Non-verbatim Transcript
Behavioral Health Commission (BHC) Regular Meeting
12:15 p.m.
June 12, 2025
PART 2

I am trying to confirm. I am seven votes for commissioner Chair Molina and 4 for Dagleesh. It is majority. We are good. Chair Molina, you are our new chair.

>> You get to do this three other times. Let us keep it going. Congrats. You are now the chair elect. For the office of first vice chair, we have two names on our slate. Commissioner Weissman.

>> Declines.

>> Member Stevens.

MEMBER STEVENS: Respectfully declines.

>> Is anyone willing to serve as first vice chair of this commission?

>> I would like to nominate Stacey Dagleesh?

>> Do you accept?

>> She accepts.

>> All right. We will do this appropriately. Do you accept the nomination as first vice chair?

>> Okay. Yes.

>> Commissioner accepts the nomination as first vis chair. Is there anyone willing to is serve as first vice chair or anyone wishing to nominate anyone for first vice chair? Seeing none, commissioner Dagleesh is the only nominee. Please state the name of your nominee.

>> Commissioner Friedman.

>> (Inaudible).

>> Root. Dagleesh.

>> Dagleesh

>> Holmes. Dagleesh.

>> Abstain.

>> Rodge. Dagleesh.

>> Tyler. You have a unanimous decision.

>> I skipped you now. Thank you. Anonymous. You have your first vice chair.

>> Congrats. First vice chair. Thank you for saying yes. For the position of second vice chair, we have two names on the list. Manalo has previously been elected. We will scratch the name. The second is commissioner Rodge. Do you accept?

>> Respectfully decline.

>> Respectfully declines the seat of second vice chair. We have no one on the list for second vice chair. Members, we will take nominations right now. Is there anyone else willing to serve in the position of second vice chair or willing to nominate someone for that position.

>> I nominate Member Stevens.

>> Are you willing to take on this position?

MEMBER STEVENS: Okay. Yes.

>> Anyone else, thank you, I will recognize that you have now accepted the nomination for second vice chair. Is there anyone else willing to serve as second vice chair or willing to nominate someone for that position? Seeing none, we will close the nominations for second vice chair. Can you please call the roll. Members state the name of your nominee.

>> Friedman.

>> Root.

>> Member Stevens.

>> Member Stevens.

>> Member Stevens.

>> Holmes.

>> Member Stevens.

>> Member Stevens.

>> Chair, you have a unanimous decision.

>> Congrats. That is fantastic. The next position, we have two members at large. They sit as officers on the executive committee. One has been nominated to serve at large. Commissioner Friedman. Do you accept the nomination as a member at large? Thank you. Yes. We still have one additional seat remaining as a member at large. Is there anyone in the room, anyone willing to serve in the position of member at large or any commissioner willing to nominate someone to serve.

>> Yep.

>> Member Stevens.

MEMBER STEVENS: Larry Shalert. It is the 5th district. We need a 5th district representative.

>> Thank you. Shalert, are you willing to take on the position?

>> I totally understand where you are coming from, but I respectfully decline. Very sorry.

>> Declines.

>> That doesn't work.

>> Any other nominations or someone willing to nominate him or herself?

>> I will nominate commissioner Holmes.

>>Are you willing to take on the nomination?

>> I need to respectfully decline.

>> Is anyone else willing to serve as member at large? Someone willing to nominate someone to serve on the committee as a member at large? Commissioner Dagleesh .

>> In pursuit of having a representative from district five, I nominate Weissman.

>> You have been nominated. Do you accept or do you decline?

>> Question for staff, what are the attendance requirements?

>> The same for the executive committee. Once a month.

>> Per year? 11 meetings. What is passing rate?

>> You can miss three. You would be doing 18 meetings like you have for the past.

>> I accept.

>> Thank you.

>> I go by many names.

>> We will take a roll call for each of the names. Is there anyone else wishing to serve as a member at large? I don't think anyone is left. We will close the nomination. We have two names on the tally. We will take both names separately.

>> Since there are two seats.

>> Seat number one. Can you call the roll? Members, please say the name of the person you are nominating or voting for when your name is called. First is Freidman. Voting for yourself.

>> Root. (Inaudible).

>> Holmes.

>> Freidman.

>> Agreed.

>> Rodge.

>> (Inaudible).

>> Tyler.

>> You have a unanimous decision.

>> Let us take the roll for the second member. Weissman. Please indicate your selected name when your name is called.

>> Friedman.

>>Weissman.

>> Root.

>> Weissman

>> Manalo.

>> Weissman.

>> Chair Molina.

>> Weissman.

MEMBER STEVENS: Weissman.

>> Shalvert.

>> Weissman.

>> Commissioner Weissman.

>> Weissman.

>> Rodge.

>> Weissman. You have a unanimous decision.

>> Thank you. Congrats. Lastly, to wrap up this election, can you read the position name and the new offer elected for each position please.

>> For chair, Manalo. First vice chair, Dagleesh. Second, Member Stevens. Second member at large, Weissman.

>> Congrats to our new returning officers.

>> While the chair takes a minute, I thank you for sharing this commission steadfastly for two years through a lot of change and staff changes, funding changes, BHSA change. We have been attending and making progress bit by bit. It is because of your care and facilitation. Thank you on behalf of us all.

>> It has been a tremendous two years. I thank you all for your collaboration and closeness. Kudos to our staff [Reading] who was here when I started. A great labor of love. Particular shout out to the staff who made this job simple despite obstacles.

Let us go back to the consent agenda. We pulled A and C off. Approval of the minutes was pulled by commissioner Dagleesh.

>> Thank you. I saw at the last meeting that yoU asked for a calf report. I didn't see it in the notations I wondered if we will get there. If not, when? If it is happening, and you have received it, I wanted it to be added to the minutes.

The other was if you could give me rules on when one is considered present versus absent. It appears if you have an excused absence, you are moved into in attendance as the definition.

>> The answer to your question, we have not received a report. We hope that is part of the July meeting. The second question, I don't know. We take roll call at the start. The question is if a commissioner is excused absence, how is she, how are we marked on the minutes relative to that excused absence?

>> It doesn't exist anymore. They used to have that option. There is only in attendance or absence.

>> If you have an excused, you are in attendance. From reading the transcript, it looks like there were excused absences. Now, they show up under in attendance. I am curious why that happens.

>> I am not sure what you mean by the excused absence that is now shown in attendance.

>> Isn't that what I see here? If I am wrong, I beg forgiveness.

>> I just want to understand your question.

>> It appeared to me.

>> You mean absence you notified the chair you would be.

>> I thought if you could give me a quick answer, that would be great.

>> I just need clarification for an excused absence.

>> We will talk about it after.

>> Good question. We fall on that. If I look at the minutes, there is a list of commissioners in attendance and absence. If you have an excused, do you still fall under the absent list or is there another category where it should be recognized?

>> I will get clarification. So I can have a different way of putting it on the minutes. I don't want to misspeak. I understand what you are asking.

>> Thank you very much.

>> On the minutes?

MEMBER STEVENS: If I am not mistaken, I heard there was a change. That makes me question how are we informed when changes happen? I would like to suggest that as their change, we are immediately informed of those changes. So we will all be on the same page after the same time.

>> Good point.

>> I just found this out a few weeks ago when they requested a report from us to the board. They contacted me. I asked that same question. The column had disappeared. When we submit attendance, that is no longer an option. I will make sure that is related.

>> I would respectfully respect that I be moved from absence to in attendance as I did notify you I was not going to be here.

>> Why don't we hold the minutes until next month. They can be approved next month. Commissioner Root.

>> I was here May 9th. I would like to be moved to in attendance.

>> We will make the correction and bring them back in July with the answer to the excused absence question. Very good question. Anything else on minutes?

>> The 5th district was not present. They are not mentioned.

>> Let us clear that up. Anything else relative to the minutes for the May meeting. We will hold them until next month. I took them off for two questions. I think Katherine is here. If you can come forward. Someone. Thank you. Elon, I see you. Both your presentations were excellent. I was captivated by the first section specifically. President trump's great big beautiful bill. It has been approved by the house. Can you give this commission a summary of how that bill affects us here in the county, our departments. Your section started with the May revise. How does the May revise of next year's budget in the state of California affect our departments and commission?

>> Hi. I am Michelle. Deputy director. The areas we are tracking in particular and similar on the side of the department of mental health is in relation to the Medicaid proposed funding cut Us. We are at $624 billion cut over a ten-year period. Some areas they are considering as part of the Medicaid updates are related to imposing a $35, up to 35 copay for adults in the expansion population with incomes over 100 percent of the federal poverty level. This is an exception for substance use disorder services.

I understand it is the same for mental health. This is a critical component to have this remain by the nature of our services. Individuals go to outpatient services. Often daily. It would be extremely prohibited. At least on this element, pleased to see it is exempting the mental health population but will impact other services for the Medicaid population.

We expect California to have a ten percent reduction. The match we get from the federal government to support the cost of services. The state supported Medicaid enrollment for individuals that are undocumented.

Also, in addition, they are considering a work requirement as well for those on Medicaid of 80 hours per month. Individuals with substance use disorders are exempted from this. Their ability to participate in these services is important. They are able to attend daily. Impact to the broader Medicaid population. That could impede an individual even though they are income eligible. The determinations for the expansion population are available after. It would increase from every 12 months to every six months.

You truncate the amount of time an individual has to maintain on their benefits, that will be a challenge. They will have to redetermine every six months. We will have to ensure they are able to comply. Substance use treatment side. We have a care coordination benefit. It is a workload to impact the Medicaid population.

Lastly, in relation to this question, retroactive Medicaid coverage will decrease from 90 to 30 days. That is the coverage period when individuals are enrolling in Medi-Cal. A lot will rely on that ability to have time to enroll individuals and not delay their treatment as a result. A lot in the bill. Impact on the populations that are highly concerning.

>> Let us do Elon's report.

>> Would you like me to speak to the President's budget or the May revise?

>> The May revise. The California budget. It is important for us to spend a few minutes talking about it. We see the governor attempting to resolve a deficit of $12 billion through a variety of mechanisms. Some pop up in state budgets. Internal borrowing. We are seeing some from MHSA money. We don't expect cuts to the funding in the budget.

We see proposals in the May revise to reduce coverage for undocumented. The new term is those with UISs. Unsatisfactory immigration status. We are seeing an enrollment freeze. If you are not on Medi-Cal by a certain date, you will no longer be able to enroll in Medi-Cal in the future. As was mentioned, California has a state funded Medi-Cal program for those undocumented. It is entirely state funded. This will limit enrollment opportunities in the future. For adults 19 and older.

There is some estimated fund savings up to over 3 billion in a few years. We expect it will result in the LOS of coverage for thousands of people. We expect it to result in the loss of coverage for tens or thousands.

We expect of loss of thousands that will lose coverage. Medi-Cal premiums for adults 19 and older with UISs. The governor is proposed monthly premiums of $100. His argument is that is essentially what people who are receiving coverage under covered California plans are currently paying. He is suggesting that this population should pay a similar monthly premium. This is expected to save $2 billion over a few years. We expect loss of coverage.

The third is not restricted just to the undocumented. It is impacting the reinstatement of Medi-Cal asset test limits. The threshold is very low. $2,000 for an individual. 3000 for a couple. That is going to result in savings of $800 million on going. That includes the IHHS impacts. We think this will result in a loss of access and coverage. There are other issues we are concerned with. These three represent intentional attempts are most concerned for DMH.

>> Just to add, I think Michelle did a comprehensive overview. In the federal HHS budget proposal, they did propose to consolidate the mental health block grant as well as to reduce the budget by $467 million. That would represent a situation where not only will we need to sort through how those allocations are made, but there is a cut. The changes that were highlighted in terms of copays and work requirements and mental health and substance use populations being exempt, I think it will have implications from a communications perspective.

When people read about these, it is hard to separate that they are exempt. That is something as system we are mindful of. The eligibility redetermination, those sound like administrative bureaucratic processes

>> Questions or comments?

>> Can you comment on the expected consequences of the loss of coverage? Does this increase visits to ER rooms? What will be the social consequence of this loss of coverage?

>> Those pieces are components. As they lose coverage in the undocumented and requirements change, we will probable hi see less individuals seeking services. Less completing treatment services. It will have a spillover effect. As a likely possibility as well.

>> The commission, given the advocacy about the good work that nonprofits and community-based organizations do have a sense. When people need mental health services, don't access it, there are physical health consequences. Jobs, school, grades, trauma. Those are all downstream impacts.

>> I would like to add one more point. In addition to what was mentioned. Even though we believe that some of these specialty mental health populations will be exempt from certain requirements, we are still concerned that clients who are not yet at the level of requiring specialty mental health services, they will still lose access. We won't be able to provide them with the care they need when they are at a lower level. It may progress. We will only catch them in the ERs. When they have a break.

It is not directly impacting our current population. We are concerned it will reduce opportunities for lower acuity populations.

>> In terms of the asset requirements, I understood that a person's primary residence was not ever included in that asset. Am I wrong? Is that still in place?

>> I don't know. I have reached out to DPSS to better understand both the value of a personal residence and cars. I don't know if that is being changed or if there is some limit I thought I saw a residence under one million would not be captured. I am not sure if that is the case. I will have to ask DPSS or another colleague to respond to that question.

>> Thank you. In terms of real estate value, the question for me becomes, does it trigger it at a million, or is there a ratio change that happens on anything over a million?

>> I don't know if there are specific calculators that takes into consideration the local home market. A million dollars here in California is different than Arkansas. I don't know.

>> The consolidation and reduced match, I am thinking of the impact on the budget side of the house and revenue to the county for services. How they will work on managing the degree in revenue and administration between the two departments.

>> That is something we are on the DPH side taking a look at. There are certainly concerns about the reduction in the federal match. The impact of what a consolidation of the block grants that had been separate would be. How those decisions are made at the state level to determine between how the state funds mental health versus substance abuse. Some pieces are up in the air. Changes to the allocation would be impactful.

Looking at the match related reductions. Implications at this point. We are hoping that it is not a significant impact on the ability to deliver services. If that stays, we are hoping that we will be in a reasonable spot. Those are the concerns on our side right now.

>> This is why I wanted to pull the item. They are both so well written and caused so many red flags. I would recommend by September, both departments come back with the report. If the big beautiful big passes. Give it a couple months and come back to let us know what that means. Your question is spot on.

We thought prop one was huge. This could dwarf it. It huge.

>> I want to thank you both for this information. There is a couple things. California is not quite liked right now. Daggers are tossed. The other is around this lame duck governor that we have. Also some concern I am deeply concerned about the Medi-Cal piece. I am concerned about people being able to utilize services. We have to get in front of it. Everyone needs to be telling someone about what they need to do. People don't often know. We can't rely on this space. It has to go outside of this space broadly.

I think we need to do more in that area. My question in the last statement I would ask is I know that that is in the near future with the governor terming out. We don't know whether we will get someone who supports the big beautiful bill or even if it passes, we still may have that dagger. I am curious. As to whether we are preparing for this potential future.

>> Thank you for the question. Let me get to the question and share our preliminary estimates. A ten percent would come out to a loss of $45 million annually. In revenue for DMH right now.

It is not clear how the department will handle that. In fact, it is not clear it is the county's financial responsibility to back fill that loss of F map rev view. It was the state's decision to expand Medicaid. There is a chance that there is a legal argument to be made that it is the state's responsibility to keep counties whole for this loss of F map.

This has not been fully investigated. The bill has not passed. That is one of the things DML would do. Is in really the county's responsibility or the state's. We would look at other available funding sources. Realignment RV view. I don't have much more information. Our rev view calculations are still shifting almost daily as we get guidance from the state on how it could be used. Still a lot of questions. We have to see what passes in the state and DC. I hope I answered it fully.

>> We have a robust agenda. Let us approve the consent agenda and ask the executive committee to agendize this. It is hard to say the big beautiful bill. The state budget. Let us go. I heard a motion to approve.

>> Thank you. A second. It is all a little unsettling. We will have approved consent Item 4C. Thanks to both of you. I hope we see you in the next few months. Turning the page, Item 7, AOT impact report will continue for a month. That is near and dear to her heart. It will be moved to July. We have three standing item presentations from the DMH director. Karen will present on juvenile justice. Our monthly report. And our update. We will go to those three presentations with our deputy director. Karen. Welcome.

>> Good afternoon. Thank you for the chance to write a little bit of information about our juvenile justice programs. I am the deputy director of the forensics psychiatry division. There is a brief overview. I will describe what facilities are currently open and a little about upcoming changes. There is currently one juvenile hall in LA County. That is where all predisposition youth are housed. There are three probation camps. Youth who are post disposition. Given a disposition of camp.

Those are in La Verne and San Dimas. There is the Dorothy Center for male and female. It holds the camp FE mall population and secure youth treatment facility. In July of 2021, the state realigned back to the country’s department of juvenile justice.

Kirby has female youth. The others are up in Sylmar and campus Kilpatrick in Malibu. The newest of the probation facilities. I wanted to talk about the depopulation plan. May 16th it was ordered to lower the population at Los Padrinos. It holds 300 youth. That plan will lower it down by 100 youth and send them to the other facilities within the system that are currently open. This doesn't involve opening any closed facilities.

To make a point, probation had one point had 19 camps and three halls and the center. This plan is actually aligning special population to certain facilities. Female population and

secure youth treatment, the plan is for them to be moved to the campus Kilpatrick in Malibu. This is all what is planned. Not necessarily will happen yet. The board of state and community corrections will need to approve facilities for holding predisposition youth. That would include Kilpatrick and kirby. To get ton next slide to talk about the department of mental health, we have been in the facilities for O over 25 years, if not more. Our staff are there seven days a week, 12 hours a day. All services are delivered on site and in person. We collaborate with the probation department. Sapc and the new department of youth development and LA County office of education. Our clinical staff is in all the living units. The staff is on site. There is a 24-hour on call that responds to any emergencies overnight. To look at what we do there, identifying the youth coming in. We have a comprehensive front end assessment.

Every youth is assessed by a mental health professional. We assess for trafficking to see if they are involved in trafficking so it can be addressed. Youth at any point can put request for service in a box in their unit. They are checked seven days a week.

At this point in time, we are treating 100 percent of the population. When I described the population shrinking the youth that remain there have high need complex needs. We are treating a large percent of the population.

Every year we look at who is this these facilities. This is for 2024. Many of the youth have substance and mental health diagnoses. 52 percent are the primary associated with trauma or stress. This is growing. A smaller number may have conduct disorder, impulse control, ADHD, or anxiety. It is very telling. It contributes to the services we need to provide. Next slide I want to touch briefly. We wanted to make sure that as the youth transition out of the facilities that they are not lost to care. The juvenile justice transition outpatient treatment services, the youth lead with an appointment. Our psychiatrists go to those programs and follow up to make sure there is no lapse in medication. This has existed since 2017.

The juvenile mental health court. Youth are placed on medication. If it is not done by a witness telephonic consent, it goes to the court. These are reviewed by staff to make sure medications are appropriate. There is a population of youth that have both DCFS and probation involvement. For that group, the juvenile mental health court provides assessments and evaluations. They participate in multidisciplinary teams. Competency training for youth. That is a brief overview. Thank you for the opportunity.

>> Thank you. I learned a lot. They are serving 100 percent of the residents. Questions? Comments?

>> I have a few questions. Curious about when we say that the DMH is serving, is it directly department of mental health or with our legal entities? Scene of the accident directly.

>> Thank you. I would be interested in knowing where these young people had resided prior to being in trouble. What communities are they being exited to. I would like to see the service area districts and perhaps some of the zip codes of some underserved communities. I think that would be helpful to compliment. I did hear you compliment Mr. Franklin.

>> That information is available.

>> Thank you for being here. You presented a very positive picture about what is going on. I hope what you U presented is what is going on now. I personally visited a year ago. Several things I noticed. The probation counselors, they are not treating these people like they have men that will health disorders. I observed one kid that was autistic. He needed this towel. That is what kept him calm. They yanked it away from him. Another place had a psychiatrist once a week. All the help there they were dealing with were all interns. None were people. All fulfilling their hours they needed for an internship. None were established therapists. I don't know if that is true or a negative. No one supervising these interns.

>> I can't speak to the probation department.

>> Are we working on?

>> We have provided mental health training in depth. We have a robust staff that are child and adolescent certified. They are checking in on a frequent basis. I believe the care is high quality. I would say that. We have a mix of licensed and unlicensed staff. They are employees. Some are collecting hours under a supervisor. We have them supervise the staff. We have had staff that stay with us. They keep gaining hours and work experience.

We have both at this point.

>> Thank you. Holmes.

>> Thank you for your report. It was a great overview. Concise. Digestible. In addition to agreeing with Member Stevens that the data is important, I am wondering about outcomes. Do you all track treatment outcomes? Your survey says 100 percent. Are you tracking wellness or how they are improving before they leave? Do you track that?

>> Some 50 percent of the youth leave within ten days of coming in. There is another population that may stay long periods of time. We look at what impact we may have. We look and monitor treatment. We have a division that looks at the care provided. For shorter

stay, we hope they get linked and get services in the community. The ran corporation has looked am some programs.

At one point, we were giving measures to see whether the distress was reduced through the treatment. We have outcomes related to that. Outcome wise, the outcome I look for is they get back to the community.

>> Thank you. Shalert.

>> You may have answered my question. I am interested in human traffics youth. Do you have a percentage you have identified? Are you working closely with community advisors with those? Are they kids that get out in ten days. They are not criminals.

>> That is a tough one. We screen all males and females using the identification tool. It gives back risk level. They don't readily offer that. This are two specialized courts. There is a dream court. Total numbers. I don't have those readily available. To fully identify that person is involved takes more time. People don't readily share that information.

>> I would like some close proximity. This is an important issue. I am noticing these camps are not on this list. Kilpatrick is. How many youth are in, can that facility accommodate?

>> I believe 60 and 80. I don't want to misstate. There are either 6 or 8 kids on each side. That is the range. It was finished in 2017. It is a completely different model. Probably the most therapeutic space in an incarcerated setting. It holds secure treatment males. It is a step down. The behavior is what allows them to go there.

That is the one that is slated to house the girls if everything gets approved.

>> Thank you. I appreciate what you are doing.

>> Thanks for being here. It was very interesting.

>> As I understand it, juveniles in the system at that time, they are assessed as possibly having a mental health condition. They are most commonly transferred to the community. I think you mentioned it. What the long term follow up process is. How you ensure if they are still having treatment.

People are lost to care. I heard that phrase a few times. There is an aversion to hardened institutions and facilities. The system favors the idea of putting people back out into the community who may be facing challenges better serviced within four walls.

When I speak with people around the community, I hear that parents are overburdened. There is not enough for a parent who is not only trying to raise a kid but one facing challenges. Is the system working as it stands?

>> Ultimately, if a youth goes home, that is a court's decision. Something the court decides. Whether that is after a long or short sentence.

It is not something, I don't think the youth are better off inside. I know families are stressed and have a need for support. That is whey we developed the JJ tots program. The kid goes out with an appointment and carried until there is a link with their community CHL

>> What is the success or failure rate? Who is tracking that information?

>> The ran corporation has been studying recidivism. They are tracked and followed. We are not currently tracking five years down the road if they are still engaged in care. That needs to be looked at over time. Do they need services five years from now? Hopefully with support, they can better thrive in the community.

>> Did I miss anyone? Thank you. Let us move on. Welcome back. We look forward to your presentation.

>> Good afternoon. Today I will be talking about youth services across the substance youth continuum. Wanting a slide on how this presentation is relevant to the commission. Prop one requires county departments report out on all services and funding. This presentation focuses on our prevention portfolio and will hopefully provide a sense of (inaudible). Still will result in local level prevention services. Youth substance youth treatment services. This is our drug portfolio. Next slide. This is a quick snapshot of the substance use prevention services. Over 150 sites. We contract out all the services. Over 40 we serve over O 200,000 people per year.

Parents, students, represent a good portion of the individuals we serve. Community presentations. On the right, you can see a map on our website of all the locations of our prevention services. A quick snapshot of some of our services. You see three different types of projects. Youth, leadership development, and positive youth development.

After school program focused on youth leadership. Public health funds youth councils. We give them a chance to participate to way in on the youth perspective of public health. Life training is to grow critical life and social skills. We fund our spot. Similar to community resource centers at parks across the county.

They focus on main bullets areas. Offering arts and culture experiences. Health and well being education. A quick snapshot of things that youth who participate may do. Drumming. Young people at a driving range. Next slide. We have a current fentanyl front line campaign to address the current over dose crisis. Much relates to the rise of fentanyl. Teens are a key target population and at risk males and high risk males listed here. Here are examples of some social media. We have a video. You can see it on our website.

We worked with different influencers to try to reach those younger target populations. Next slide. Data around the frontline campaign. This lists out some influencers. The engagement rate and view through rate. How many people saw the creative and did something or changed their thinking. Some different markers. Impressions made. We reached 87 percent of LA County teens. 351,000 teens. 62 percent of those exposed to the campaign who were aware of the campaign stated they intended to carry naloxone. 11 percent were not aware and said they would carry it.

A marker of trying to increase familiarity with OD prevention Medi-Cal. This is cannabis. Another campaign. The treatment slides, we will see why this is so important. Social media campaign. Our bigger choices campaign. Some visuals of social media. Creatives. We do have a website at the bottom to have the slide at well.

I will transfer over to youth treatment services. There is a snapshot of the system. The smaller circles are the different levels of care. Early to outpatient recovery services. Intensive outpatient. Residential services. With draw management.

The bigger yellow circle describes the types offered within those levels of care. Group counseling. The right is a snapshot of the drug Medi-Cal certified substance abuse treatment looks like. A lot more outpatient sites. One residential site. 50 percent occupancy.

Before those changes, we had a lot of referrals from probation. Less now. We are serving the majority. We offer field-based youth services. These are the youth admissions across, since fiscal year 1819. A dip with the pandemic. We have been increasing those numbers since then.

Not quite. Almost back to pre, we are beyond prepandemic numbers now. The reasons why youth come into the special substance youth treatment. I want to distinguish this. This is not how many are using these different substances. It is how many are coming into treatment. The key is the blue line. Youth coming in are primarily coming in for cannabis. It doesn't mean they are not using other substances. That is the main reason they are coming in. Cannabis has been more normalized in culture. It speaks to the increased use of the substance. Some demographics.

The blue is the LA County youth population at large. The green is who we are is serving in O our system. The intention is to get a sense from the general young population to the population we are serving. We are overrepresented on the male side. Underrepresented resented on the female side.

Age side, underrepresented in younger age groups. Overrepresented in older adolescents. Race and ethnicity, serving more people than represent the general population in terms of

young people. Overrepresented in terms O F black and African American populations. A few slides to present moving beyond the drug Medi-Cal system.

In prior presentations, I talked about 95 percent initiative. Youth focused arm is this rise initiative. Reimagining youth is substance use engagement. We want to rethink the way services are providing for the youth. We are only serving 3000.

They are not interested in their services. Kind of forcing them to do so. What do you want in terms of substance use treatment. Even if you don't want it, what would make it better. How do we enhance youth engagement? How do we build more welcoming environments. We are providing funding to purchase things like video games. To contribute to podcast studios. Some of our agencies already have this. Ensuring youth services are appropriate.

We are getting input. This is the bridge program. Our effort to engage family members providing agencies to. Convening family is support groups. The bottom right is numbers of how many families and groups.

>> Thank you.

>> Thank you. Some quick questions. On the slide regarding the primary substance abuse among youth patients, you highlighted the marijuana line. Is self reported? They are coming in saying I am here because I am having a problem with marijuana. With the rise program that you have highlighted at the start and showed us the map, in public transportation, they talk about the last mile. A hurdle to use public transportation. If you are not able to easily trek the mile, yo won't go there. It came to mind when I think TABT great programs. Do you see these last mile issues? Are there people that need them, may they are having that geographic limitation and trying to get to a center or program. Transportation or other issues.

>> We have heard that transportation can G an issue. There are youth transportation services. Part of what we are doing to address that is expanding our field base services to go out to them.

That works well when people are open to services. A combination to increase the percentage of young people.

>> Anyone else?

>> I was thinking about the current climate. Are you preparing for what may come if this is dragged out to ensure those who need the services feel safe enough to receive them. I can appreciate the outreach. How would we work to improve the messaging. Feeling uncomfortable right now.

>> We regularly use our social media. We don't have the strongest social media. That is why we use influencers. I think that has been the most successful way to reach out.

>> I will make it quick. I want to tap into it so I can get the agencies that they can be aware of it. Sanctuary O of hope is good at making sure. I will probably reach you to make sure I can find that online.

>> We will have to adjourn. The quorum is lost. We won't do public comment. Our meeting is adjourned.