SHIP SUBCOMMITTEE MEETING

☐ **Bias** ☐ **Trauma** ☐ **Economic Drivers** ☐ **Access to Care** ☒ **Behavioral Health**

June 17, 2020 | 2:00 p.m. – 4:00 p.m. | Call: (669) 900-6833, Access: 393-128-009

Members Present: Kate O'Donnell (Co-chair), Gary McConahay, Jeremy Wells, Angela Leet, Curtis Landers, Tori Algee, Gayle Woods, Andrew White, Don Erickson, Cherryl Ramirez

Members Absent: Athena Goldberg, Carol Dickey, Holden Leung, Jackie Fabrick, Janice Garceau, Karun Virtue, Katrina Hedberg, Rebekah Schiefer, Reginald Richardson, Tatiana Dierwechter, Kera Hood, Isabella Hawkins (Co-chair)

OHA Staff: Christy Hudson, Krasimir Karamfilov, Rebecca Knight-Alvarez

Members of the Public: Kari Goldstein (Albertina Kerr), Romy Carver (Columbia Pacific CCO), Tori Scholl (Comagine Health), Kristen Johnson (Oasis Center of the Rogue Valley), Katie Alverson (Advanced Health), Jack Hochak (Dynamic Changes), Debby Jones (Addictions and Mental Health Planning and Advisory Council), Ann Kasper

Welcome & Agenda Overview

Kate O'Donnell welcomed the subcommittee members to the meeting. She asked the members to introduce themselves. The attending subcommittee members introduced themselves.

Christy Hudson informed the subcommittee that the work was nearing the end. The subcommittee will review the community feedback received on the draft strategies and finalize the strategies. Next month, the PartnerSHIP will review and approve the plan. Also in July, the subcommittee will have its last meeting to flush out the activities, revisit the short-term measures, and discuss how to move into implementation.

Healthier Together Oregon & Implementation Framework

Christy Hudson remarked that as the plan moved to implementation, the work would be shifting to a new framework and a new name for the SHIP: Healthier Together Oregon. There is an accompanying website in draft form that is managed by OHA employee Elizabeth Gharst. As the plan moves into implementation, the conceptualization of the plan will be moving away from the five priority areas. The work will involve taking the identified strategies and threading them through the new eight categories: health communities, healthy families, healthy students, housing and food, behavioral health, equity and justice, workplace development, technology and innovation. The reason behind moving to eight categories is that it will address the intersectionality between the priority areas. It also helps to remove redundancy in the

strategies. The strategies were consolidated from around 70 to 58, which made them more actionable and achievable. The eight categories also speak to the work in a way that meets a broader audience.

Gary McConahay stated that as there were multiple pathways to suicide, there were multiple pathways to reducing suicide. It's not uncommon to touch upon different areas that might not sound like behavioral health. The term *behavioral health* is ambiguous. When people are looking at the term from a cultural perspective, mental illness and mental health have lots of different views. No one structure is going to meet everybody's cognitive structure for the work. It's fine, as long as people can find what they are looking for when looking at the buttons on the website.

Christy Hudson added that a stand-alone PDF document and a more detailed implementation plan would be provided on the website to explain the work and the reasoning behind the process.

Review Community Feedback

Christy Hudson explained that over the past month, OHA had been soliciting feedback on the drafted strategies across all subcommittee areas. OHA contracted with seven community-based organizations that worked with the priority populations. There was an online survey in English and Spanish which was shared widely. There was also an open invitation to anyone who wanted to submit written feedback via letter or email.

Christy Hudson noted that the seven mini-grantees proposed to hold in-person listening sessions and community meetings in April. That didn't happen, but the organizations did an incredible job getting feedback in a time of enormous challenge. Many of the mini grantees used the online survey that OHA built, while others modified it to serve the needs of their community. A few of them convened virtual focus groups.

Christy Hudson pointed out that the OHA survey was distributed to 12 state agencies and other partners. The English version received 1,038 responders (42% response rate). In terms of demographics, overwhelmingly the people who responded to the survey were white educated women. The Spanish version of the survey received 21 responders (76% response rate).

Christy Hudson remarked that the overall themes that emerged from across all five priority areas included strong support for the drafted strategies; increased messaging about Collective Impact; interest in supporting activities to better understand implementation; interest in measurement and transparency in accountability; concern for feasibility; equity vs. equality; call to center priority populations in planning and implementation; strengthen strategies for incarcerated, LGBTQ+, disabled, homeless, immigrant/refugee, and older individuals; strategies are Portland metro centric; strengthen attention to language-related needs; white savior complex (i.e., some of the strategies feel patronizing).

Cherryl Ramirez asked for more details on the theme *increased messaging about Collective Impact*.

Christy Hudson answered that the people involved in the plan work had to be more mindful about ensuring that the work was a collective impact process. When looking at the Health State Assessment and

the State Health Improvement Plan, the OHA team has been relying on the MAPP (Mobilizing Action throuhg Policy and Planning) framework, which ends when the work enters the implementation phase. Collective Impact is a somewhat new way of approaching complicated social problems that involve a number of actors. There are six principles, such as creating a shared agenda and shared measurements, being in constant communication with each other, desiloing to advance complicated societal problems, among others. A number of things about it have been handy to this process. As the work moves into implementation, everybody needs to be true to the spirit of collective impact. This will be brought to the PartnerSHIP in a more intentional way when implementation begins.

Tori Algee asked about the timing for reaching out to various communities with these questions. The world has changed so much since COVID descended and it has been so informative in showing structural racism, both in terms of disproportionate COVID cases among people of color and then having these terrible killngs in the last few weeks that shine a bright light on racism. She wondered if some of the answers would change at this point, given what we have been through in the last three months. Now, with the protests and everything else in the last couple of weeks, our world is changing.

Christy Hudson reported the feedback from the mini grantees about the Behavioral Health subcommittee strategies. Overall, communities are very supportive of identified strategies and want priority populations to be centered in the implementation. The reports are in Basecamp. In terms of the OHA survey, Gary McConahay and Carol Dickey stepped in to help review all the comments that came in through the survey. Overall, people were very supportive of the strategies and excited about what was identified. Two strategies raised concerns. One strategy was around reducing isolation and loneliness among older adults. While there was support for this strategy, there were also people who thought that the strategy should consider all people in our community who were lonely and isolated. A second point of concern was the strategy, in Goal 2, around the callout partnership with law enforcement, both at state agency level, as well as at the community level.

Gary McConahay added that he read in a lot of comments that the term *behavioral health* was very culturally specific. When outreach activities or services are done, they are defined from the point of view of the people receiving the service. While in the U.S. behavioral health is understood to mean mental health, other cultures interpret the term to mean other things as well. This might have contributed to the white savior comments. Although that may be fine for the current behavioral health structure, a lot more outreach and community-based work, not clinical-based work, needs to be done, that comes from the point of view of the people neededing the help.

Christy Hudson asked if Gary McConahay would propose using a different term than *behavioral health*.

Gary McConahay answered that it might be nice to have another term, although he didn't know what it would be. The term has a definition in the Oregon Administrative Rules and it is different than how many people think of behavioral health as mental health.

Don Erickson remarked that behavioral health was introduced to create some inclusion but distinction between traditional mental health versus inclusion of substance abuse disorders, and define the term that was more approprite to capture both of those issue types under one umbrella. In creation of behavioral

health systems, for instance, it became evident in many communities that we were not just alking about mental health services, but we are also talking about a full array of adiction-related services. He asked if that matched Gary McConahay's historical interpretation or if it still lacked value.

Gary McConahay answered that he agreed with that interpretation and its evolution, but he didn't know how helpful that interpretation was for the people who commented about it from their idiosyncratic point of view. It's a hard thing for people to go into a clinic. We witnessed that from COVID. At the back of the DSM (Diagnostic and Statistical Manual), there is a whole section about behavioral health disorders and mental health disorders in other cultures that most U.S. experts would not recognize as behavioral health issues, but for that particular culture or point of view, that needs some kind of community intervention around.

Kate O'Donnell asked the subcommittee members if they wanted to look at the terms they were using or look at the actual strategies they were using and think about applying that lens to the strategies.

Don Erickson asked if it was possible to insert the definition that the subcommittee had been using in an accessible place, so that it clarified that when the subcommittee used the term, it meant this.

Christy Hudson answered that there would be brief language on the new website for the eight bucket areas.

Gary McConahay added that there should be some acknowledgement that the state definition of behavioral health didn't match the need or the perceptions of mental illness from minority cultures – an acknowledgement that the definition might not fit for everybody.

Christy Hudson posted the current draft language for the website in the chat box for the subcommittee's feedback, comments, and edits. Don Erickson agreed to help.

Incorporate Feedback and Finalize Strategies

Christy Hudson remarked that the subcommittee needed to finalize the strategies by the end of the meeting, ensuring that the subcommittee had called out the priority populations that were of most concern to it, as well as incorporate all community feedback. It is an opportunity to consider where the subcommittee stands today, given that the strategies were developed not that long ago, but in a different world. Changes informed by COVID-19 and anti-racism protests are encouraged. The Institutional Bias subcommittee had identified two new strategies informed by the current events: a strategy addressing concerns related to public charge and a strategy addressing bias in criminal justice systems.

Christy Hudson stated that OHA heard from both Oregon Department of Education (ODE) and the Oregon Youth Authority (OYA) that the agencies would like to see either a new strategy or strengthening of strategies specific to youth. OYA's request concerns youths who are not in school or in a traditional school setting, as well as the need of transitional aged youth (age 18-24). Feedback from the OHA survey called for more attention to the SPMI (serious and persistent mental illness) population and the homeless population, specifically people who are in and out of emergency rooms and jails.

The subcommittee discussed and edited the strategies under the two goals. The subcommittee ran out of time to consider strategies related to youth and the SPMI population.

Public Comment

Kate O'Donnell invited members of the public to provide comments and ask questions.

Ann Kasper shared that what the subcommittee was writing affected her and her family directly. One thing missing is the peer perspective. She recommended to have a peer look at the strategies and the language. If these strategies are about mental health, the subcommittee would want everybody at the table. Two other things missing are quality assurance and feedback. For example, the state puts people with behavioral health issues in programs, but are the programs working? Does the state get people's feedback? Is the state wasting money on programs that don't work? She told a story about her last 6-day long hospital stay. She was transferred from Oregon to Washington state because there weren't any beds in Oregon. She got telehealth inside the in-patient unit. She didn't see a live doctor for 6 days. The state needs to look at the quality. What are people with behavioral health issues put into? They want to get better. Just put them in good systems.

Steven shared that consumers considered stigma debilitating, because the diagnosis of mental illness was debilitating to confidence and treatment received. It's a black mark, if one is diagnosed with schizophrenia or bipolar disorder. These people find out that there is a lot of disrespect that can go to other people in the community besides one's neighbors, friends, and family. Substance abuse can become very sensitive to treatment when providers are not clear on the problems associated with using substances, including intoxication, health, finances, criminal activity, and relationships. Oftentimes, in these mental health agencies, the people who are involved with it had a history of substance abuse that they may be lenient and unclear about how much substances can erode somebody's life, especially a person with serious and persistent mental illness who has difficulties tolerating sobriety, never mind intoxication. The last thing is that when we are talking about suicide rates among the elderly – suicide rates for veterans were mentioned and they have a very high rate, while most, but not all are men – the rates are very high for elderly men, who may or may not be veterans. He agreed that getting care for all age groups was relevant and we should be suspicious about why the rates were so high.

Terri commented that she had been going to many open round tables with youths about how to support them and their mental health. She expressed a desire to be a part of the conversation, if this is going to be an ongoing conversation about creating more action items for supporting youth.

Kate O'Donnell noted that that would be part of the conversation, in terms of implementation. Youth Era, a great resource, is involved with the Governor's Behavioral Health Advisory Council.

Ann Kasper added that as a person who had been in these systems in and out all these years, she didn't like the term behavioral health because it didn't describe what she was going through. When she hears the term, she feels like control and that people want to control her. It's not about healing. What term can be added that talks about people healing and moving on?

Next Steps

- Christy Hudson and Don Erickson will work on the definition for behavioral health.
- Christy Hudson will schedule a follow-up meeting next week to discuss youth and the SPMI population.

Adjourn

Kate O'Donnell adjourned the meeting at 4:06 p.m. The last meeting will be on July 17, 2020.