



**Office of Health Equity Advisory Committee Meeting
Public Comment Section
May 12-13, 2014**



Day 1: Monday, May 12, 2014

Motion: May 12 and 13, 2014 Agenda

Public Comment – Section 1.

(No public comment)

Motion: March 25 and 26, 2014

Public Comment – Section 2.

(No public comment)

Motion: Bylaws Consideration

Public Comment – Section 3.

NICKI KING:

I would only encourage that you adopt something that people can have -- that the public can have access to and easily follow so that they understand what your rules of procedure are. And that's all I am suggesting. So, if there is a decision you need to make between one code or another, I hope you will select the one that is most easily available to the public.

10:20 a.m. OHE and Strategic Planning Update

Public Comment – Section 4.

PETE LAFOLLETTE:

I do Mental Health Services Act stakeholder advocacy under the components of reducing disparities, economic disparities, including racial and ethnic. At the beginning of this year I participated in a Mental Health Services Oversight Commission meeting where the chair spoke about last year's audit and how if things did not change with the service act and comply with the service act then these funds would disappear. However, by the end of the self -- self -- health policy item on the budget provision they were breaking into a song of 99 bottles of beer on the wall. The office had been commenting on their \$99 million established budget annually.

What those numbers do not remedy is the conditions of poverty and hopelessness for consumers in the underserved communities with unmet needs that the Mental Health Services Act was designed to address. As long as consumers continue not to receive the opportunity, upward mobility, education, all of these things that the services act was designed for, including to increase the wellness and the health of individuals and communities through taking action for social change, strategies to restructure mental health systems to be more recovery-oriented - and I do emphasize recovery - and community-based to protect our civil and human rights to be more accepting, inclusive and diverse organizations and communities to maximize our individual and collective strengths, potential and creativity to make wellness and social justice a reality for all. All of these outcomes are addressed in the reform -- should be addressed but are not in the reform process.



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Humanity cannot be lost in these policy discussions, given the huge public expense for non-recovery and disability, substance use and abuse, poor nutrition, incarceration, hospitalization, institutionalization and a long list of atrocities that as a public and a society we simply must avoid in the future. Thanks.

RICARDO MONCRIEF:

I was trying to get my partner Alberta to come up here, but she refuses. But we do represent a special combination of social forces, I might say. We represent the micro- and the macro-elements within community; the macro-element being the big picture. What is the big picture? What does the big, interconnected holistic picture look like? And Alberta represents the multi-disciplinary coordination of these elements. So together we've got these bases covered.

And we kind of frame it under a Stanford review for innovative social change project they call Collective Impact. And I have to say that most people will look at Collective Impact as just rhetoric, but it's much, much more. It's much more. It's a much more intensive application of organizing, making collaborations, enforcing accountability issues, getting people to stay at the table. And that is -- you know. They made a very special point of saying, you have to get your community organizers, your idea people, your conceptualizers, you have to get them at the table and keep them at the table.

But I want to talk about -- a little bit about what General Jeff was -- we had a conversation out in the hall. This conversation is about how do we get resources. This money that seems to float around at the grass tops sometimes, the grass mitt, how do we get those resources down to grassroots people, you know? Because it seems like, you know, I've been in the business for like 25 years of doing community work. And it always seems like resources capacity gets absorbed in these middle lands. They get lost and good programs get lost, good matrix get lost. The community does not own its own data, and it's time we took charge of that, you know. We have to be point specific on how we use data and how we apply them to programs.

Also real quick. I'd just like to know if during our strategic planning are we going to cover areas like political networking, legal support systems? And I say legal support systems because we have a shopping center that is not responsive to the community. We have a public housing sector, the only one in Marin County, that we would like to change over to a land trust and using that to build cheaper housing, affordable. Stop gentrification and keep people in a social safety net that they can visibly feel and touch on a day-to-day basis. We also were thinking of making a recommendation that came out of Maryland, Pennsylvania, New Jersey, where they use a structure called Health Enterprise Zones. And these are --

Okay, I'll wrap it up real quick. But Health Enterprise Zones are zones used for the -- to establish the relationship of private/public partnerships, you know, to further the health interests of targeted communities. And with that I would like to say that anybody that wants to talk about Collective Impact for lunch or anything like that please grab me and we'll break some bread. Thank you.

NICKI KING:



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I am really encouraged by this plan. I think it is a wonderful step to advancing a much more holistic agenda to achieving health equity. Having said that, I think there are two things that it critically needs. When you think about health disparities and health equity in the state, the California Reducing Disparities Plan has focused most of its resources on the quote/unquote "Big Five" and they are called out on page six of the CRDP.

I would like to advance and want you to include in your strategic plan the notion that equity cuts a lot of different ways. You need to, I think, include specific mention of the disability community, of immigrant communities, of religious minority communities, of smaller ethnic communities, because they are also suffering from problems associated with lack of access to health care.

Finally, I think you really need to - and this is partially because I guess I'm an evaluator - but, you need to consider utilizing evaluation as a means to actually help you achieve the things in Strategic Priority F. Most people think about evaluation as a report card as something that comes in at the end to see how you did. I want you to consider using evaluation as a formative process to help you actually decide how you are meeting the things that are in the individual goals. I think it's a much more boots on the ground method of knowing where you need to correct before you spend all the money and I'd like for you to think about that. Thank you.

11:20 a.m. U.S. Department of Health and Human Services (HHS)

Public Comment – Section 5.

(No public comment)

1:00 p.m. Presentation – OHE Climate Action Team

Public Comment – Section 6.

PETE LAFOLLETTE:

This very timely discussion reminds me of a story of the frog that is slowly but surely being scalded to death and it dies when it's too late. I'd like to thank the good doctor and wonder if you would discuss or touch upon incentive programs. Recycling, make recycling less marginalized and more mainstream so it's not just people with carts behind their bicycles. Have lifestyle choices, incentives for lifestyle choices. Think globally, act locally. A regional and centralized lifestyle versus decentralized.

The solution. I wonder if we really need to start thinking in the broadest terms. Maybe in forming something similar to the Army Corps of Engineers or what we saw after the Depression in the Dust Bowl where broad segments of the population started to address these problems. Because I really believe that nothing less than altruistic response is really going to make much of difference. And great things can get done with altruism. The public recognition that we are all in this together and we must find an incentive and solution to this really pressing problem. Thanks.

RICARDO MONCRIEF:



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I'm going to take a chance here. This is a kind of like a political question. As you know, as we all know, there are those of a political persuasion who would like to keep the flow of pollution flowing unabated and whatnot. And they are using, you rationale, scientific rationale such as the receding orbits of the moon, the solar flares, vulcanization, periodic climate changes that occur 7 years, 11 years and one occurs every 7,000 years. Hence the Sahara used to be a lush land. So they are using this.

And what I see is that we are in a war against corporate America, nature, and the conservative political elements. Nature is going to take its course and it might create climate changes anyway. But what I need to know is -- some of these things are controllable, some are uncontrollable. What can we do politically? What can the average activist, you know, arm themselves or to push back on this systematized apathy that is coming at us from those political persuasions. Are we looking at political strategies here? Yes, sir.

RICARDO MONCRIEF:

Well I'm more interested in the gravity placed around some of this rhetoric, you know. It's inaccurate and it's used for different causes. It's used for political causes rather than for the betterment of our environment. We've got to find strategic ways to intercede and counteract that push as much as we possibly can. So any clues that we have, we are going to put into our, you know, our strategic matrix and go about -- as best as we can go about using it, you know, to do that type of push-back. Thank you.

1:40 p.m. Presentation – California Reducing Disparities Project (CRDP) Strategic Plan to Reduce Mental Health Disparities

Public Comment – Section 7.

PETE LAFOLLETTE:

The California State Auditor, the Mental Health Illness Policy Organization, and others, including Rose King -- she is the original MHSA author, have documented the Mental Health Services Act funding are not reaching the most seriously ill, they are reaching only 5 percent. A principal party set out to generate success story statistics by serving only 5 percent of the public mental illness clients and only new clients and new programs. The calculated purpose of excluding all underserved clients in the existing system was to generate deceptive statistics that are irrelevant and accrue insult to consumers and their family and friends suffering from the tragedy of untreated serious mental illness and the despair leading to increased suicide and incarceration.

On a personal note, I find it such a tangled web and so much collusion I still don't quite understand how they get away with it and how it's done, as state employees, lobbyists, oversight commissioners agree that they would get better performance data by serving new clients in new programs.

The strategy also produces a bonanza of new grants for Rusty Selix's clients such as the Mental Health Association and contract providers and the California Institute of Mental Health, the premier grant consumer and producer of conferences, training, reports of unknown utility, and employer of legions of consultants and



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the proper special interest connections. The major grants to conduct programs from which there are minimal audience of questionable benefits from these grants. Entrepreneurs of every conceivable service for stakeholders and unwanted stakeholders for -- and resulting in unwanted and unknown products get aboard this same gravy train. And once again, it's of such of enormous proportion it's actually called the \$10 billion bait and switch. And I still don't quite understand how they are getting away with it but I know from personal experience that it's very real and it's very much happening.

STACIE HIRAMOTO:

I am the Director of REMHDCO, the Racial and Ethnic Mental Health Disparities Coalition. I believe this is the first time I am addressing this honorable body and I want to congratulate you for the work you've done already; it's very impressive. I staff with my other coworkers the CMMC, the California MHS/Multicultural Coalition, so I know what a tremendous job it is to be on a coalition and also to staff it. Rocco Cheng took away my thunder. He, I think, gave kudos where I wanted to -- to everyone such as Ruben and CPEHN for putting together and facilitating this. And also the Office of Health Equity, formerly the staff from OMS, the Office of Multicultural Services. They are really to be commended for being a model of how to engage the community and I just wish that more government offices would do as they have done with this project. It's just been tremendous working with them.

But I wanted to, I wanted to invite all of you. There is an open invitation to attend the CMMC meetings. They are still taking place every three months. The next one is Thursday, June 19th. And in conjunction with that meeting, we will probably be having a class training open to the public. So, if you call me or go on our website, we will have more information on that. But again, particularly everyone at this body is welcome.

And the other thing is I wanted to mention that if you would like to support the CRDP please come to the OAC meeting on Thursday, May 22nd. There will be an item and we could use your support at that meeting. And again, don't forget that the CMMC not only encompasses the five populations in those reports, but other populations such as Middle Eastern, other religious groups and the deaf and hard of hearing and others. So, thank you.

STEVE LEONI:

I'm a mental health client and I have been an advocate for mental health services for the last 25 years. I am fairly well-known in the mental health community though not necessarily here, for those of you who are not part of that community.

I wanted to address something that's a little awkward, perhaps, but those of you who know me know that I am a strong proponent of cultural competence and reduction of disparities in racial/ethnic groups, et cetera. But, I want to point out that clients, mental health clients are a community of their own. They are -- thank you, Delphine. We have our own set of discrimination against us. And I'd like to make the point that in terms of the broader health equity, which is the purview of this group today, that while this California Reducing Disparities Project is long overdue - it's wonderful work they are doing, actually working on practical



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means of reducing disparity - your job would be only half done if you don't do that because mental health consumers as a whole are dying 25 years before their time.

And basically I'll address this a little bit later but I don't want to tread on it too much on this, but basically just like the deaf community, the mental health community is made up of many different ethnicities and races. There may be some variations, but the commonality of a community, actually it's been called client culture, is that that you band together in the face of discrimination. And we have had that experience. And there are multiple barriers to our health. There are socioeconomic determinants. We are locked in low-income, many of us. The list goes on. And if you only have equality with the so-called mainstream mental health community, your job is only half done in terms of health equity. You need to go further. And I'm hoping that this strategic plan will allow for that broader viewpoint. Thank you.

RICARDO MONCRIEF:

I want to share with you these three quick tools that we are using. One is called the functioning scale, and Alberta will tell you a little bit more about that if you want. And that tracks families in crisis through a continuum to a state of self-sustaining wellness and to include, you know, things like prevention and protective factors, and we're working on that. The second piece is what we call the DCW, which is a designed communications work team prior to the collective impact piece.

And what I want to see is three hours a day for four days a week for six weeks of a team of people getting together to do all of the background work that needs to be done, collecting the data. There are many things - about 60 pieces that have to go into a master plan. This master plan will generate progress indicators which we can then forward up to the state and we can see what we are doing.

The other piece, the last piece is the -- this is a matrix that we've created. And in this matrix we talk about what are the health determinants. This column tells if it satisfies the state requirement and where it's listed in the state records - the organizations that are doing the actual work to address those particular health determinants - and do we have a narrative on it. Like I have here, "not yet" and some remarks. The object is to create a narrative so we can develop the progress indicators. And that way hopefully we can eliminate, visibly eliminate, you know, health disparities and build equity at the same time. Thank you.

KATE KARPILOW:

I want to start by saying that I think the CRDP is one of the most important efforts that has ever been undertaken in the mental health field to address communities that are long overlooked and are the future of California. I want to underscore that point. Saying that, as you know, my organization, my partners, we have a serious concern that those communities are made up of many sub-communities including men and women and boys and girls, and there are distinct mental health profiles for those groups. And as a consequence, not only do you have different conditions that are gender-linked, but you also have promising and proven practices which are gender-linked.



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If we begin to put public dollars into programs that we are not linking to gender in a systematic and strategic way, then we are potentially not researching and understanding not only the causes of mental health conditions, but the practices that will improve them. So you've heard this argument from me before. But I want to end with a question directed to Ruben, again underscoring the importance of this, which is: I didn't hear men and women, I didn't hear gender in anything else other than LGBTQ. And I would like to ask, is this concern not based in the same reality that I share? And if it is something that we do share commonly, and I think we do, how can we correct this train which is 20 engines being pulled, has so much force behind it, to actually in the strategic plan for the themes, the goals, and the strategies, begin to explore the conditions and the research and the practices that we need to understand from a gender perspective? So I end with that question, thank you very much.

RAJA MITRY:

Ruben, I notice that one of the beginning slides on CPEHN's health disparities page where it asks in the box about demographic information, what's the person's race. A person like me could mark White, but that wouldn't identify me being of Middle Eastern Arab background. I hope CPEHN and others will consider having a place to gather distinct heritages, Arab as well as others who similarly fall in a racial category as White. Otherwise health disparities will continue within our unrecognized ethnic communities without this appropriate data.

I have a question. Would you be able to please clarify what constitutes a community of color? Might one make a distinction between people of Arab descent along the Eastern Mediterranean such as Lebanese, Palestinian, Syrian, and those of darker color from Arabic-speaking countries on the African continent, for example Sudan, when it comes to be considered a community of color? Who besides the obvious race and what criteria are there to designate a community as being one of color?

**4:30 p.m. Debrief | Public Comment Period/Public Comment for Items Not on the Agenda
Public Comment – Section 8.**

STEVE LEONI:

I kind of wanted to continue what I was saying earlier, kind of a little maybe mini-presentation about the issue of the inequities around clients. And a couple of things I want to talk about. One is that there's a lot of stigma and discrimination and that extends to the health care field. And when you go in to see a doctor you don't always get listened to. You say "I'm a mental health client" and they don't always really take what you're saying seriously. I know, I was in a position that I went someplace and they checked out some things that they had read that mental health clients typically have, and when I started asking them about the complaint I originally came in for, they told they didn't have time. And that's very, very poor circumstances.

Also some of the training going on. I have a friend of mine who is an advocate in Los Angeles that guest-lectured at a class of health care administrators in college and they were still studying -- their textbook indicated that schizophrenia had a uniform downward course and cited a 19th century psychiatrist by the



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name of Kraepelin. And that is very outdated information. The entirety of mental health in California is predicated on recovery now and certainly in public mental health. I was talking to a nurse in the practice I use and they said, well we don't accommodate the concerns of mental health clients too much because that might be enabling them. And that word "enabling" comes from the old psychodynamic era, which has been largely abandoned for the last two decades by most of the field. So outdated training, outdated ideas, you know, serve as barriers to people. As I repeat, the mental health community, the client community is dying 25 years before its time, on the average.

So some of that has to do also with that we live in poverty. If you are not on benefits even in employment you tend to have lower-paying jobs. There's a lot of discrimination out there about that. And that puts you -- to talk about the social determinants of health, that puts you right at the bottom of that scale. And you are also -- because of discrimination you are also very, very isolated. And I am being told that it's time to go so I'll leave it at that and hope I can contribute more later.

**1:00 p.m. Strategic Plan Report Out of Small Groups
Public Comment – Section 9.**

NICKI KING:

I actually want to encourage you to -- if you want to use the matrix I think it's a good thing. Particularly for operationalizing it and for seeing where you've got overlaps and where you've got potential conflicts. I think it's a -- I think it's a great tool. But I want to encourage you for your formal strategic plan to keep a narrative focus because most of the people who look for strategic plan kinds of things are going to be looking for narrative and the explanation that goes with narrative. So this may be a great way to make it real, make it happen, move forward and tell how you're going to move forward, but I don't want you to lose the strong narrative aspects that you've got down here now.

STEVE LEONI:

I was lucky enough to be in the group where some of this was thought out. It's a great idea. And I think by making the narrative a little more comprehensible and condensed like that you will actually -- it will be easier for people to read this document, which is what you want. You want people to be not afraid of it or not get lost after the second page because there's all this repetition and where was I. I hate that. I mean, I noticed that as I was looking at it it was like, wait a minute, I'm going over and over and back and forth and around. I think this makes it more succinct and kind of lays out a roadmap, if you were, as for the narrative. It's great.

DOMENICA GIOVANNINI:

And I want to agree. I know that the communication piece came up quite a bit in a lot of different areas and for me that is an over-arching stand along objective that needs to be addressed throughout the entire strategic planning process is how the information is going to be communicated and packaged to communities



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and how that is all going to happen. So I kind of like this setup a little bit better because again I think communication is like its own over-arching, necessary strategic direction.

LAUREL BENHAMIDA:

I just have a question. A survey was issued after the webinar that you have; it's due today. And that either -- as you said, the whole thing or comments. But how does this change here impact the validity of that survey and the process of getting engagement from people who aren't here today? I mean, this is a huge, diverse state.

LAUREL BENHAMIDA:

My mind moves slow as I become older and older and so I need a long time to absorb, although I love this kind of layout. And there are people here whose minds work faster and they're saying good. I think maybe the way the survey went out it was difficult for organizations with little capacity to slog their way through and that's why it was good that you said, you don't have to do the whole thing. Although maybe that message could have been stronger from the beginning. But this might be something that later could be also, once you have it tweaked and refined, that might be helpful for people in terms of understanding what the process -- what turn the process is taking.

LAUREL BENHAMIDA:

Well you might get more information from people who just couldn't make your timelines with the complexity and the, you know, sort of academese or mental healthese of the -- so.

**4:30 p.m. Debrief | Public Comment Period/Public Comment for Items Not on the Agenda
Public Comment – Section 10.**

LILYANE GLAMBEN:

I had the delight of missing your morning session because I was at the Mental Health Matters event. I just want to encourage if at all possible, ways in which the committee can somehow integrate these kinds of incredible opportunities. It was very consumer driven and it was inspiring, invigorating. And those kinds of opportunities for stakeholder engagement, you know, are just worth their weight in gold.

LAUREL BENHAMIDA:

And I spoke with Debbie about this earlier but it's a chance to say it again. This is a wonderful venue but I would like to see going forward after the summer, meetings in community-based locations.

LAUREL BENHAMIDA:



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To me it means the Croation Cultural Center in Sacramento; it means Salaam, which has, you know, high-tech lecture halls, which is for the Muslim community. It might mean a Sikh gurdwara. It means getting people out of these places and into places where people are that are experiencing disparities.