmental department of mental health think this way in terms of, oh, they just want to contain their patients in the way that, like we were saying, perhaps that's what a lot of the public wants. But this is what they kind of orient to in their, in their measures.

Are we keeping people off the street? Are we keeping them out of jail? And so that's what success ends up looking like. And so if a person is in an apartment and therefore not homeless and not in jail, and they're not really doing that well, there is a way in which that can come to look like success in some of these safety net systems.

Now in the other world, you're not worried about homelessness, but jail sometimes actually. Right? But if you have good, if you have money, you can often hire good private attorneys to get someone diverted right off the bat instead of languishing.

You end up with very different goals and metrics. So actually one of the things that was most fascinating to me was when I first started hanging out with one of these, elite private case management teams. I asked about outcome data. They didn't really have it. And then I asked about who audits you. And they told me, well, we don't really get audited, but they said, well, we get audited by the families every two weeks. And what they meant is they kind of had to justify their work to the families who were paying lots of money.

And so this gets back to that thing of, who are the real clients?

In some cases, in some sense, the real clients that they're trying to appease in these elite private settings, are usually the families who are paying for things. So this means that the measures of success might be something like just getting somebody back to college after a psychotic break, helping them develop hobbies.

Oftentimes the measure of success is doing something that looks more like family therapy with helping to sort of fix some family dynamics. And I don't mean this in some cynical way, where it's like the families, they're the true clients and, and only their needs are being met. I mean, it's not quite like that.

But in some cases I did see situations where success was defined in terms of what the families wanted. And these typically are upper middle class and above, right, families. And so sometimes their ideas of success were very much wrapped up with ideas around social class and respectability.

Lizzy Ghedi-Ehrlich: Yeah. And clearly how class just plays such a role in what your framework for success looks like and how that then might affect the people whose jobs it is to actually try to help you achieve that success. That is so interesting. And that brings us, I think, actually nicely to this exact moment. We're here in the present now, but now we're in, sort of the hyper present, because California has just very narrowly approved Proposition One that was a ballot measure that would devote $6.4 billion, to build new housing and more treatment beds, as they're called for people. Ialways envision a literal bed, but really it just means spaces where people will be able to be treated.

For people with mental illness across the state. So, given your research, your expertise, all you've known and learned from being a researcher and also a person actually doing this workout on the street and with other people who have done it, tell us a little bit about what you think may happen based on the passage of this new funding source. Or what do you think are the things that we need to pay attention to in order to actually have it achieve the promise that it has?

Neil Gong: Sure thing. Yeah. I mean, I think so people were wary of Prop One, to some degree for good reason. So in part because there was a lack of clarity on how much of this big bond measure was gonna go towards involuntary treatments. But this meant that we got caught in a policy debate rut. Things end up always getting framed in, in this sort of civil liberties question of, is it gonna be forced treatment or is it voluntary? Are there times when it's appropriate to force someone? Should we never force anyone? I mean that's not an important question, but there are other questions, and there are questions around quality of care because, for instance, Prop One has passed, and then the question is gonna be, what does this treatment actually look like? I ended up writing an op-ed precisely about this, which was that, no one on either side of this debate was really getting into specifics about what kind of things we would be funding.

The idea of having additional beds is almost meaningless, because you're talking about slots and different kinds of programs, but these could range drastically in terms of approach and quality of care. Let's take what that means in terms of if we are adding more forced treatment beds or more say locked residential settings.

You can get stuck into this kind of question of should that ever exist? Should it not? But what we know is that there's huge variation in the kind of experiences people have in these. So, for instance we have pretty good evidence that with a lot of forced treatment, people report feeling traumatized. I mean, or actually in some cases people end up being diagnosed with PTSD after the fact, not related to their initial psychiatric crisis, but actually related–

Lizzy Ghedi-Ehrlich: But to the treatment.

Neil Gong: –treatment. Yeah. We see some evidence of elevated suicide rates after hospitalizations.

At the same time that that's true, it's also true that in some cases it might be what saves someone's life and if done well, where people are treated are with respect, that they might say, well, I didn't like that that happened, but actually, it did help me or got me on, on a trajectory towards being connected to more services.

And so, one thing we really have to focus on is the quality of the care. One aspect that I've been writing about with my colleague, Alex Bernard, who I know you also had on the show we've been writing about how do you actually make the limited amount of forced treatment that we might need? How, how do you make it sort of less bad, right? From a kind of harm reduction frame?

And so one of the things we focused on is really prioritizing patient voices having peer workers and as people with lived experience of mental illness, also lived experience of say forced hospitalization or conservatorship really have a primary role in redesigning some of these kinds of policies and even the physical spaces. And we can apply that kind of thinking to a lot of elements, right?

Even things like the court procedures that someone goes through and perhaps they're going to, or they're going up for a conservatorship or something along these lines. But there's tremendous room for improvement in, in what people call procedural justice. So aside from the question of the outcome, is the person actually listened to, are their needs taken into account?

And again, this kind of Housing First model. I've seen tremendous variation, and in fact, we see this tremendous variation in, in terms of the outcomes data, where some people seem to do really well and others don't. My best guess based on what I've seen is that there's a lot of programs that are not implementing it very well.

And so this comes down to things like making sure that you have the requisite staff and points of contact. So we're not just sticking people in apartments and leaving them there until they cause enough trouble that it's time to hospitalize them again.

Lizzy Ghedi-Ehrlich: Yeah. Yeah. Well, you've given us a lot to think about. I think going through the history of things and also just giving us some detail on the actual lived experiences of folks that you met and were able to talk to and showing how that kinda person-centered approach that I think we sometimes talk about in healthcare really has a

place in so many different policy realms, including certainly this one, whether it's housing or mental health response or both.

And now I love that you've given us so much information that I think people will be able to use to continue understanding what is about to happen as these new funds hit California, and as that construction starts and as those programs begin to, to start up. And we'll be along for the ride. Thank you so much for educating me and thanks for coming on the show.

Neil Gong: Oh, thanks so much for having me. It was a pleasure.

Lizzy Ghedi-Ehrlich: And thanks for listening. For more on Professor Gong's work, check out our show notes at scholars.org/nojargon. No Jargon is the podcast of the Scholars Strategy Network, a nationwide organization that connects journalists, policy makers, and civic leaders with America's top researchers to improve policy and strengthen democracy.

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