

**Office of Health Equity Advisory Committee Meeting  
Public Comment Section  
February 03, 2015**

**Motion: September 30, 2014, Meeting Minutes**

***Public Comment – Section 1.***

*(No public comment)*

**Motion: Debrief the September 2014 Meeting: Lessons Learned and  
Recommendations for Future Tele-Conference**

***Public Comment – Section 2.***

**PETE LAFOLLETTE**

Thank you. Pete Lafollette of Ventura County. Nothing that you haven't heard already. Humanity cannot be lost in the conversation and recovery and other general topics. And it's a lot more useful when you see that people are here in a meeting and being engaged, so that's always preferable to something that is televised.

**Motion: Proposed Bylaws Amendments**

***Public Comment – Section 3.***

*(No public comment)*

**10:00 a.m. CDPH and OHE Updates**

***Public Comment – Section 4.***

**PETE LAFOLLETTE**

Thank you. Mr. Kim, we're glad to welcome you, and I'm wondering if you had a chance to look at the Little Hoover Report. It did come out, for everyone's information, on January 26<sup>th</sup>, and the title is "Promises Still to Keep: a Decade of the Mental Health Services Act."

Mr. Kim, I wanted to ask you, to what degree do you think these recommendations and the overview will be incorporated into providing direct services, into bringing the Act up to speed in the shortfalls in some of those areas, et cetera?

MR. KIM: Thank you, Pete. I haven't read the entire report. I know about the report, and I know one of the challenges that was confronted in the report was -- I think the report identified, hey, we're not necessarily using the funds in the best possible way. And, at the same time, it said get more money out there. And so, it seems like -- not a conflict, but I think we have to figure out what's the right blend in making sure that the money goes out quickly but is used in the most appropriate ways. So, I think we're going to take a look at the Little Hoover Report and see which aspects do we really want and make sure that we can enforce and comply with.

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But, it's very challenging. Whenever you're starting up a new governmental program -- this is really a new governmental program where you've got stakeholders that want to do a number of things with it. It becomes very hard to figure out how do you prioritize? For what types of services? What types of clients? And for what types of areas?

**STACIE HIRAMOTO**

Thank you. Stacie Hiramoto, the Director of REMHDCO, the Racial and Ethnic Mental Health Disparities Coalition. And I just wanted to congratulate and commend the Office of Health Equity in regards to the continued rollout of the CRDP. I've been involved with the CRDP probably from inception, and I really want to compliment you and your staff. The way the RFPs, the way the public comment, the way the communication is, I seriously feel that -- I know you have way too much on your plate, but I wish that you could do some kind of -- what's that called -- a toolkit as an example of how government entities can work collaboratively with communities and with stakeholders.

And I don't speak just for underserved communities, but also from other stakeholders that, when they would attend the public comment periods or sessions, they were really amazed that you were taking public comment on the RFPs so early that everyone had a lot of notice, that you did it around the state. And also just the attitude of your staff and the knowledge they have of what it takes to work with the community -- that it's not always clean and neat and polite and pretty and it -- you know, if you were just going to pick the people -- listen to the people that agree with everything you say, then it's not really, you know, robust public comment.

So, again, I know it's taken a long, long time, but I really want to commend your department.

**NICKI KING**

Hi. I'm Nicki King and I'm with the CRDP Program -- I'm the African American Project lead. My remarks are directed to Dr. Sisson's description of the status phase to the CRDP. And, first, I want to absolutely endorse everything Stacie said. I think it's amazing and I've been around looking at government and how they do things for many, many years. The Little Hoover Commission Report reflects the disappointment with the accomplishments of the MHSAs in general, but I think, after really looking at it, it really reflects two things. First, that current evaluations of the MHSAs programs have not reported effectiveness and second, and this is maybe more critical, that expectations of the MHSAs were perhaps not realistic and not well enough defined to begin with. If you say you're going to deliver everything and then you don't, you've fallen short.

We all know how much scrutiny the process and outcomes of Phase 2 of the CRDP will receive and we all want it to be successful and well-documented. This

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situation brings us to a potentially dangerous position as you prepare to roll out Phase 2 of the CRDP. Ten million dollars sounds like an awful lot of money, and it is, but the individual projects funded by the CRDP will be small, pilot-type projects and it is unlikely that those individual projects will yield the kind of data that will prove efficacy in a way that seems conclusive to groups like the Little Hoover Commission and, therefore, to the public at large. The fact that local grassroots or community-based nonprofits don't usually have high capacity for evaluation or maybe even enough knowledge of the evaluation process and what it yields to make good selection decisions on their individual evaluators makes the situation even more critical.

I urge OHE to provide both ample technical assistance to bring the Phase 2 contractors up to speed on the importance of sound evaluations and a list of potential resources to help them identify qualified evaluators. I know the hook's out, but I prepared my remarks and I want to get finished. The American Evaluation Association maintains such resource lists, and the association's minority issues in evaluation, health, and LGBTQ topical interest groups also have specific lists of evaluators from diverse groups with the appropriate experience and cultural sensitivity to do these kinds of evaluations. Thank you for the opportunity to address this point.

**PETE LAFOLLETTE**

The remarks this morning and updates contained a lot of goodwill, and goodwill instills good outcomes. However, on what we've been talking about with the services act delivery, at a recent Mental Health Services Oversight and Accountability Commission meeting, the Commission commented to Jahmal on by what justification the CRDP funds would be reviewed.

And I thought, considering the source, that was a very revealing comment and contained a Freudian slip. On the report from the Little Hoover that we've talked about and overview of the editorial comment, the astonishing thing about the report is its focus on what a poor job the Mental Health Services Oversight and Accountability Commission has done, then concludes they should be given more authority. This makes absolutely no sense. Really, it is mindboggling that thirteen billion dollars has been effectively laundered through the mental health spin cycle. Now, to what degree that is an exaggeration, that can be up to you. We all know a lot of good has been done from the services act; however, it has gone to about ten percent of the target population.

So, there are ongoing problems with data collections, with baselines being met - this, at a broad state level. No central governing authorities at fifty-eight county, fifty-eight different spending plans. And when the prevention and early intervention contracts are not followed as they're designed, the retroactive results are increased institutionalization, hospitalization, incarceration. These are the things that the tax-paying public is supposed to avoid through the correct implementation of the services act. So, as the title says, promises still to keep with the services act. Thanks a lot.

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**1:00 p.m. DHCS Update**  
***Public Comment – Section 5.***

**DOMENICA GIOVANNINI**

Hello, all. My name is Domenica, and I'm notably known in this group for working with Marin City, but I actually work with different organizations and populations in Northern California. So, I appreciate the presentation from DHCS, especially in this venue, as well as hearing about the prevention focus and the upcoming collaborations, because I feel that's absolutely necessary to actually impact these type of issues.

My one comment is I just cannot stress the importance enough of marketing and dissemination of this information to consumers. I appreciate the efforts of Branigan (phonetic) Outreach as an agency, but I encourage this group, as well as DHCS and the other departments, to take a step further and empower and enable local communities to tell their story and to tell yours, because the communities can be leveraged for this information at all. Outreach is changing because of changes in demographics to the consumer population, ease of access to information, and technological advances. So, outreach, to me, as a proud millennial on the record, is not simply convening donors, webinars for granters, or even outreach to the press - that, to me, is simply reporting donor cultivation.

So, in closing, telling your story spans really beyond marketing contracts and grant periods. So, if you really want to make change within the department of DHCS, as well as the other ones represented here, people need to know how to continue the conversation or even start this conversation in these communities and with their population. So, I just hope this is embedded in all the processes.

**RAJA MITRY:**

It's Raja Mity, a member of the California MSHA Multicultural Coalition. You know, the strategy of effective delivery of care likely recognizes that quality care includes culturally-appropriate or congruent services with a person's or family's cultural background. And it's sensitive to respect for generational values and how age is perceived by old world cultures in terms of their wisdom. Also sensitivity to their cultural history, including impacts of any historical and complex trauma.

Native Americans say culture is medicine. Well, that applies as well to other communities whose cultures span many centuries. It's one of the ways that could engage people in their own health care, as well. And please consider any possibility of ensuring language about cultural appropriateness in any strategy approach meant to attain quality outcomes. Thank you very much.

**1:35 p.m. HiAP Task Force Update**  
***Public Comment – Section 6.***

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**STEVE LEONI**

My name is Steve Leoni. I'm a mental health consumer and advocate of many years. And I kind of wanted to say something. I don't see it going on here, and I'm glad it's not but, as a cautionary piece, I wanted to throw it out there because, as I'm sure you're all very well aware, the mental health clients have been made scapegoats for a lot of violence recently. And, you know, any time something happens and there is any kind of mental health convicted -- involved, they say, well, a person with a history of mental health commits whatever, you know. And it goes over and is repeated over and over and again.

I simply wanted to make the point that probably many of you do know but, as a cautionary piece here, you know, a person -- first of all, clearly the stats show that people with mental illness are no more likely to be violent than anyone else. Do some people with mental illness do commit violence, sometimes extraordinary violence? Yes. So do some members of every group.

What I want to point out here, though, beyond that, is that one of the issues that happens with mental health stigma is that, once you see this is a person with a diagnosis, you sometimes fail to see anything else about them. That's just wipes out -- that becomes their identity. Think about have just one identity. And a lot of things we're saying, starting with Cynthia Gómez, talking about the need to look at reframing things. It's not a personal issue - that it's a social issue. And the upstream issues that lead to it - the antecedents. And a person with mental illness is exposed to all these antecedents, as well.

If a person's standing there and they're hearing voices and they think you, walking down the street - they've never met - they think you are the source of that voice and they're angry, so they walk up and slap you. All right. Well, that's violence. And it happened because of the mental illness. But the decision to engage in violence to solve that is not necessarily mental illness. It's part of a broader context. And so, I just hope that we have that kind of sophistication as we go. And if any of this comes up -- and somewhere out there, it's going to come up, which is why I'm saying I'm very grateful it hasn't come up here. That's just my plea. Thank you.

**DALILA BUTLER**

Hello, you all. Thank you for taking my comment. This is Dalila Butler. I'm with PolicyLink. And I just wanted to make a quick comment, first of all, just to commend the Health in All Policies Task Force for taking this one, creating -- you know, thriving, safe communities is especially important and we really appreciate that you are spending the time to do this.

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One thought about who to talk to in order to develop kind of a plan that's responsive is to think about developing these actions based on input directly from the community themselves. I know that, in our work with the Alliance for Boys and Men of Color, you know, a lot of the things that have come up as solutions today from the Parks After Dark work that came up after programs like Summer Night Lights, JOBS, efforts to look at healing circles, and other things. Those all come up in conversations through the Alliance for Boys and Men of Color and many other solutions. So, I think really having an opportunity to kind of gather -- for the state to play a role in convening folks and gathering input from the community can really help to identify what actions are needed.

And, finally, I just wanted to say that I think that the process that was modeled by the California Reducing Disparities Project and some of the work that they've done to get community input is a great process to look to as a model. Thanks again.

**PETE LAFOLLETTE**

Thank you. On the subject of school shootings and violence, there are so many that the public becomes desensitized and, researching the subject, ninety percent of shooters were prescribed SSRI medication. I recommend this article by Rob Pell, "Antidepressants and School Shootings: Doctors Write Prescriptions for Murders."

And just related to that, it's a lot more subtle, but it's every bit as epidemic, is "The Untold Story of Psychotropic Drugging." It's a documentary film put on by the Commission for Community Concerns. They can't measure -- the findings are it cannot be measured. The chemical in the brain -- how the drugs that are sold don't work. Even the president of the American Psychiatric Association states they don't know where chemical imbalances come from. And it's a DVD that puts -- sheds a lot of light on these interrelated subjects. Thank you for this very important topic.

**3:00 p.m. OHE-AC Subcommittees**

***Public Comment – Section 7.***

*(No public comment)*

**4:00 p.m. Elect OHE Committee Chair and Vice Chair**

***Public Comment – Section 8.***

*(No public comment)*

**4:30 p.m. Planning for the May Advisory Committee Meeting**

***Public Comment – Section 9.***

*(No public comment)*

**4:50 p.m. Debrief | Public Comment Period | Public Comment for Items Not on the Agenda**

***Public Comment – Section 10.***

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**STEVE LEONI**

Thank you. Steve Leoni, mental health consumer and advocate of many years. I just -- actually this comment arises out of things I that heard earlier in the meeting today. Two things occurred to me that might be kind of interesting. You were talking about how you were going to be changing the membership of this Advisory Committee. People will be leaving and you have a deliberate of policy of trying to bring in new blood because there's just no way you can represent everyone at this table. And it struck me that a problem that we'd had over in the mental health side, because I'm a member of the Planning Council and other groups, as well, many people - and particularly thinking now of communities, not necessarily professionals, but some of the grassroots you might want to hear from - they don't have a whole lot of experience, they don't know what these issues are. It's kind of a stretch for them to come here.

And you can't just take someone and say, oh, you're a member of this group or that group and drop them in a slot here and expect them to do well. It just doesn't happen. That setup does no one any good. And what struck me was that -- Jahmal earlier was talking about working with counties with their departments -- departments of public health there. And that one of the things you could be doing would be having sort of this kind of Committee dealing with health equity issues out in the counties - locally - where people could participate, perhaps maybe have less sophistication than are at this table.

I mean, because the only way, if you're going to have community X, I mean, not everybody can really rise to the level of policy discussion that you might have here. And the only way you're going to find those people is by recruiting enough people so that the talent rises to the top from whatever group it is. And you could have venues in the counties for doing that, and then it becomes evident who really has some really good ideas and who can represent the communities well and, eventually, they can wind up here. So, I'm just proposing this as a mechanism for your capacity building or infrastructure building that might help people this table and other efforts connected with it.

And she says five seconds. I say really quickly then, the other thing was, if I may continue just a sec, it struck me that there are a lot of disparities involved in the implementation of, like, managed care. As a senior and as a disabled person, you know, when you have substandard housing, you're poor - there are all kinds of things that cause problems the way that things are set up now, and it struck me that, whether it's on this Committee or collaboration-wise, you should be really looking at the Department of Insurance and the Department of Managed Health Care as partners for some of this effort, because you have a very, very broad effort and a lot of the health care is delivered by private sectors. There you are. Thank you.

**Proposed Bylaws Amendments**  
***Public Comment – Section 11.***

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**STEVE LEONI**

Steve Leoni. I've been a member of a number of Committees and organizations over the years and this is not unfamiliar kind of conversation to me. And I think actually Rocco may have covered it just now, a bit of what I was going to say. But let me repeat it. You know, you have these three-year terms for being on this Advisory Committee and I just saw an example today of some people rotated off - and not by their choice. It was -- I don't know what the process was, but they said, well, you're not coming back. And to do a two-year term in a situation where you have a three-year existence on the Committee and you may leave, I mean, you'd have to have a rule that, if you get elected in your third year, that somehow you're immune from --

AC CO-CHAIR GÁLVEZ: Yes. That's what staff said.

MR. LEONI: Okay. Well, because that's the only way it would make sense. And it's even worse if you talk about a vice chair for two years and then the vice chair by tradition moves up. That's four years. So, you'd better have more than a three-year term. I guess it sort of offends me a little bit and it seems kind of messy. And I know that at the Planning Council we have one-year terms and I agree with what you said that, you know, it's a lot of work to build it up, you know, and then you're gone.

AC CO-CHAIR GÁLVEZ: I thought the Planning Council met more frequently than four times a year.

MR. LEONI: No.

AC CO-CHAIR GÁLVEZ: It's four times a year?

MR. LEONI: Yes. We now have teleconference -- or actually, they're in-person meetings with phone-in capacity for our committee structures, but we only meet four times a year. Now, we meet two and a half days when we meet. It's a big long thing with Committees all built in. You know, but we meet only four times a year and it's been that way as far back as -- and I've been working with them since 1996. You know, but even there at the Planning Council, I mean, we have three-year terms and, you know, so our leadership is one year at a time because -- well, you never know if you're going to be -- I mean, there's no hard and fast rule that you can't stay on there for decades, but you do have to be reappointed every three years.

So, I'm just saying try not to muddy the waters too much. I mean, think about what's actually going on here before you do that and whether it's fair or not -- and you just, like, get yourself elected and you're guaranteed to continue on the Committee. So, anyway, it's just some thoughts.