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LACDMH MH-BHC

Thursday, April 10, 2025

10:30 a.m. – 2:00 p.m.

>> Okay, we're at 11:00 a.m. Welcome to the L.A. County Behavioral Health Commission. Today's meeting is dedicated to the MHSA update fiscal year 2025-2026. This will be the commission public hearing and hearing your input and feedback on this plan update. I apologize for that. Let me begin with a visual introduction. Sorry about that, everyone. Let me begin with a visual introduction of myself. I have dark brown curly hair, brown skin, brown eyes, I am wearing a forest green long sleeve blouse, black pants, black shoes. Welcome all. For those of you in room, restrooms are outside the doors to your left. And another quick left.

There are snacks and drinks on that corner of the other room. We also have binders that have the updates in them. So please take a binder. Those are for you to have. We also have our agenda in prints on that table. I think that's it. Chair.

>> MICHAEL MOLINA: Thank you very much. Kenia, good morning. This is Michael Molina. Chair of the Behavioral Health Commission. Welcome, everyone, to our monthly meeting of the commission. Kenia, can you please call the roll?

>> KENIA FUENTES:

[Roll Call]

Commissioner Susan Friedman, present. Commissioner Imelda Frausto absent. Commissioner Bennett W. Root, Jr. present. Commissioner Erica Holmes present. Commissioner Reba Stevens present. Commissioner Dalglish present. Roche present. Commissioner Jacqueline Sandoval present. Commissioner Lawrence Schallert here. You have a quorum.

>> MICHAEL MOLINA: Thank you very much. Moving on to item number 3. Colleagues, new business. We have an update on our upcoming board election process. Kenia.

>> KENIA FUENTES: Are we speaking about -- will the executive committee -- yes, we have a nominations committee and that has two members, Commissioner Weiss men and Molina and that needs to be submitted for full commission for ratification.

>> MICHAEL MOLINA: Commissioner Weissman and Commissioner Molina has volunteered to serve as the Nominating Committee. If there are any questions to discuss, we can certainly discuss that. But we're looking for a motion and second to move. Thank you, Commissioner Dalglish seconded. Stevens seconded. Any questions about Nominating Committee?

All right. Seeing none, let's have a roll call vote, please, Kenia, for our Nominating Committee.

[Roll Call]

>> Can we have a discussion?

>> MICHAEL MOLINA: Yes, Commissioner Stevens.

>> REBA STEVENS: I'm trying to envision what the current executive team looks like, being yourself and Commissioner Weissman are on Nominating Committee which tells me you won't be running for that petition.

>> MICHAEL MOLINA: That's correct.

>> REBA STEVENS: So it's really important that we are -- I don't know, encouraging folks to participate if we don't have a slate as of yet of interested folks. So I am a little uneasy, because I don't -- I'll just say, I just hope folks are, can you just encourage, Chair, all of us to participate so that we are able to, you know, have a successful election? I'll leave it there.

>> MICHAEL MOLINA: From your lips, Commissioner Stevens, we completely agree. And Commissioner Weissman and I will be working diligently to make sure we have a full slate to present to you. I believe Kenia, is it not true that the next step is to poll the Board to see if people wish to serve on the Executive Committee for next year?

>> KENIA FUENTES: We sent the survey already and it's been sent out for anyone to self-nominate.

>> MICHAEL MOLINA: Thank you. Any other questions or comments? All right. Let's call the roll, please.

[Roll Call]

Commissioner Friedman, yes. Commissioner Kathleen Austria, yes. Commissioner Erica Holmes, yes. Commissioner Stevens, yes. Commissioner Victor Manalo, yes. Commissioner Stacy Delgleish yes.

>> MICHAEL MOLINA: There's a lot going on on the first 5 minutes of the meeting. Thank you. All right, colleagues, we're going to move to our item number 4, standing items. We have two presentations before us. The first is coming from our folks at SAPC. So we ask those representatives to please come forward. Good morning. We'll get your microphone to work, all right? No problem. Technician is on his way. Great.

>> Prevention and control. I am the Deputy Director there. Our bureau director Dr. Tsai is unable to be here today. So I'll do a quick presentation because I know we're short on time. So we'll introduce the concepts around our prevention services and

if there's additional questions later on, we can always bring back content as well. So I think we'll pull up the slides in a moment. There we go. So we can go to the next slide. I think you might be familiar with the Institute of Medicine continuum from perhaps the Department of Mental Health services, but just kind of a quick overview, the graphic here is really meant to depict the populations served within our prevention programming. The first being Universal. The green folks that you see up here in the circle, that's for the entire population. If you look at the selective, that's a subset population due to being at higher risk for substance use. You'll see fewer images of people in that particular category.

And indicated individual showing early signs of substance use. So we categorized the way we deliver prevention services within this structure to find the work we do. So you'll see examples of our programs up there in each of the categories. The easiest being in a media campaign would be an example of Universal. It touches everyone. Selective would be our student well-being centers that are about 40 schools across Los Angeles County that are specifically higher risk high schools. So those being selective. And then indicated being examples of educational sessions that we would have specifically with probation youth as an example who are using. Next slide.

The way we structure, this is a very busy slide but it's meant to give high-level indicate how we go about designing our prevention programming. This example is particularly on Cannabis or marijuana and we look at national and state level data. We look at the prevalence and how many people have a particular condition within a community. So you'll see for example, individuals who are 12 to 17 who have used Cannabis in the past month is an example of prevalence. We look at contributing factors. Things amendable within a community to be able to change those local prevalence issues. And so you see an example being perceived great risk of daily Cannabis use. As well as perceived risk of harm to the adolescent brain as being contributing factors to substance use.

We also look at access and availability. So that's how easy it is to get it from our families and friends. And how available it is within our communities, for example, through retail Cannabis stores, retail alcohol outlets, et cetera. And oftentimes, you'll find that regions of Los Angeles County that have higher alcohol and cannabis outlets have higher correlation with substance use as well, because it impacts the way, as you see in the next area, this social way we perceive substance use to be what we see in ads, and media, and music, things like that all influence our social norms. And so you'll see examples of data and how that varies throughout Los Angeles County as a whole and across our service planning areas. Once we look at state and national data, we look at kind of we do local needs assessment. So we do environmental scans, individual and group interviews with local community members, surveys of local community members, et cetera, designed to be a way of really getting what is the community that we're serving really look like and what are their particular needs and not

necessarily in bigger groups such as the service planning area or the county as a whole.

And once we have all of that data, our prevention providers will then design interventions that specifically target those things that kind of rose to the top of needs within their particular assessments throughout the community. And so that brings us to, you know, different types of programming in different areas and different focuses based on the actual needs assessment we have in our data finding. Next slide.

So this is an example of key strategies we have at SAPC overall. So our network providers would also be working in these broader categories. So focus areas being able to increase education and awareness through positive youth development programs. Mobilizing communities to develop strategies that address local concerns over substance use. Enhancing data collection, and also launch media ad campaigns. And you'll see on the type of programming that we have. Just to highlight at the bottom, if you have access to this, those are links to our media campaign at the bottom so you can get a sense of what our Fentanyl frontline looks like and #big choices. And in every corner and type of programming we do in each of those areas.

And kind big picture. These are the kind of presentation programs that we fund. So we do some directly operated work. We, as I mentioned, have 43 student well-being centers located in high schools across Los Angeles County being at higher risk. We also have 6 connecting to opportunities to recovery and engagement centers or CORE Centers located within public health centers and that's where individual community member can come and get education around substance use or referrals to treatment. We also partner with other county departments which are highlighted here. First being Los Angeles County Office of Education. Or LACOE. And they work with youth development efforts. And we work with county Parks and Recreation doing positive activities with young people and building leadership skills. And L.A. County library with my brother's keeper program that supports with individuals within those particular community as well and then lastly our biggest bucket of funding is our community-based organizations. These are subcontractors for us. And we've got 35 agencies that essentially do more education-oriented school with schools and communities. And 8 community collaboration programs, they're essentially coalitions we have in each planning Service Area to work with our prevention provider and community members and look at what kind of policies and advocacy-oriented work can be done in though locale, around Cannabis and alcohol use as well. So overall we spend about \$60 million in our prevention programming being part of our Department of Public Health. And we are federally required to spend 25% of our federal block grant on substance use prevention services. We use about 50% of that particular allocation and funding sources and with what we want to do on the front-end so individuals hopefully doing continue with substance use or substance disorder diagnosis. So these are just examples of more specific programming if you want to take a look. I know we're short

on time. But this is an example of Fentanyl line campaign how we targeted particular community members and age population based on the data we had and campaign focused on community awareness. So, really, wanting to make sure folks understood the riskiness of fentanyl and other substances they may be taking and distribution of Naloxone and things like that and what they can do with individuals and for them if they know someone, how to refer or carry Naloxone in the event someone needs to be revived from an overdose.

And lastly, we have examples of programming we had in the earlier slide. 3 steps is drug take back community events where community members can come in and turn in substance that can be diverted or used, so for example, if someone has oxycodone in the home because of surgery, turning those into not diverted young people. We have yellow there what is called sticker shock campaign. That's going into, in this case, liquor stores or alcohol outlets and reminding us that to not purchase sales for minors and things like that. And having those visual cues to help change people's actions around sales to minors. So these are a few examples we have on our prevention programming. You can go to the next slide. We're happy to go in future sessions to go over in detail if it's helpful and based on prior conversations, we put together an outline what we hope to discuss in future sessions. And those are listed here. Of course, if there's any questions or additional details or topics that are of interest to the commission, please let us know. Otherwise, our intention presentation on May 8 will be value-based care for treatment services, essentially how we fund them and how we're doing creative efforts to really motivate our provider network to look at outcome-based care. Thank you very much.

>> MICHAEL MOLINA: Thank you. Another excellent presentation from SAPC. Thank you. I lectured a lot. Colleagues, questions or comments? Beginning with Commissioner Roche.

>> This is a great presentation. Can you talk about effectiveness and prevention program if you can speak to how you're distinguishing any success you're seeing from national trends for example? I think fentanyl has been decreasing nationwide for 2 years now. And factors to I don't understand. I don't know if you can just be sharing your evaluation how you know it's you and not something else?

>> Yeah, that's always a complication with prevention when we're trying to measure something in many cases doesn't actually happen and it does present exaggerates from prevent perspective. Our network providers, I'll speak in generality, but we can bring that back in a future date if need be. But broader approach we take to evaluation from our contractor perspective, that's 35 and 8 providers and doing the same data collection, looking at their surveys, looking at their findings. And we have a data evaluation team at SAPC that also looks at the service data submitted by our contract agencies and they will do some evaluation work on that. I have to get more specifics about how they go about doing that, but it's part of the prevention framework

not only to the assessment piece but carry that through evaluation. And then for the Fentanyl campaign, I think we would need to have some metrics we can share on a future day how we look at where we have changes kind of in behavior. Again, it's a little bit tricky because it's who sees the particular post on Facebook and things like that. And does that actually convert to a particular action? That's a little trickier to do within the media campaign. But we do have some elements on doing the evaluation for those as well. I just don't have those today.

>> MICHAEL MOLINA: Thank you. Commissioner Friedman.

>> SUSAN FRIEDMAN: Thank you very much. One is who is running your media campaign?

>> Yes, so we subcontract it out to a community-based provider. Our particular vendor is rescue and they've been doing our media related campaign for last few years. And we have an area within SAPC under Anton Moore, strategic development branch that has a unit that's responsible for outreach as well as our media oriented campaign. So SAPC as well as Department of Public Health takes active role in shaping what the images look like and make sure they're reflective of the community. So we have folk's expertise in media campaign. And we subcontract the actual work. The billboards and postings you see on Facebook, et cetera are subcontracted out for development by a vendor with our input and they actually do all the postings and things like that.

>> SUSAN FRIEDMAN: So it's basically a social media campaign?

>> We do a lot of social media. I think we do very little, like television ads just due to the cost. But we focused in areas around social media postings. If you have seen our Fentanyl frontline campaign, we had billboard on 5 Freeway and 710 Freeway. Which is near DMH when is very exciting. And we do mostly those things on buses, those little ads on buses or Metro and things like that. We posted there as well. But really very little media related work and much in the social media space or billboards and like bus and things like that.

>> SUSAN FRIEDMAN: I'm curious if anyone has done an evaluation to see if those cost a lot of money have any affect whatsoever? I mean, I might see it, but I'm not a Fentanyl user. And I assume people who are Fentanyl users just goes over their head. I mean, I can't imagine a billboard having -- I'm wondering about the evaluation you do.

>> Yeah, that goes to the earlier question so we can provide additional email. For our Fentanyl frontline campaigns, the billboards we had on the freeway, those are not just intended for individuals who might be users, but also you and I, because part of it is to kind of really increase understanding in the community about the benefits of Naloxone and the ability for that particular medication, we can carry it around with us, and can revive an individual who might be experiencing an opioid overdose. So that could be also young people who get a hold of that, unfortunately.

[Audio frozen]

I can speak loudly if that helps for folks in the room. I think that's really what we have done around that to see not only can we target individuals and do that on different types of campaigns and individual users but also how can we work with individuals who might come individuals, young people, et cetera that might be having an opioid overdose and we want to make sure we have those life saving options available to them.

>> MICHAEL MOLINA: Thank you, Commissioner Friedman. Commissioner Weissman.

>> What are the preventions there and we're deeply affected in the area I work in.

>> Absolutely. So we know methamphetamine is a huge problem in Los Angeles County as well. We have a prevention and treatment community collaboration group we meet with, providers and other interested individuals to be able to make advancements in that space. We also prior to Fentanyl campaign, we had a targeted campaign as well and specifically targeting the users and focused in placement and things like that. But we've focused from a SAPC level how do we coordinate and collaborate with providers and other stakeholders in the community? We do that through the targeted media campaign that we have. And then our prevention providers may also do marijuana related work. But, yes, a focus of ours as well.

>> MICHAEL MOLINA: Thank you, Commissioner. Commissioner Dalgleish.

>> STACEY DALGLEISH: Thank you for your work. I'm curious about Naloxone. And the distribution. And the pricing of it. Because I see that it's the often expensive and that might be a barrier for people who might want to use it.

>> It is available for you and I to get it at a local pharmacy over the counter. That's right available. We also distribute in various ways within the community. So through our harm reduction providers, that's a predominant way that we do that. So we've got several harm reduction providers that will distribute Naloxone into the community. We also encourage our treatment providers for individuals who are enrolling and discharging in treatment services to provide Naloxone as they come in or leave the program. We understand that folks will generally have recovery and sober goals to be abstinent upon their discharge. But some people relapse so we want to make sure those sources are available. And Department of Public Health has a community-based program. So community-based organizations can reach out to DHCS Department of Healthcare Services to get free Naloxone. And that's not restricted to substance use providers or anything like that. That would be any kind of community provider that can do the application at the state in order to get a supply that they would be able to distribute within their programs. And I also believe it's available at public county library as well. So that might be another place.

>> STACEY DALGLEISH: That's great. I've been getting kits. And distributing them to like Lyft drivers and Uber drivers. I'm wondering if you know anything about often that particular group of professionals are able to use this?

>> I don't have any stats on that. But it's a very good idea to be able to distribute it to those types of individuals and that type of employment. So I will take that about share that with our team.

>> STACEY DALGLEISH: Thank you again.

>> MICHAEL MOLINA: Commissioner Austria.

>> KATHLEEN AUSTRIA: I like to know about education programs and where they're located across the districts and the SPAs. What's the content? Because I know it's variable between the providers, who they're targeting and competency, the cultural competency of all the trainings.

>> Yeah, and that will, like you mentioned, vary cross the county. We have 35 agencies that focus in the education space. Oftentimes that is happening either in school setting or locations where young people are. We also have evidence-based practice that's escaping me now but we also require particular evidence-based practice for our education programs to provide some level of consistency across our programming. But we strongly encourage providers to adapt curriculum and things like that to be culturally competent to the communities they serve. And so they're able to make adaptations and things like that to their curriculum as they need to. But we do have, on our website, we have where our prevention providers are located that we can share that with you as well.

>> Okay. And who's reviewing it from public health? There are public educators reviewing this? That it's appropriate?

>> Yeah, couple of ways we do things. So we are, when we have our prevention contractors doing prevention education within the community. We have a team at SAPC under our prevention chief that has a team assigned basically to different provider agencies. So they will have visibility on developing a work plan they do for us. They will oftentimes submit curricula, flyers they have, things like that. So as a county we have visibility on that. We also have the CORE center for recovery and engagement that's operated inside the public health centers and they do community-based education. We have developed various basic curricula on various substances and things like that that we do have and we do conduct from a county operated perspective. I have to check and see if they've also shared those presentations with our community-based providers. I'm just not sure. But those are kind of ways we've engaged in kind of how we're doing the education. But we do not have health educators specifically on our staff. But we do the CORE Centers are staffed and they would be doing the education on behalf of the county.

>> MICHAEL MOLINA: Thank you, Commissioner. Commissioner Stevens.

>> REBA STEVENS: Thank you for the presentation. Is this accurate information or is this an example?

>> That's accurate information. There's a link to on the bottom 2025 strategic framework. And I pulled elements out of that in order to kind of create that. But, yes, it's all correct information.

>> REBA STEVENS: So with this accurate information, I'm very much interested in understanding how this ties into the coalitions that have been created, the 35? And where those 35 coalitions are per the SPAs. And also concerned about the social norms listed here for Service Area 6 because it tells me that we need to look at environments and what is missing and how do we address these unmet needs that are happening as a result? I think this is alarming Commissioners. And I think we should look at this data per the SPAs. And address that.

The other is around the needs assessment. So I hear about the social media, and I'm glad Commissioner Dalglish was able to give you something to walk away with. But I'm also interested in how the coalitions are promoting, if they are participating in this campaign as well. And then in reference to the cost associated to the harm reduction tools, I mean, is it necessary if we are looking at saving lives to have a cost associated with it at a drugstore? And I'm sure we do. But at the same time, I'm thinking you know, 40% in the mortality rate, future item share is that we would be asking information around the death rate. Because we know that through public health, 40% of folks who actually died unhoused on the streets is 40%. So could you answer? I know I said a whole lot. Because I want to make sure it's on the record. But in reference to the 35, you know, perhaps bringing that information back, or helping us understand how they're participating to help advance the media?

>> Specifically how are 8 coalitions across the county are contributing to the media campaign, is that correct? Yeah, I would have to -- I would have to check and see how we're doing that and to what extent we're engaging them. We do focus groups and kind of our engagement with individuals within the community to get a sense of is our message actually hitting the mark with the target community? And I know we pull from various regions of the county and stuff like that so it's reflected. But I don't know if that is specifically being pulled from our coalition. So I need to check specifically how they're being engaged.

>> MICHAEL MOLINA: Thank you, Commissioner. Following up from Commissioner Austria and Commissioner Stevens question about the organizations, the 35, I'm just curious. Those of us on the commission, let's take a scenario. And one of us may know a great local organization. You mentioned school, faith-based locations, who we think, boy, this would be a great place within the areas that we come from that would be a terrific community-based organization that could provide services through you. How would that organization apply? Do they propose? Is it an annual RFP? How

do we encourage organizations that we know to come to you for funding to have these programs in our local areas? What's the process?

>> Sure, and we can share that link with you as well. We do contract for a multi-year contract so it is not something typically open continuous where we add providers.

>> MICHAEL MOLINA: Good to know.

>> In the same way we do for our treatment network because it's a Medi-Cal entitlement program. But we do have a link to our master agreement. It includes kind of all of the requirements. So we would say, kind of just generally speaking, to have agencies get on the master agreement first, and then when we do open up a new solicitation, anybody on the master agreement would be available to apply. We've also kind of had more informal discussions with agencies as well. They're new to our network. We know contracting with the government can sometimes be challenging. So we've had different conversations in advance of even that process to kind of get a sense of the kinds of programs that are available in the community. Is there anything we can do in advance of kind of more formal release that we have or to provide additional support, you know, on how to navigate that process?

>> MICHAEL MOLINA: Great. But there's something on your website people can be directed to. Great.

>> REBA STEVENS: How is lived experience for those who have been very successful and perhaps abstinence, how are they folded into all the work in which you are doing?

>> Within the prevention space or more broadly?

>> REBA STEVENS: Across everything. Because people with lived experience could be everywhere.

>> Couple of different ways, I think probably the predominant space for individuals with lived experience with the component of the continuum, substance abuse counselors are about 80% overall because of their personal lived experience. That's kind of the predominant way we engage. And we also see a lot of individuals who have lived experience start as a counselor and they progress through the organization. So for example, we have executive directors that were once clients of organizations and things like that. So it is something that is really the heart and soul of substance use disorder treatment. We don't have, because of the predominance of individuals with lived experience as counselors and service delivery folks, we don't have as strong like a peer network in the same way that mental health programs do. But it is something that we are building as the state has made that new billable category within the Medi-Cal Program, we're providing scholarships to individuals to kind of complete that test to be a peer counselor, and then trying to encourage our agencies to also bring on that workforce as well, in addition to kind of what they're more used to with the substance abuse counselors.

>> MICHAEL MOLINA: Thank you Deputy Director Gibson. It's always great to have you and great presentation as always. We look forward to next month.

>> Appreciate it.

>> As Ms. Kalene comes forward, you know, April is always dedicated to the presentation of which is now the behavioral services act. Our upcoming year and then to provide the opportunity for members of the public to make comments relative to the proposed presentation and report that it will eventually make its way to the Board of Supervisors. So this annual meeting not only is required by ordinance, but it is also an important moment for us each year to get a full understanding of what's to come from the BS HA. And provide comment and we colleagues in the form of a draft letter and then final letter will send our comments to the Board of Supervisors which they will use in conjunction with the report that will be received by the department. So that's in order today. Kalene, welcome. We look forward to your presentation. And colleagues, as reminder as our Board continues to come on and off, you may want to use the printed presentation which is in your packet to follow along with what I'm going to assume is an excellent presentation by Kalene. Go right ahead.

>> KENIA FUENTES: Sorry, I don't know what the TV is doing back here. Soon as it comes up, you'll have a visual of it on the TV. And you'll also have the print. And everyone else can see what we're doing. It's just your TV.

>> MICHAEL MOLINA: And verifying, despite this TV's stubbornness, virtual people online can see everything? Thank you.

>> Thank you, Commissioner Molina. I will introduce myself. I'm Kalene Gilbert. I'm the mental health services act coordinator with Department of Mental Health. And I'm a middle-aged woman, blonde hair and I want to give you through our MHSA annual update. This is last MHSA conversation we're going to have. Next year will be a transition year as we plan. So first I want to share that our annual update was posted in the comment period was from March 7 to April 7. It was posted in English, Spanish, and Korean. We have solicited feedback and have let folks know it is online. And we have blasted it to folks. We received no comments. We were surprised. This is the first year that I've seen that we received no comments. So let's go on to the first slide. I'm going to start talking about what I'm going to go through and talk about what this plan is, the years it covers. So first of all, we'll talk about the purpose of the MHSA and the development of annual update. And I'm going to cover the community planning process. The population enrolled in Medi-Cal and needs assessments that drive our programming. Overview of MHSA components. Community service and supports which is like our outpatient services and linkage, and crisis services. Prevention and early intervention. And then workforce education and training. I'll talk about innovations. We'll talk about capital facilities and technical needs and ends on budget. I brought with me some of the leadership in areas of prevention and early intervention in the area of our crisis services. And also when it comes to linkage. So home and

innovation so that you can hear little bit from them about the great work that's being done out there. Next slide, please.

And I will, too, we've got binders up here and you all have your binders. I will try to get to the components and page numbers and details reflected on. I really want to stress before I start that this is a very, very short summary. We just picked highlights of some of our programming. The plan is over 250 pages. There is just an enormous amount of programming and work in there that we just would be here all day if we need to cover it. So I want to be clear this isn't a reflective of everything we do, but just giving folks an understanding what kinds of services do and where we think they really shine.

So I'll start with the Mental Health Services Act for folks who are not familiar with it. It was passed in November 2004 as proposition 63. This proposition imposed 1% income tax on personal income in excess of a million dollars. And I always like to say it super, our system. We were a smaller system prior to the MHSA. Passed in 2004 and we really launched our programming in 2005 and 2006. MHSA is reason why we have expanded our in fact programming and this is the breath of homeless services, housing support and full service partnerships, field-based services and this has been the vision of MHSA and L.A. County has certainly been building this over the past 20 years or so years. And so proposition or the -- sorry, Mental Health Services Act statute requires that we hold community planning process and every three years develop a 3-year plan. And on the interim years, we do an annual update and that's what we're doing now. So annual update covers 3 time periods. It covers the outcomes from programming from the year prior, 2023-2024. And it covers the community planning process for this year, or for this plan. And it also covers the budget and changes in the coming years.

So it does span 3 time periods as we start to dig into some of these programs. That's why you'll see some different dates on some of our tables. But it is through this community planning process that we obtain important feedback and broad stakeholders. I'm going to point out couple of places which stakeholder feedback has driven some of the programming and expansion and decisions, and this particular time, it's a little bit different. We have a 2-year plan and state has asked us to cut short to get us back on cycle with the rest of the state. We went off cycle during COVID and gave us an extra year on plan. So this is getting us back on track. Next slide. So this the community planning process. The goal of the community planning process is to ensure community stakeholders take an active role in advising county on service needs. We spent time from April to June of 2024 with some informational sessions, helping folks just doing some orientation to MHSA and having a conversation around data and data metrics. And that's going to be really helpful for us as we go forward into BHSA and how we're holding our services accountable. And from July to December, what we did is we spent the time to do deep dives into each area of programming. Each component, and so that we made sure our stakeholders had a really clear idea of all the programming we do have. One thing we learned from the previous years, when we asked folks what he

needs were, they listed things and raising awareness was one of the things. And what our folks need to know what we have. The other reason we did things in that way, we wanted to make sure we developed this annual update piece-by-piece. So that the end product is just a collection of all of this information. So that has been presented throughout the year and it's not just one big batch of information at the end of the year. So all of this has been presented with our stakeholders and this is the combination with the addition details.

We have just a little bit of information on the stakeholder attendance. And you can see, I think July, August, September is where we got a lot more participation as we were winding down on decision-making. I think we saw that drop-off a bit. We have some feedback here on who is participating. We do have a process by which we identify stakeholders to ensure we're reflecting folks that are required to be represented by statute. And to make sure we have a group that is reflective of the diversity of L.A. and is balanced. It's open to the community and we want community input. You can see community stakeholders at-large were largest group of folks that participated in these meetings.

Next slide.

Some of our needs assessment information starts on Page 8. That's our population. Right now we're going to talk about the population enrolled in Medi-Cal. That is the focus for our DMH. We are the state plan. We're responsible for serving Medi-Cal beneficiaries with severe or mental illness. And here in Los Angeles, approximately 40% of our population are Medi-Cal eligible. And we have a diverse county here. We have 13 threshold languages, but for our race, ethnicity distribution, it's 58% Latino, 13% white, 10% African-American. And we're working to make sure that data is captured. Our API is 9% and American Indian Native-American is .1%. And top 3 languages are English at 60%, Spanish at 33, and Armenian at 2%. And we provide services in more than the 13 threshold languages. We're responsible for ensuring we can provide services to those who need it regardless of language. So we have access to things like language lines. And we really do working ensuring we have a diverse staff. That's always the ideal.

So I'm going to start with the next slide. Okay. So this is just an overview of the major, MHSA components. So I noted this is MHSA is a revenue source from the state. All of those tax dollars go to the state. [Lost audio]

The MHSA lays out exactly how we're supposed to spend those dollars. So you can think of these as little separate accounts. And I'll go through what each of them are, but we have the largest one is community services and supports at 76%.

That includes outpatient crisis linkage. PEI, prevention and early intervention at 19%. Workforce education and training, that's WET. And CFTN, that's capital facilities and technical needs. Those are on comments we need present and we fund it at our destruction and only out of CSS component. And innovation is 5%. We are to set aside

5% annually to try new ideas and once they're done, look at them to see if they've been successful and consider how we may be able to continue them. So we're going to do a deep dive into each component. Community services and supports. This is our largest CSS. 1,006. And we got home under linkage and we'll talk about that a little bit. Outpatient care services, alternative crisis services, housing services, all of our housing, not only housing services but rental assistance and supports. And even funding for new housing that comes out of that housing piece. Linkage, planning, and outreach and engagement services. So in terms of services by Service Area, you can see that this is just for CSS for all the different funded services. We have our largest portion served in L.A. Metro at 35,000, second-largest in the South Bay Area.

So Full Service Partnership. This is our most intensive program. But it offers and provides services for children, transition age youth and adults and older adults. It's provided directed operated and contracted providers. The majority of our FSP providers are contracted providers, particularly with children. These services, they provide 24/7 crisis response and counseling and psychotherapy, field-based services, integrated treatment for co-occurring mental health and substance use disorder and in fact, our directly operated FSP docks are trained in medicine assisted treatments or MAT. And linkage to employment, housing physical care. And the model for this program is whatever it takes. And so the idea is we've got funds for services. We've got funds to help you with housing or whatever it takes to help you with your recovery goal. The goal here and the target population is around folks who are homeless who have a history of incarceration or hospitalization.

And of course, the goal is to reduce all of those things. And to increase independent living and overall quality for life. For children services, we want to make sure we're helping children and youth stay out of the child welfare system and the juvenile justice system.

Full service partnerships, we served 12,585 individuals and 877 which were new to us. And as I noted, are directly operated versus contracted. We have 24 directly operated sites and largest age group that is served is adults. Next slide. And what I don't have here but I do want to note, we have our outcomes which are listed and reflected in this report that show reductions in homelessness and reduction in hospitalization and reductions in -- sorry. In justice involvement. Outpatient care services. This is probably largest service within this component. This provides the broad array of specialty mental health services for adults and children. This is kind of the meat of the requirement that we have in our obligation to the state and our commitment to serve the local population. So those services include assessments, individual and group therapy, crisis intervention, case management, housing, employment support, peer support, co-occurring disorder treatment and medication support services. This is our outpatient clinic system that you see in every Service Area. We have a mix of contracted and directly operated clinics that serve both children

and adults. This also includes our client run centers, our wellness centers. So it's a really broad array of services which should be available and accessible in every community.

Priority populations here, again, individuals who meet this specialty mental health criteria, meaning not only for adults and children that have a mental health disorder, but are also having symptoms that significantly impact their ability or suspected mental health disorder. And it's not new anymore. It's been with us for quite a while but we have mild-to-moderate folks who have a diagnosis and have a higher functioning level.

Outpatient care services, we serve 121247. And 24454 which is new. I think it's because of age span. 0 to 16 and 16 to 25. And 26 to 59.

>> [Off mic]

>> This includes contractors. It is everybody who is served. It is everyone.

>> KALENE GILBERT: And so this is, yeah, it's a pretty large clinical system.

So if we go to the next slide, I'm going to invite up, we're going to talk about alternative crisis services. There are number of programs there. Thank you, Jason is joining me. I don't know if we talked and dived into this enough so I thought it might be good to highlight things. Thank you for joining.

>> Thank you. My name is Jay Sun. And I'm one of the programs managers in manage care operations. My senior deputy director, Jacqueline Balcom is unable to join so I'm feeling in for her and I'm going to talk about alternative crisis services quickly. ACS is a comprehensive range of services and supports for mental health individuals designed to provide alternatives to emergency room care or acute in patient hospitalization or institutional care. And reduce homelessness and reduce incarceration related to mental health. And the services are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs. For example, FSP and assertive community treatment programs and housing alternatives and treatment for co-occurring substance abuse. The population is targeted at individuals over 18 years of age and older of all genders and race, and ethnicities, and languages spoken.

ACS programs include psychiatric urgent care centers. There are 8 urgent cares across the county. And in residential services and crisis residential programs, law enforcement teams, and restorative care villages, and PMRT psychiatric Mobile Team response teams and 9 crisis Call Centers. I'm here to feature one of the programs that's crisis residential treatment program. It's short-term and structured residential program. Average length of stay is about 30 days and maximum is up to 90 days. And currently, the program is for adult population and utilized as an alternative to hospitalization for individuals experiencing psychiatric crisis or episodes who do not have medical complications requiring nursing care.

The program serves Medi-Cal and insured clients. And referrals can be made to providers in the community or through DMH office. And each provider has 16 beds or

less. It's relative small residential program. And more than 90% of individuals served are homeless who experience mental health crisis. In fiscal year 24-25, we received over 2,000 referrals, and about 1900 individuals were admitted and served. And the average length of day for those were 36 days.

And individuals are being discharged to homes, to go back home, or board and care, sober living or traditional housing based on their needs. And I just want to talk to you about a success story.

Thirst person is in early 30s. And he started hearing voices in his 20s. Severe paranoia and suicidality. And he was in and out of the hospitals and in and out of homelessness and hopelessness. And he considered suicide by a cop. And he was referred to one of our CRTP program and he was quickly stabilized and went back to the community. However, because of his symptoms and substance abuse, he was arrested and referred back to one of the CRTP program and this second time around, he was able to quickly get stabilized and determined to get better. Now he's discharged to a residential program, long-term residential program and he's aiming to become a substance abuse counselor.

So this is one of the clients that was served. And he was able to go back and was able to function in the community. So these are the residential services we provide for individuals for experiencing crisis in the community. And we're helping them to go back and get better. Thank you.

>> KALENE GILBERT: Did you want to wait until the end?

>> [Off mic]

>> MICHAEL MOLINA: CRTP.

>> Some of the CRTP restorative care villages. So it's a one-stop shop at olive view campus as well as L.A. GMC and Rancho los amigos. And we also have other stand alone CRTP in the community. So not only we have crisis residential programs on those campuses, we have other CRTP programs in the community providing services.

>> MICHAEL MOLINA: Thank you. Can you continue, please, Kalene?

>> KALENE GILBERT: More on ACS, that's Page 60 if you want to do more of a dive there. We can move on to the next slide. So Dr. Maria Funcus was not able to be here today but I'll go over what's new. Our housing program under CSS covers a wide variety of resources and services. It's intended for individuals experiencing home license or have serious mental illness or serious emotional disturbances and we provide temporary housing, permanent housing, move in assistance, eviction prevention. And mental health housing case management services. We spent at least with MHSA more than \$40 million in just MHSA in these kinds of housing services. And some examples of the programs we have in capital investment program, housing supportive services program. I think that's the program it attaches some of the new housing projects that are coming online where we're putting folks on-site. The federal housing subsidy unit

that manages Section 8. Housing assistance program and housing for mental health program. Diversion re-entry mental health program that is the ODR.

We have our Office of Re-entry where we're working collaboratively with DHS and taking people out of incarcerated sites and providing services and pairing them with SFP and housing. And interim housing and TAY shelter.

So, again, goal is really providing permanent and interim and permanent housing, ultimate goal is always, always permanent supportive house. And helping to help folks at the level which they need the most. Now in assistance and supporting services for housing retention. Preserve license residential care settings which I know is something that Dr. Funcus is a champion and investing in new housing resources. And securing housing and retain housing. Page 78. Let's go into couple of stats around here. For the capital investment programs, 110 of our 162 permanent intent supportive housing developments have finished construction resulting in 2,706 units for occupancy. In 2023-2024, we were able to house 250127 minor children and we have there's a concentration of need. The federal housing subsidies unit is the DMH Housing Authority contract with 7 or 2,749 housing vouchers which were provided to 2,498 households and this was a 14% increase from the previous year. Together with individuals and families, 3,606 folks were housed. Housing for mental health. This is a specialty program where FSP clients are referred. Actually, out of the 407 clients referred to this program, they were in permanent support of housing during FSP clients and justice involvement. And referred by the Office of Diversion and re-entry. There's a 93% retention rate for folks who participate in this program.

It's worth it.

>> [Off mic]

>> KALENE GILBERT: Absolutely. Enriched residential care program. This is providing additional support for folks in-house settings. Let's go on to the next slide. Interim housing. This is most often our shelter program. And we house across county. And we were able to contract for 763 interim housing beds across 24 sites. And that served output rate stays at 90%. Highest number served is in Service Area 4 where we have our concentrated needs and the lowest number is Service Area 3. And of the 1,081 folks who exited the program, 32% exited to permanent housing. So we'll talk a little bit about the supplemental service IHUB. And this is an exciting support for the program.

And we have the enhanced emergency shelter program for Tay. Also uses MHSA funds who are unhoused or immediate risk of becoming unhoused during fiscal year 2023-24. There are one shelter in Service Area 2, 3, and 4, and 4 shelters in Service Area 6. And on the right, we have providers delivered those services along with their bed total.

In addition to these one of the things that we wanted to share is that Maria has worked with folks to do a bed rate study. And there is a plan to right now an RFA is

going to increase our housing availability significantly. There are new bed rates and all sites will provide housing navigation. The current and interim housing sites are going to add the opportunity to apply to and add an LVN or mental health clinician on-site. So we're adding more beds and services to our beds. And this is just in as part of the stakeholder house, we got a lot of feedback from folks. So there's a lot of folks on specialty communities, particularly TAY. Older adults. Justice involved folks and also working with some housing vendors who are able to specialize in serving LGBTQ+ and Veterans. Through permanent intent housing and supporting housing beds and that solicitation was done. Application is being reviewed now. So we have significant expansion on the horizon and meeting the needs of some vulnerable populations. I'm going to turn this over to Aubrey. Aubrey is our chief services and including Veteran and military families and we really wanted to highlight the work that was done with homes.

>> I'm Aubrey Lovely. If we can go to the next slide. So I'm here to talk about home and outreach and engagement team for fiscal year 23-24. As Kalene mentioned earlier, our FSP in homes and serving individuals who are refusing all services and care. Mental health care, physical healthcare and shelter. So we are countywide. We have teams. We have 18 teams across the county and 223 staff. And services we provide are basic needs. So going out with food, water, tents, blankets and things like that. We provide any housing supportive individuals that are ready to go into including motels. Utilize interim housing. And we have clinicians, psychiatrists, nurses, counselors, caseworkers to provide the full scope of psychiatry and mental health services in the field.

And we do as needed and the stats will show we do initiate our own hospitalization and within DMH to do this and the county, I guess. So really proud of what we do. So the data from 23-24, we served 2200 clients. 246 were, 51/50 in the community. And we have LPS conservatorship and 87 of those were granted through the Court and 96 them didn't make it through. And we have individuals in permanent intent housing and 247 into interim housing which doesn't include individuals who we may have moved into a motel on temporary basis.

And next slide, we just wanted to show a success story of ours.

>> This is not in the packets, but these are photos.

>> So this is an individual where home is proud of. He was being -- nobody could serve him. He was somebody being touched by all of our state county and entities and law and fire and every hospital. He was paralyzed from a gunshot wound. So this is somebody that home took on as one of our first cases. Lots of contact with him and we conserved this individual. And he went into a locked placement for period of time in skilled nursing facility. And now is in an open setting. Also transitioned from conserved by the public guardian office back to his family now. He's connected with

everybody. That's him now. So he's doing great. And he obviously authorized us to share his story with everybody. Next slide.

So this is a numbers game. Over one-half million dollars. He was just cycling through everywhere. Once conserved --

>> If I may interrupt. I know you're looking for the prints. This was after we had printed. So it's not included in your packet. But we will make sure we share it. So the pictures in this slide is not included, but I'll make sure you get the final version of it.

>> Next slide. Post conservatorship and his yearly cost was \$100,000. And not only was he cared for and safe and healthy, it was a substantial number of impact to the county. Not only cost, but the amount of time he took up from our law enforcement partners and fire department and things like that was pretty dramatic. So just a success from home and one of many, many.

>> MICHAEL MOLINA: Thank you. What's your name again?

>> Aubrey.

>> KALENE GILBERT: Yeah, she will be back. I'm going to step away because I'm inviting -- actually, I'll start with planning outreach and engagement. Planning outreach and engagement is one of the components we have under CSS. This is really what funds our planning process. It's what funds our SALTs. And UsCC. And this is about engaging the community and bring the community into our planning process and raising awareness around DMH and DMH services. And so where we've really focusing most of our efforts for a very long time now has been on supporting the underserved cultural communities whereby we have several groups. We have a group dedicated to Latino Community, the African-American community and LGBTQ+ and not only they advice us on programming and recommendations, but they also use these funds to do projects out in the community to engage their communities. And in the long past, I've seen everything from getting on to local radio programs or local newspapers, or just trying to find ways, particularly, when we're working with communities who speak other languages to make sure they have a connection to our services.

So right now what I'm going to do, I'm going to invite up my prevention and early intervention team and they're going to go through the next few slides. Prevention and early intervention. That's our second-largest component at 19%.

>> Good afternoon. No? I'm Conchi Tate.

>> I'm Dr. Carrie Pezanti. And I'm manager with prevention services and I oversee early intervention and suicide prevention.

>> So today, Carrie and I are going to present to you some of the programs under prevention and early intervention. I oversee prevention services. And so I'm going to cover two programs that has been with us since fiscal year 18-19. We partnered with another county to expand the program and another program we started from ground up engaging stakeholders.

So next slide, please. So presentation after care, this is a program DCFS launched back in 2008 in fiscal year 18-19. And we had the opportunity to partner with them as they were doing a lot of the prevention work. With our partnership, their capacity to address well-being, mental health issues was kind of like our target. And what we did was, we worked with them closely to address protective factors and risk factors. Protective factors include social connections, knowledge of like just development when it comes to children and families. And ensuring that they're connected to the concrete supports. So the families that receive these services are from the generative community. But they are more lined with selective prevention, because they're at-risk of going into the DCFS system. And there are 8 agencies that provide services across the county and two countywide programs that really target the API population and the American-Indian population. And the services include outreach, case management. They do a variety of events for families like family night. They do a lot of financial literacy supports, as well as wellness activities and supporting and linking to concrete supports.

So this slide outlines a little bit about the outcomes that we saw during fiscal year 23-24. This program is, as you heard from before the public health team member, we really use that public health model. So this program has Universal prevention where they go out into the community and do big community events. And they also have a very selective and tertiary service delivery. So that's the top number that you see that is the case navigation supports. So these are families that have a lot of needs. And there's 527 families that were served. And you will see some of the impact that was made based on the protective factors survey that was administered. Just highlighting some of them, social connection we saw increase of .6% from 2.4 to 3.0. As well as increase in social-emotional competence for adults and children.

And with the large events, we were able to reach about 37,000 individuals. And able to collect about 3,000 surveys. That's definitely an area we do need to improve. It gets challenging when we have large events to get folks to kind of stop and complete a survey. So that is some of the things that we are working out with the Agencies and DCFS team we work with. We can go to the next slide. The other program, this is a program we build from bottom-up. We have started in the in Service Area 1 in the Antelope Valley area. And this was after the tragic deaths of two children. And we did a lot of stakeholder engagement to see what are the needs and missing out there? This was created from the community family Resource Center. So it's ah one-stop shop where families can receive variety of services from case management to workshops around parenting. As well as like even just health services. And housing supports. And if a family is not enrolled in Medi-Cal, they support in that process as well.

And so this slide outlines little bit about the impact that we were able to make during fiscal year 23-24. We were able to collect about 2500 surveys. So we do the BUPPS survey which is Universal prevention screener. And we were able to collect

about 1,000 single event surveys. And able to make some impact, I would say, with regards to we were seeing individuals reporting they were able to cope better. They're able to understand when they're triggered. And support their regulation, as well as they were getting a lot of linkage and access to care supports. And with that, I'm going to turn it over to Carrie.

>> Thank you, everyone. So early intervention services in L.A. County have been implemented from 2009 to 2010 and these primarily focus on early onset and mental health symptomology. So these are clients that are, you know, qualified for specialty mental health services, and within our programming, we implement evidence-based treatments, community defined treatments, and promising practices. And so our target population, and these are typically low intense clients. These are maybe treatment sessions once a week. If you're working with children, that might be twice a week where you're integrating a session with the client and also with their caregiver or their parents or family members. The target populations, highlighted in the slide is low intense. So there might still be targeted case management and some supports that are also needed to get them connected to resources.

Services are typically less than 18 months. And on average, our clients, especially, majority of these services are with children and youth and TAY. Typically we're seeing 4 to 6 months of treatments, but there are cases where they can get up to 18 months. This applies to all of our early intervention practices, except for first break. For first break clients, they can be seen up to approximately 2 years. And sometimes it may be a little longer, depending on the individual needs of the clients. So our target population specifically, children and youth of distressed families, underserved cultural population, trauma exposed, individuals experiencing early onset, children and youth at-risk for school failure, and children and youth at-risk for experiencing juvenile justice involvement.

Next slide, please. So when we look at number of clients we were able to serve last fiscal year, there were 35,638 clients served within our legal entity and directly operated programming. Out of those unique clients, we had 15,606 clients that had not received mental health services before in our system. So that means they have not had any types of treatment prior to coming into the PEI services. We have an ethnicity breakdown of last fiscal year. If you want to take a look at that slide where it talks about the primary services are delivered to our Hispanic population at 55%. Unreported at 21%. 9%, white. 8%, African-American. 3% multiple races. 2% API population. 1% native Hawaiian and .25% Native American. Primary, our services are delivered in English at 76% with secondary Spanish at 21%.

You can take a look at our breakdown that we noticed last fiscal year is that the San Gabriel Valley and East L.A. County had the highest number of clients served last fiscal year with the number and newest clients, highest number of newest clients were actually in our San Fernando as well as L.A. East County. So we're serving quite a few

family, children and youth and TAY, adults and older adults. They range from birth to older adults. So we have programming that ranges the lifespan. And also programming that especially works with children and families as having parents and family givers being the change agent. So give them skills to help their child and youth and be healthy. Thank you. Next slide.

Suicide prevention. So I'm going to pivot and talk about the suicide prevention. Really, this has been a year of concentration of really upping and increasing our trainings, the work that we do with our clinical staff and ensuring they have the skills to work with clients that are presenting with suicide ideation, intent, plan, or means. And really broadening that work. So over this past year, we focused quite a bit on prevention and also post prevention. And in this suicide prevention, we have a new perspective on focusing on post-vention, and active engagement with outline team, we call it SPACE. And educating and addressing information and sharing information not with only our community partners and directly operated clinics but also our general public. So our teams do training with different departments. We do training in the community. We work with schools. We'll do training and get requests all over the county. We've gotten requests from different workforces, different industries that really want to address suicide prevention and how to ask questions, how to be aware, and how to find and refer and link individuals to resources.

So some of the work we want to really build on our existing community resource and we have been intentional about building collaboration and comprehensive efforts. So these services include really focusing on community outreach, engagement, and education. Linking direct services and improving of quality of care to individuals contemplating, threatening or attempting suicide. As well as evidence-based interventions not only through our trained staff on the suicide prevention hotlines but also as I mentioned earlier, we really invested in training our clinicians in both our directly operated and legal entity providers on working with clients with active suicide ideation.

We've also been implementing loss and grief group training so that clients both indirectly operated programs in our programs if they lost some loved one by suicide.

So another focus really is building an infrastructure to further develop and enhance suicide prevention efforts across all age groups and really focus on cultural appropriateness and cultural communities. We are navigating, there's still quite a bit of stigma. So we're being very intentional how we roll out programming and conduct training and what languages we're offering trainings and partnering with different cultural groups, faith-based organizations to make sure we can get that training out. And that we're really increasing anyone in our community can go to different places and be able to find resources and get link to services.

Next slide, please. During our suicide prevention trainings. We were able to collect 688 surveys last year. And some of the feedback that we received on these

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trainings is 95% of the participants agreed or strongly agreed that suicide prevention programs were successful meeting their goals. 98% of participants need or strongly agreed with the statement as direct knowledge of the resources. And 99% agreed there was a depth of knowledge in subject matters. So we really have training in expertise in our department and we spent quite a bit of time collaborating with public health. And we collaborate with LACOE, DCFS, any requests we get, Parks and Recreation and the public libraries.

So on the other side, there's another part of the slide that does talk -- and SALTs. Yes. And SALTs and USCCs.

Thank you, Reba. We also want to add there's data from our SMART team. And I know Miriam Brown was not able to be here today but there statistics there. 84 presentations were conducted in schools. 850 referrals. 90% received early screening. And 10% received consultations. And primary focus of intervention was centered on-screening at 39%. 23% crisis intervention and 11% to linkage.

>> MICHAEL MOLINA: Thank you very much. Colleagues and members of the public, just for information, we're slated to conclude the presentation around 12:45, which we will then follow-up with public comment both in the room as well as virtually. And then followed by questions and comments by the commission. Thank you. Please continue.

>> KALENE GILBERT: It is really hard to under state just how much -- as you start to look at the budget too. We're doing a lot. So next slide. I will go quickly through some of these. I really, if I could choose when I want to spend some of my time I definitely want little bit of time to make sure we talk about innovation program and amazing work they're doing and talk about the budget. So I'll gloss over some of these. Our workforce education and training component, this is funds used to support not only the training of our workforce but more importantly incentives and training outside to bring people in. We all know we have a huge crisis when it comes to staffing. And specifically, here in L.A. County, making sure we have staff that are culturally confident and provide the care people need in their communities.

So this has been essential funding for that. Next slide, and I'm going to invite Aubrey backup. She's going to talk very briefly, but she will talk about Hollywood, not too briefly, but briefly about Hollywood 2.0 and IHOP.

>> Thanks, guys. So two of our biggest innovation project we're proud of to see in the next few years is Hollywood 2.0 program and IHOP project. So Hollywood 2.0 has established our field base care teams and variety of levels of care. And it's in collaboration with our clinical base support and called Hollywood mental health cooperative. So we're partnering with service groups and Hollywood Walk of Fame. And we have 100 beds there and they're always full and ready to go. We also have a new Dawn. In east Hollywood we partner with. We're partnering with a clubhouse and these have been done in the last fiscal year. We have established a hyperlocal media

campaign to raise awareness for Hollywood 6th .0. And they engage in regular meet and goes stakeholder meetings with Hollywood forward and make sure we're getting input there and establish contract with RAND Corporation to evaluate our program implementation and impact. And things to come are finalizing contract with Pacific clinic for supportive employment services. A move hopefully coming this summer to bring both field base and clinic-based to Hollywood and working on two potential providers to establish a UCC and peer respite hopefully to come at the end of the year. That's a brief overview of Hollywood.

Located in Hollywood. Yeah. Second program which has changed some names, but currently known as IHOP. Our interim housing outreach program.

Our collaborative technique working with DMH and DCH and providing treatment for people with severe mental illness, substance use and inner housing sites and Kalene mentioned we're anticipating a huge, bringing in huge number of new sites that are going to need supports for DMH and providing support for all interim housing sites. So lots of funded and DHS funded and funded by COHI and things like that.

So currently for those teams, they've been in active recruitment and building. They will be countywide across all service areas. Up and running is teams in SPAs 2, 4, and 6. And spa 1 should be up and running in June. So that's 170 staff. Since the last update, 114 of those staff have been onboarded. We have 34 in queue with start dates and actively recruiting the rest.

We have over 800 active IHOP clients. And are in the process of finalizing contract with UCLA and the California policy lab for evaluation of the program.

>> MICHAEL MOLINA: Thank you.

>> KALENE GILBERT: I think folks have been here maybe some quite time. It was back in 2016 or 2017 when we talked about that triage program. So making that connection Hollywood 2.0 is the new version and implementation of that. We're excited to see that move forward and thrive the way it has. I'm going to go to the next slide. This is just a quick brief slide on another new proposed innovation project to try to tap into any unspent funding we have and be able to utilize it for consultation and support for the programs that are going to have to transition and provide direct services and become early intervention providers and their services fall under that category. It's part of that knowledge and support and bringing them up. But also FSP, making sure we have everything we need and to develop more clubhouses which is going to be BH-Connect.

Next slide. So there's -- sorry. One more. CFTN. Capital facilities and technical needs. This is funding we need to set aside for housing. Projects during fiscal year 2023-24 included Jacqueline Avant Children and Family Center. And olive view children's crisis stabilization unit. And some for tenant improvement and new facilities. Making sure what we have is in good shape. L.A. general mental health rehabilitation centers. Children's community care village high desert. Jacqueline Avant transition

Asian youth center. Modern Cal Center. And integrated behavioral health system and that's our electronic healthcare system we need to maintain in order to continue to provide service and claim for services and keeps our records as well. And also used for technical improvements. And that can be anything from improving telehealth services and resources and things like that. There's a variety of needs there that's actually going to increase with BSHS that's coming. Next sly.

So 24-25. This slide and I think the next couple of ones, the main point that I want to make here is about changes. So it's revising the 24-25 budget that was in the three-year plan. And I shared with this group previously these are not reductions in services. This is right-sizing to what we're actually delivering. So I want to repeat that. There are no reductions to services here even though you're seeing a reduction in budget. This is us looking at how much we're spending and try to adjust the budget to be more reflective of that. We get very ambitious, but staffing shortages and number of other things have really challenged us to grow some of our programming. So this is our effort to clear that up and especially, in preparation for some of the changes ahead.

This is our recommended budget. This is, I usually like to include this to show MHSA is just one source of funding. It is 31% of funding this year. It usually is really more in the range of 25, 27%. Millionaires did really well. And one of the things you see in the slide is this is a volatile source of funding, and what makes that challenging is we have to plan 3 years in advance and we don't know how much we're getting really until the year of. So we have to make sure -- and there's a 3-year time limit, so it's created a lot of challenges in being able to make sure we are able to spend down the funds. But we have certainly with we have specific needs coming up so we're grateful for what we have now.

Budget project changes. This is similar to last slide. Next slide.

Then this is the, I like our volatile lead chart. Blue Line is what the revenue we received from the state. Orange lining is expenditures which you see have been rising pretty steadily, like COVID, we took a little hit if then came back up. And then with our budget, you can see our budget trying to keep up with the increased receipts here.

And you'll see sometimes things do change such as you see in 2022-2023. We were told we're getting not quite twice but almost a billion and we got 572. And so sometimes things like disasters and other things change. We're not sure for example, how the fires are going to impact especially with delayed receipts. So something to consider as we develop our budgets. The 3-year forecast in the next slide. 3-year forecast in the next slide. This was the asked for unspent funds. So you have our carry over funds and projected allocation in the coming year. Projected utilization for 25-26. And then we want to make note that innovations WET and CFTN are all ongoing sources of funding. So innovation can be spent over 5 years. So those are planned for. WET and CFTN is funded for. And this is intended to maintain us at least 5 years into BHSA. Because we will be able to maintain that category of funding but it will be much

more difficult to fund given the other priorities and shifts that have been made. That means we have a balance. And this is the funding that is going to help us maintain that outpatient while we shift the system to be in line with BHSA. Total cost. This was an -- thank you very much, I didn't know we had this chart available to us. This is a dashboard we have available. So if there's an ask, we can produce this pretty quickly.

But this is an MHSA cost by Supe district. And then total cost by Supe district. And we asked for a breakout. And so next slide. You'll see a breakout by different services, alternative crisis services, Full Service Partnership. Outpatient care and prevention and early intervention.

Pretty consistently outpatient and FSP are our priciest services. And here's the total client counts. That should correspond also with the expenditures. I just want to acknowledge the team. First Robin and her team who have put that report together that is in front of you over the year and prepared all these wonderful presentations for me. I think she has done a wonderful job and are I also want to acknowledge Darlene Horn who built our community building process and has done a great fantastic job. And I just want to acknowledge those folks.

>> MICHAEL MOLINA: Thank you, Kalene. Lots of information. And thank you to the DMH staff who have joined us today and added to this annual presentation to the commission. Appreciate all the work and as you said at the very end, Kudos to all the staff who worked so hard to make this presentation and the information and the binder so thorough. Colleagues, we're all dying to ask questions, but we're going to go to public comment. I think it's important to listen to public comment because it may inform and educate the questions we ask. So we're going to move directly to public comment. Anticipating a number of folks interested in public comment by the number of people virtually right now. We're going to limit public comment to 2 minutes per person.

So Kenia, would you like to take the microphone to people or take the people to the microphone?

>> KENIA FUENTES: It's up to you. Whatever you feel would be more orderly. It may be taking it to each person? And we go in order of -- we'll start from that end of the room and just come back around?

>> MICHAEL MOLINA: For those people in the room, Kenia will bring the Pike phone to you. We tried this at our Town Hall last week and let's do it this time as well. If you like to provide public comment or just indicate so Kenia those you're interested. And Daniel will bring the microphone to you. After we take public comment from folks in the room, we will go virtual and take comments from people who joined us online. So at this point, -- thank you, sir. We will begin. 2 minutes, please. 2 minutes. Good afternoon.

>> Good afternoon. This is Andria Macpherson from Service Area 5. I may sound a bit restricted. I had dental work this morning. 2 crowns put in. So excuse me. Sorry about that. But you talked about the statistics and data according to population of

L.A. County. And is this data based on the severity of that population? Because of the numbers -- because if the numbers are based according to general population of L.A. County alone, that means, for example, I'll give you an example what I'm talking about. 6th% of programs would adhere to the necessity of Native-American population. But if the Native-American population community is 10% of the mental health population of L.A. County suffering from mental illness according to either PTSD or poverty, or genetics, then how would that program, how would all these programs be linked to the community resources according to their mental health chronic illness population?

I wanted to know topics like PTSD, domestic violence, so you would prevention. How available are they according to, of course, the necessities of communities and populations as well? Oh goodness gracious. Suicide rate is 35% Latino and 31% African-American. But there's only 10% African-American. So are there more programs according to that particular community? Because people are more open to peer-on-peer type of population in order to give their personal information and in order to adhere to their necessity. Sometimes it has to be more open with programs that have that eye to eye contact.

>> MICHAEL MOLINA: Thank you very much. Appreciate it. Next speaker, please.

>> Good morning, everybody. I am from SALT 7. I name is Yvonne Sandoval and I'm here to report some of the good things with our area. So Evelyn who is our peer support person and our chief, Manny Rojas is actually right now in New York visiting the New York clubhouse so that they may see what is going on there to bring here to our area 7 now. When we say SALT 7, what it really means, because I'm sure there's got to be new people on the line. So what it means, what does it mean? It used to be called SPA. But it has changed to SALT. Right? So SALT stands for Service Area Leadership Team. So I welcome you any time to come on visiting us here at the commission meeting, online or in person. And definitely, come out and visit us at SALT 7. Right now we're having a hybrid from center in Whittier. Okay. So there's that.

With our Jamie Gomez who was our liaison and tech guru who has done so well with our SALT 7 and Instagram, and social media, he is getting ready to shoot a podcast, hopefully, in April also, but in May, and I was told he will be doing a podcast with I don't know what Commissioner, but a Commissioner and a surprise star. Now, before I turn the mic over to our next SALT 7, Sydney, get out your notepads and pen because she will be announcing dates and events that will be happening from here on.

>> MICHAEL MOLINA: Thank you. Next speaker, please.

>> Thank you.

>> Good afternoon. I'm Sydney from area 7. What we have every Tuesday and the next one is actually on April 16. Every Thursday is East Los Tacos and it's called Ariento. And we have a spring jubilee on Walnut Park. And next one is on April 27,

which is Para dio El Niño. And that is also in east los tacos. And the clergy lunch when I will we at the Artesia library.

>> MICHAEL MOLINA: Thank you very much. Next speaker.

>> Good afternoon. I'm SALT 6 co-Chair. At this moment, we don't have anything great going on but we're working on take action at this moment. Question. What part of program was that she was talking about? That's in SALT area 6?

>> She was speaking to all the MHSA funded programs in SALT area 6th.

>> MICHAEL MOLINA: Thank you, sir. Next speaker, please.

>> Good afternoon. Just so everyone knows there's a handout going out that covers the talks and there's a PDF code. Good afternoon, thank you for allowing this spice for all of us come together and have a discussion. I'm Dr. Estradar Mohamed for Los Angeles County of mental health. I'm on medical leave awaiting ADA accommodation and I speak today not on personal ground. But I speak today in defense of public safety, systems accountability and the future of care for our county. I also speak as a family advocate, navigating the CARE Court process. I've developed a model of transformation. Designed not only to designed institutional harm but prevent. It's called bureau care to custody pipeline. This maps fragmented care and neglect from family and services and homelessness and incarceration and irreversible harm. It is not theoretical. It is preventable. And it is happening now. Despite multiple warning submitted between 2019 and 2023, a child died by suicide January 2024. Within weeks, the county health services employee took her own life on county grounds. And already this year, more families have been displaced without coordinated care following the wildfires. This is not a failure of intention. It is a failure of infrastructure. What we are facing is not a crisis. It is a cry- sis. That opens open asylum and prison and treatment sites for untreated small, especially in communities long excluded from equitable investment. Over the years, I've contributed to improvement prevention and early intervention, quality assurance, workforce education and training, contract monitoring and management division, clinical liability and risk management, and ARISE. Work now developed into departmental strategies but deeper issue persists. When those closest to the crisis are excluded from the systems they help shape, the result is symbolism, not safety. One example that transformation of Arty to now called ARISE, antiracism inclusion and solidarity and inconclusion. I was excluded from implementation.

>> MICHAEL MOLINA: Could you please wrap-up, sir?

>> Publically funded initiative was built used with my input and without Fidelity and those closest to the crisis at the table.

>> MICHAEL MOLINA: Next speaker, please. Thank you.

>> I like to make a public comment.

>> Hi, no public comment. But Bruce sport man. Commissioner from the drug and alcohol. Thank you for having us out here today. I represent supervisor Holly Mitchell.

>> MICHAEL MOLINA: Great to have you with us, Commissioner. Great to have your presence. Next speaker, please.

>> Good afternoon, Chair Molina. And I would like to address 2 L.A. mental health and MHSA annual update for fiscal year 2025-26. First item on Page 232 subheading interhousing multi-disciplinary IHOP, subsections expectations for fiscal year 25-26, first bullet point states recruitment and hiring IHOP staff including DPH clinicians for in-patient SUD treatment. How many positions will DMH will make available for workers? Questions in second bullet point same subsection. How will DMH ensure full-time role for our peers in equal standing with other members of the IHOP team? When will DMH implement new training curriculum for mental health community health worker in addition to those listed on page 249 subheading sub-Section A CDEFG. To better support their role and responsibility on the IHOP team and their future career advancement and promotion opportunities. Second item. On Page 246 under subheading mental health career pathway subsection number 1 intensive mental health recovery specialist training program the last sentence states DMH will not continue this program after this fiscal year. Why is this discontinued? Will the training program be funded through another source and if so, for how many years? What is DMH's strategic plan to engage if recruit and cohort and peers? Dizzy DMH have a specialist training program for L.A. County mental health community worker who are interested in psychosocial reasonable take field and case management career opportunities? If no, what are the reason for this discontinuation. For L.A. County mental health community workers employed at peer resource centers that will become clubhouses Page 210 under innovations.

>> MICHAEL MOLINA: Thank you, sir. What page was the last one you talked about? 246. Thank you very much.

>> May I just say one sentence? Thank you. Moreover, will this training meet the criteria for L.A. County mental health community health workers to receive the recovery practice for leaders, training under subsection 4B. Thank you.

>> MICHAEL MOLINA: Next speaker, please.

>> Jim associated with JW.org. And this Saturday.

>> MICHAEL MOLINA: Go ahead, sir.

>> This Saturday, April 12. 7:00 p.m. The event held at JW.org for the community that people may be able to come and not suffer isolation, which is this struggling for people with mental health. And also dignity and worth. This supportive community encourage well thinking, light stress, and help us avoid the stress in times we live in. Even though some have lost their houses. This community is able to help them find the houses and get over their trauma of loss and fires we've had. I have seen

it in person and aided in the suicide provincial. So this Saturday is a celebration of memorial of Christ that this community of Jehovah's Witnesses supplies for everyone to come to. And it would do well for Department of Mental Health Commissioners to encourage this for the sake that it enhances the whole person care addressing not just the mind but heart and spirit. This carries the hope that over comes despair and trauma. Please join. Zoom number. Got your pencils out? Zoom. Number 82172701513. And the Passcode is memorial. The word memorial. M-E-M-O-R-I-A-L.

Everybody is invited. And this is worldwide event. So it does not exclude nobody. It's all inclusion.

>> MICHAEL MOLINA: Thank you very much. Anyone else on this side of the room wishing to be heard? I want to make sure. All right, anyone on this side wishing to be heard? That are not DMH staff. Let's move then to our virtual participants please. If you can instruct the AT&T operator.

>> KENIA FUENTES: AT&T, can you provide instructions on to unmute and be put through?

>> AT&T OPERATOR: Yes, if you like to make a public comment and you're on the phone, please press 1 and then 0 at this time.

You may remove yourself from queue at any time pressing 1, 0 again and if you're using a speakerphone, please pick up the hand set before pressing the numbers. Once again, if you have a public comment at this time, it is 1 and then 0. One moment, please.

And we'll go to line number 7.

>> Hello, this is Charles from area 6, Service Area 6 and I want to thank you, all, for having this meeting.

>> MICHAEL MOLINA: Thank you, Charles. Thank you very much. AT&T operator, next speaker, please.

>> AT&T OPERATOR: Once again if you have a public comment at this time, it is 1 and 0. And, sir, we have no one in line in queue.

>> MICHAEL MOLINA: Thank you very much and once again, anyone else wishing to be heard at this time? Seeing none, we're going to move to Commissioner comments and questions. Kalene, if you can come back to the table. I'm going to begin with Commissioner Schallert since I rudely interrupted him and then we're going down the table at that point. Do you have a question or clarification, Commissioner Dalglish?

>> [Off mic]

>> MICHAEL MOLINA: Thanks, Commissioner. Commissioner Schallert.

>> LAWRENCE SCHALLERT: What if I have 10?

>> MICHAEL MOLINA: Choose your top 2.

>> LAWRENCE SCHALLERT: That's a hard one. I have to -- maybe just --

>> MICHAEL MOLINA: That's a very good point if I can say for point of clarification. Our staff is available to you at any time during this deliberation time if the question comes up as you go through the binder and you find other questions or comments, I know Kalene and staff are ready. And willing to take our questions by phone, by email, et cetera, to assist you in the next month or so as we dive through this BSHA mounds of paperwork. That's a very good point you make, Commissioner. Go ahead.

>> LAWRENCE SCHALLERT: This is hard. Let me finish with the restorative care. We had a lot of questions about how to get into those just recently, I had several questions about how do we identify referral criteria and revival protocols for the restoration care and the crisis housing program? And it's just not clear and I would like some clarification about that. If we can get something clear, does it have to go through a navigator? Can anybody refer? There's a lot of questions in my area about how to get into these cool programs that nobody knows how to get into? Maybe you can answer that later. The other question, and among many is, I can't see anything about the tree program and I can't remember what the tree stands for. But what I remember about it is, you're going to get 0 to 5 mental health consultation that program and it's a preschool-based mental health consultation which in my experience, many years of experience that's one of the most powerful presentation program there is. And I haven't seen anything about that. I tried to find it in here but it doesn't mean it's not there because this is pretty thick. So we'll start with those two.

>> We have the experts here and Conchae can speak to prevention.

>> LAWRENCE SCHALLERT: Thank you.

>> Before services refer us to providers or facilities at restorative care villages, partly urgent care centers partly under DMH, there's no referral process. You can just step in.

>> LAWRENCE SCHALLERT: I understand that. Because urgent care on all of you is right there next to the new DMH strictly operational provision. And from urgent care, you can go across the other way.

>> If someone is not in urgent care and utilize crisis intervention, for example, because of community licensing, there's certain things required. Like chest x-ray or skin test for TB. That's required. But that's something that can be arranged at urgent care centers. Other than that, if somebody already has like TB test result, they can refer themselves to crisis residential. We have two ways to do that. You can go through our office or you can directly refer themselves, I mean, refer someone to crisis residential.

>> LAWRENCE SCHALLERT: Maybe we can get something in writing on that. And do you have something who can talk about 0 to 5 tree.

>> So the tree program is something we did with LAUSD where we walked with them on the youth center and to co-locate LAUSD social workers at the sites to provide supports to the caretakers and to work with families. And that program has now fully

been transitioned to LAUSD. And they're implementing it on their own using their own funding.

>> LAWRENCE SCHALLERT: Oh, that's good for LAUSD. But no other district, because that's a really powerful program. And from a commission point, I'm not talking for other Commissioners, but for myself, and my experience, 0 to 5 mental health consultation is one of the most powerful prevention programs there is anywhere. And there's lots of research around that from the Georgetown model so I don't know if we have any influence to try to make that a program countywide, but that would be my recommendation.

>> MICHAEL MOLINA: Thank you, Commissioner. Commissioner Roache.

>> Something to that effect, if you can speak to why that might be the case in your presentation, you alluded to maybe it being a tricky business to anticipate 2 or 3 years down the line. But just sort of know if you have greater insight into that number why.

>> THOMAS ROACHE: Secondly, one thing that sort of isn't addressed, and specifically I was looking forward in the innovation piece is this idea of partners accessing funds in a timely manner or reimbursed in a timely manner, and strong hung by bureaucracy and papers in general and if that's something under the microscope of innovation of work.

>> I'm sorry, can you elaborate on the second question?

>> THOMAS ROACHE: I can give you couple of examples. Last week I visited the people concern over the course of an hour or two conversations and two things came up. First was we do work, we have a partnership with DMH and it takes months to get the basically the money we're owed for some of the work we're doing. Second thing they brought up is the fact they will have clients that come in. And these folks desperately need psychiatric care. Sometimes they're losing 10, 15, sometimes 20% of clients that come in the door solely due to the facts these folks can't stand to fill out the amount of paperwork they're required to in order for the organization itself to seek reimbursement which is startling to me. To the point where people are concerned and now just using their general fund to pay for their own psychiatrist so that person who needs the care can get it right away. They're having to by-pass a bureaucracy that's been I am possessed on them. When we have system in place that is impeding care, that's problematic. I wish I had more specifics for you. I'm sure we can call them and have them speak. Maybe that's something down the line but those are things I hear more or less commonly insight visits I'm seeing. It could be wrong. I like to hear your feedback on that.

>> I can speak to your second question.

>> My name is Remi Hondal and chief deputy of the department. Sometimes we receive little or more information or maybe there's a line not filled out, it's not to add more to the bureaucracy, it's just the paperwork we are also required to submit and also

required to have on hand. And as far as the Medi-Cal paperwork and documentation, that's a statewide requirement in order for them to get or receive the payment. So that's not a DMH rule. Most of the time in order for Medi-Cal, it is a lot of paperwork. It's a lot. But I acknowledge that. But it's not a DMH rule for that.

>> I know I can speak to our quality assurance division that has been actually been working hard to minimize the burden on staff when it comes to things like assessment and some of the paperwork that is required. So recognizing it's challenging. I think there's a focus on trying to make at least what we have to do as easy as possible. It is a lot. And I also want to just comment that oftentimes, there's a balance between kind of that work and that bureaucracy and need for accountability and transparency and data collection and all the things we are being asked to do and some of the things we should be able to report on to show how we're going in our services. Some of these things are always going to be necessary if we want transparent and accountable system. Trying to find the best way to do that, and the least amount of burden is always going to be the challenge. But we don't stop trying.

>> MICHAEL MOLINA: Kalene, can you address the unspent question?

>> KALENE GILBERT: I wish there was a single answer that I can give for that. It is a large amount of funds. I will say, I will start with the volatility and planning and the need to plan many years in advance. So then we try to build a project. I think we find ourselves, I will admit we find ourselves becoming really conservative. Because we're not going to be getting so much dollars. And it's going to go down next year and it does it. And when you have a 3-year timeline on that, our CEO does not like one time ongoing program. So then you have to find really big things to spend dollars on in a short period of time and that is hard on the community as well. But there are a lot of other things. Bureaucracy is one of them and what it takes within the county it get funds out the door is a channel. And I personally always want to be so much more optimistic. Like we can do this. I know what the steps are and it's pretty easy to move forward. But there are so many steps, and it does come back to transparency, accountability. The county is responsible to be transparent about our budget and contracting process. So that's what starts to grind the gears down and make it hard to get those dollars out the door. I can speak more, but we want to acknowledge it's there. It shouldn't be there. One of the pieces of advocacy that we've had around BHSA is we want a longer timeline. 5-year timeline would allow us to give us the time to keep those funds and allow us little bit more flexibility to ensure we can keep a program ongoing, because it can take up to a year to get something launched.

>> MICHAEL MOLINA: Thank you.

>> That's the thing we can't start programming based on unspent fund as Kalene said because it's not fair to the community when we stop it, because now the funding is gone and it's become a one-time fund. Because we may or may not get it next year. And, again, it depends on the taxpayers. Certain years, we do better and certain years

we don't do so good and same for the millionaires. And it's based on that formula. Sometimes we have more money we could spend would show up in the unspent.

>> MICHAEL MOLINA: Thank you. Commissioner Holmes.

>> I think prevention and intervention has been one we turned around on because of restriction and population it's focused on. So the expansion and prevention has been a really, really big deal for us. But now, it's certainly not a good thing. We rather see dollars go out into the community but this is going to help us with the BSHSA transition. When we hit July 26, those dollars are component neutral. They don't stay CSS and this is going to help our outpatient system while we need to trend down and shift over to some of these new components and 30% housing piece.

>> [Off mic]

>> No, we've never reverted. We have always managed to spend the dollars down. We're kind of a year now and we have a year in advance funds. But we've not reverted to date.

>> MICHAEL MOLINA: We're going down the table. Commissioner Holmes.

>> ERIC HOLMES: I have two questions. I was looking at the number of participants served. And you might not have this information but I was wondering, given that it's almost 3 times as many adults served as TAY, I was wondering if you can disaggregate data and say how many are DCFS involved?

>> KALENE GILBERT: I think age wise, we can do that. I'm looking at my data person. That's something that might take us a minute. We'll see if we can gather that information. But we can breakout by age.

>> ERIC HOLMES: And just by reason for asking that is because if we're talking about prevention and early intervention, and we know the difficulty that those children involved in the system early, that they have, it just stands to reason a lot of those adults could have been caught earlier. So that was the first question I had.

>> MICHAEL MOLINA: You're requesting that report?

>> ERIC HOLMES: Yes, I'm requesting that report back. And then the second question I have, believe me, I know that, you know, you all are like driving the Titanic. And I applaud you for all the work that you do. The programs you oversee and the communities that you serve. But one question that I have that I often see is missing is a focus on supports, like family support for families dealing with adults with mental illness. And the example of the success story that was shown by the young man who was in the wheelchair and then he had a million dollars worth of services and then got him conserved and 90,000 and he's back with his family? I deal with a lot of adults that deal with mental illness and adult children, and it is so difficult for them to A, get information about how to help their children. And B, how to get supports for themselves to know how to deal with and handle and how to navigate this system. And I'm wonder are there truly robust programs that parents who have adult children or family members who are dealing with the adults, how they can get help for their loved ones?

>> KALENE GILBERT: I would start with partnership and support for NAMI. They're the largest organization. We have really robust NAMI organizations here that provide that support for parents.

>> I'm sorry. Can I just say one thing? I just want to say one thing because you brought up NAMI and I'm going to hush. For example, yesterday I was doing some research for a family. And NAMI has online support groups for caregivers. And none that are in L.A. They're virtual ones in Texas and Virginia and I was like how are there none that are occurring within the next 6 months? But they went from March until June. And there were then you in California at all. Even virtually. When I went on Texas you have to put in your zip code and the family here couldn't be in support group with NAMI. So there's none here. I'm very familiar with NAMI. So that's a problem.

>> KALENE GILBERT: There are in-person meetings. That's something I don't know about their full network online. That's something we can ask our partners.

>> ERIC HOLMES: They're not listed.

>> What NAMI specialize in is to help individual families navigate the system. It may be registered or listed under another name rather than just this. It could be that. We can look into it. And we work with NAMI very closely and we'll share the feedback and ask them if they have something listed differently.

>> KALENE GILBERT: Within the department, we have roles in each Service Area we call Service Area navigators. And their role is to identify to know their community and their community needs, and their providers in the community and to help individuals and family members navigate and find services. There should be a number of doorways in. But thank you for the comment. This is something we can take back.

>> MICHAEL MOLINA: Commissioner Friedman.

>> SUSAN FRIEDMAN: I'm wondering if you're satisfied with the number of stakeholders that participated? Your program is wonderful. It is complicated. It is beyond complicated than any other department and the county. And I realize all the hard work you're doing. But I am wondering if you're satisfied with the number of stakeholders. And secondly, when you find out that you do have this money left over, isn't that a perfect time to get out there and say to the community, hey, we have this. If you have ideas, we want to hear from you. I mean, figure out a certain way that's more manageable than that. But do something. Because there's every person I talk to and I talk to a lot of people. They never even heard of MHSA. They don't even know what it is. They haven't a clue. They never heard of being a stakeholder. And they would like to be.

>> KALENE GILBERT: Thank you for that comment. And I'll start by saying two years ago within our stakeholder process that's exactly what we did. What are the needs? We have these dollars. And we have these unspent dollars and what ideas do you have? And we have variety of recommendations that came forward which many

were implemented and that's something we can report back on and talk about particularly in the areas of prevention. Some, the larger ones take longer. So we've had a year and some are set to go out to bid. Like the expansion of family Resource Center is a good example of large expansion that came out of the stakeholder process with unspent dollars. And I think are we satisfied? We will always want to see increased participation from the community. And so I love seeing some of the numbers we're seeing with BSHSA and generating interest and doing things in person and online and expand accessibility. And Dr. Horn has started a program over the last year she calls beyond the walls. And she and her team members are going out to community settings like libraries just to find a community member we don't usually reach and talk about mental health and talk about the stakeholder process and invite people in. So the team is really trying to find other ways to engage and bring people in and continue to advertise our process. It's hard to reach folks across L.A. County. I think we have some of our stakeholders take action events coming and that's an opportunity to in veto people in. So I would say, this is something we're passionate about.

>> Certainly we're passionate about this and we also talked about having meetings at different times of the day. So individuals that work at this time who cannot make it here can come to evening meetings and we also talk about taking the show on the road, not just libraries and community centers and things like that to expand our reach to stakeholders. Because we do want to hear from them. And we also like to request you also to help us with that and spread the word when there's stakeholder meeting to get more participation. We exist because of this participation because of the stakeholders. And we want to continue to engage and have more numbers, more people come to these meetings.

>> MICHAEL MOLINA: Thank you. Commissioner Weissman.

>> Thank you. I have a request for presentation follow-up.

>> BRITTNEY WEISSMAN: Because I understand unspent dollars are humongous this time around but not uncommon for DMH to carry a balance. So my request is, as we look to BSHA, if we can work with the finance team because it's not just start up that delays, the payment and the spend down. It's really like longer term contracts. Budget to actual and managing that more tightly will give us better perspective on how much is unspent much earlier in the case than end of the year. And we would love to understand that more thoroughly.

>> KALENE GILBERT: Thank you. We agree. This is first time we have come with an adjustment to those bungles to actual to try to do exactly that.

>> MICHAEL MOLINA: Let's make a report back at a future meeting so we have a better understanding. The question comes up every year. So let's figure it out.

>> We'll invite them midyear to do a presentation as to where we are and what the projections before and where we end up in the next six months.

>> BRITTNEY WEISSMAN: And how we can look at that time respectively for BSHA. There's so much more that could be done if we had earlier notice about ideas, spend down and plan and all of that. Thank you. And the other question goes to Conchi. The question on early intervention spreadsheet with the percent of completion. Some of these EVP has not completed up to 50%. If someone, if folks don't complete the EVP, fewer than 50% of people complete the EVP, how useful is the EVP? I'm on 130-131. If going forward, I know this is really wonky and technical and you don't have to Tracy it right now. But it just seems to me the point of EVP is 100% completion and we're maintaining program with less than 50% completion rate. I wonder if that is to our collective benefit? I'm sorry.

>> Sorry.

>> BRITTNEY WEISSMAN: Forgive me.

>> There's different practices and different reasons for common completion. So depending on the practice, so I'll give you an overarching.

>> BRITTNEY WEISSMAN: Like peer. What happened there? It was such a big push and it's on the bottom. And in alpha order.

>> With 17%. So Dr. Kara is our guru in the department but I can give you an overarching idea. When clinicians determine completion, so sometimes clients will end treatment on their own. And that may be considered a dropout rate. So the 17% may not be reflective of the treatment. In the system, they went through the entire course of treatment. So that's part of what that number can stand for. So it looks very low. I think for peer specifically, we have a psychologist that oversees the program and implementation and first break work, I know the county is also working now with the state as we're moving through BSHA, really implementing some changes to our first baked programming. I think we probably would work to address some of that and how do we do engagement and specifically with first break clients, there's a ton of engagement with the families, their caregivers. It's not just a client individually. So I can kind of give you that framework but we can probably get more information back to you.

>> BRITTNEY WEISSMAN: That's helpful. Rather like an investment. If we're spending staff time and investing in these programs and so few completions, is that really worthwhile? It sound like more of a conversation for later. Thank you so much.

>> MICHAEL MOLINA: Thank you. Commissioner Manalo.

>> I had one question for Aubrey.

>> VICTOR MANALO: Congratulations on that increasing the numbers of home teams. Is that enough to cover L.A. County? It seems like it's -- I mean, it's great to have that number. But is the intent and I saw there was also some challenges for in terms of hiring staff and things like that. But is the intent to raise a number of home teams in the future?

>> I don't believe so. So I think sort of our vision and the way we work within the -- so whole outreach system and we partner with LAS A&M VT and clients get acclimated to us and we serve the small population and our hope is that the other teams within the department the SP teams and act can serve the bigger chunk of those people. Right now, home is fully staffed. And home doesn't have hiring issues. Thankfully. We're happy with that. I think the challenge is put through sometimes for people, we hold on to people for quite a while. Because as we build things out, there's challenges around placement, around appropriate placements and things like that. Most of our clients can't go into traditional sites and working diligently to get people online, single room and occupancy site. More robust services. And as we're continuing to build out the resources, we will be able to move more clients through. But I don't think we need more boots on the ground. The teams carry good caseloads. Nobody is carrying like a waitlist per se. So as we expanded, we doubled. I think what we manage is good. I think if we get bigger, we lose the ability to do the thing we do and the way we do them.

>> VICTOR MANALO: Where do the referrals come from that go to the home team? Is it just from county department?

>> We get referrals from everybody. Community members. Other outreach teams. Law enforcement partners. Offices. Anybody can send a referral our way. We don't take referrals from hospital or jails. Because those aren't people we -- we need to know where the person is. If they're being discharged at a hospital with no sense to go, but we take referrals from everyone.

>> VICTOR MANALO: Thank you. Appreciate that. And the other question I had was in relation to the stakeholders as mentioned by Commissioner earlier that when I looked at the government agencies that are involved as stakeholders, they're mostly county agencies. Correct? And I come from a very specific perspective here because I was a Councilmember in one of the Los Angeles counties. And city is struggling specifically with homelessness. And it's not because, it's really a little complicated. But a lot of it has to do with people recognizing, people living in their cities are recognizing now that there are unhoused people living in their neighborhoods. They're in the parks or wherever they're going. And they're not -- they may call the Sheriff's department, but they're going to call City Hall first. So cities are getting pressure about doing something. And so for me to sit here and hear about all the great work that's being done, and that I know my colleagues, former colleagues in cities throughout L.A. are just up to here because they're getting pressure from their constituents about why isn't anyone doing anything about the unhoused people in our neighborhoods? So I'm suggesting and I would love to help, as Chairman suggested, to connect some City Council folks with you. There are counsels of government and Artesia we're and prop A money and they're trying to navigate. But I would love to see them get engaged as stakeholder in this.

>> Certainly. That's a great idea. I work with Gilbert from Gateway city and he's in charge of the homeless initiative and we'll invite him more often to come to our meetings. Others as well. Let us know and we love to invite them.

>> MICHAEL MOLINA: Thank you. Commissioner Austria.

>> KATHLEEN AUSTRIA: Why are the unspent so high and it appears service participants overall to me appear low overall for MHSA. There's a lot of really good quality programs out there. You know, seems like there's great staff. Great programs. And low participation as a whole. But as a whole, like FSP. That's a low amount of people who live in the county. Why is FSP so low? And I'm wondering if that's correlated? Not spending enough funds and perhaps knowledge of the programs? Why? Why around we having more participation in our programs? And not just that one, but this is an overall question and that was an example.

>> I don't know overall, we'll look into this.

>> 12,000 out of, you know, 10 million?

>> Certainly.

>> KATHLEEN AUSTRIA: As I look through here, it seems to me that out of 10 million residents in L.A., there's a lot more need than we're touching. And we need to identify that. I mean, we have outreach and engagement. People are working hard. I just can't fathom why. And here's a hearing we had, zero written public comment? That should not be. Why are there little comments in the room? I'm just very concerned about that. And also in the past, because you do have so much information to provide to the community and to us. We should be doing this as really a whole day where we used to do it as a whole day or 4 to 5 hours. I guess do a better job with outreach. And I will take responsibility on my part, although I citizen it out.

>> We will look into that. Thank you.

>> MICHAEL MOLINA: Commissioner Stevens.

>> REBA STEVENS: Thank you very much for this presentation today. I'm going to work really hard not to be too critical. Because I really do appreciate the information and what you shared. But there so many ways I believe not only for myself, but for the public to really be able to narrow down where you're going and what you're talking about. So I want to start with some of the DMH staff that identify our unhoused neighborhood as homeless and the homeless. And I think we should start looking at language and how we're identifying people. Right now, the County of Los Angeles has this huge crisis. And I think that we could do better by identifying folks who are unhoused as unhoused individuals.

That's one. The other is around the community of planning process. And so this is a lot of good information and I attend those meetings. And I'm still questioning the ability to get folks to actually participate heavily. There was a time years ago when there was interest and we had a lot of people that showed up. I think that we can improve in that area. But I believe people are hurting and right now we have this crisis.

And there's no reason to have unspent dollars at any rate. The County of Los Angeles right now is looking under rocks for money. And we are sitting and siloing and having all these unspent dollars when there's a great need in our community.

But around the capital facilities, one of the questions I have are legal entities eligible to apply for funding for capital facilities and technology?

>> It's supposed to be for county buildings only.

>> REBA STEVENS: That right there we have to start looking at. I'm looking through a different lens. So we rely upon who provides the majority of the services that are being provided. They happen to be from the people you are contracting with. And so I believe that's a barrier. And it's an unfair process it seems to me. That doesn't seem very equitable. The other is around, and I mention the change of language. Early intervention. You know, there is so much housing that is needed right now. And so I believe there was one slide where you were mainly talking about Altadena, not Altadena but Antelope Valley. But what I didn't hear was all of the wonderful services that you're providing, I have to believe there are people there also knocking on those doors or entering those spaces that are in need of housing. And so I would like to know how are you providing that service? The other is when providing the data and the numbers, it would be very helpful to use the general population numbers first, which actually allows us to see when you're talking about percentages. Because Black people are 7.7% of the population. If we're 10% and Latino is 10%, it's not balancing. So I think its needs to be clear so we remember to remember there's a disproportionate number in the number. Surveys administer, that's terrible when you look at the county and unmet needs. We don't do enough around collecting that data or around unmet needs. And then the last thing I would say is around our stakeholder groups, DMH, USCCs, Service Area groups. And one of the requirements and this came from your office, Kalene, the by-laws or stakeholder groups and the requirements is to come to this commission meeting. And present and give us updates. There's a disconnect there which challenges me to believe any of the data you're writing in reference as stakeholders, particularly, like with the CPT, because it's not actually working in the way in which it's written. So where is the accountability and last, last, last thing, Chair. I promise.

>> MICHAEL MOLINA: I always expect the last.

>> REBA STEVENS: It's around recommendation around the unspent dollars. I think we should also be thinking about our county, Board of Supervisors and their agendas that we either divide those dollars by 5. I would prefer the first thing my recommendation would be we are funding maybe one time spending fund legal entities or fees for services. I'm curious how Cal aims is working and if that's the why those dollars are not spent and understanding where the dollars are coming from? What dollar is unspent? We need to be clear about that. And I want to remind us as we're talking about a stakeholder process, that even in our Service Area groups, you make it too difficult for people to spend those community dollars. So when we have 60 in SPA

6, there's over \$60,000. That's going to go back to you and it's unfair to the community when you're saying we want to get the word out. And when you think about the low number of those surveys. But I can go on and on and I have whole lot of things I can say. But I think we should be considering funding our community CBOs with this unspent dollars.

>> MICHAEL MOLINA: Thank you, Commissioner. Thank you very much. Do you have any more questions?

>> I gave my time to Reba.

>> TYLER CASH: I'm Tyler Cash. And I'm the new supervisor so it's nice to meet all of you and see a lot of faces. Prior to this work, I doing the role of deputy and homeless services. And I understand that system and that sector very well and of course the strong correlation agency to mental health. Kalene, I appreciate the presentation today especially the part of prevention. I know there's going to be probably a lot more conversations at the county level between the prevention programs you guys have and the prevention programs La Casa and the new homeless department. I don't have any additional questions. I just want to reiterate what Commissioner Victor said and engaging the cities. Some. Work I did was making sure all our cities were engaged with stakeholders. It's by far been my experience the number one issue you see, wherever you see communities and councils bring up. So it's would be very prudent to be part of the conversation and aware and educated on what's going on here. On that note, I will make a recommendation. Supervisor is Chair of the ECHA. Region committee of homeless environment. And it includes membership from the industries. And they have brought up comments about MHSA and it would be a wonderful opportunity for you to connect with them and I'll reach out to them to facilitate that. And measure 8 stuff and pass all that, they're working on developing the standardization of care. And of course, we want to make sure mental health components are baked into that. So that's all I'll say. Thank you.

>> MICHAEL MOLINA: Thank you, Tyler. Welcome board and it's great to have you on this commission. Colleagues, where do we go from here? As you know, we have complied with and concluded the required public hearing and discussion relative to the BSHA. Our next job is to draft a letter that companies this document to the Board of Supervisors, particularly, describing some of the questions and concerns that has been articulated very well this afternoon. I wrote down number of things that came up repeatedly like the unspent balance. I think it would make sense and I would recommend and encourage you and urge you, colleagues, if there is or are issues or concerns that you would like addressed in this letter, that you send to Kenia within the next week within the next week here are the issues I want to see in the letter and describe that issues so that we can compile that list and Executive Committee gets a chance to take a look at it.

>> KENIA FUENTES: I'm sorry, someone has their mic on and you're coming through our meeting. I think it's one of our interpreters.

>> MICHAEL MOLINA: All right. So Commissioners, if you don't mind, if there is an issue or there are issues you like to see in the letter we send to the Board of Supervisors, that companions this document, please send that information by email to Kenia in the next week. We will compile it and start working on the draft letter that will be forwarded to all of you for review before we meet again in May. So that's our homework, Commissioners, if that's all right. I don't see any objections. So we'll move forward with that. Are you talking to me? Oh, Commissioner Dalglish, do you have something to say? We don't want to lose the opportunity for you to make comments. I'm sorry. Wonderful. She submitted comments in writing to Kalene directly. Terrific. With that being the order asking all Commissioners to please send your comments to Kenia within the next week. We will officially close the annual report and the public comments, and that takes care of the items on the agenda. Just two quick announcements, Commissioners. I first want to thank all those who participated in last Friday's CARE Court Town Hall that was conducted by this commission. Folks, the meeting is still going on.

Meeting is still going on, please. I like to thank all the people who participated in the CARE Court Town Hall last Friday evening. We had over 70 people participate. In particular, Commissioner Weissman who joined me in person. Commissioner Manalo and others who joined us virtually. It was an eye-opening meeting and difficult meeting and a lot of reflections were given and we were putting together a report that will be sent to the Board of Supervisors on the findings and recommendations made at that meeting. Thanks to Kenia, Crystal, and Alison and staff. We saw a whole new group of faces so it was really, really good. Secondly, I know that we have talked about reuniting in August for a new retreat. We wanted to look at a date and a date has been identified, Kenia, can you remind us of the date again?

>> KENIA FUENTES: It will be August 13. That's a Wednesday at the endowment.

>> MICHAEL MOLINA: I know Commissioner Friedman has shared her concern. So Kenia, can I ask you to go ahead and formally poll the commission to see if August 13 is a good day for everyone? I think we went ahead and chose a date without asking the commission. Oh, we did ask.

>> KENIA FUENTES: I will send a survey out.

>> MICHAEL MOLINA: Good. All right. Commissioner Weissman and Commissioner Stevens.

>> Just to let you know the Executive Committee considered unspent balance in our Town Hall line item for the behavioral commission budget and are working to create a Town Hall from the Town Hall line item. On BSHA with SAPC and MHSA staff from the department. So that will happen between now and the end of June. And Kenia is

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our point person for logistics. Point of that is to raise awareness for future beneficiary is that process.

>> MICHAEL MOLINA: Terrific. Thank you.

>> REBA STEVENS: I just want to remind us while we move this meeting to the second week, that it is still a barrier for our Service Area 2. And I just got to give a shout-out to Barbara Wilson who is one of the best advocates I know who's unable to attend this meeting as a result of how it's changed. In addition, we should really look at the calendar and find a space that's empty and then work to fill it in.

>> MICHAEL MOLINA: Thank you. Commissioner Friedman.

>> SUSAN FRIEDMAN: I like to second that because the month makes it impossible for me because I also serve on the state board and that's exactly when their meetings are. So as a commissioner, I have to miss half the meeting and I can't be at the two places at the same time.

>> MICHAEL MOLINA: Thank you very much. Any other announcements? Seeing none. We will adjourn at 1:54. Thank you.

>> KENIA FUENTES: Thank you to all our services. We appreciate your patience. We'll see you in couple of weeks.

[Meeting is adjourned]