

L.A. County Behavioral Health Commission

Remote

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>> Thank you very much for your comments. Do we have anyone else on the line wishing to make public comments?

>> We have no one else. Thank you.

>> Thank you very much. We'll move on to the next item on the agenda, the consent agenda. Is there any item from the commissioners you would like to pull off of the consent agenda? Commissioner Austria?

>> I understand Elon will address the budget?

>> Is legislative update or budget report?

>> Budget report for our budget or overall?

>> Our budget, I believe.

>> I want to take off the legislative --

>> Item "C." Okay. Anyone want to take anything off of consent? Seeing none, can I have a motion to approve the consent agenda except for item "C." Is there a second? Objections? Without objections, so ordered. We'll move on. The consent agenda has been approved except for item 4-C. Commissioner Ostra asked for that to be pulled. Welcome.

>> Good afternoon, everybody. How are y'all? I was watching from upstairs. I know there was at least one question I heard. Kathleen, I think you asked it. Can you repeat the question?

>> Kathleen: Yes. My question is what was the impact of the state budget? Says reductions, but it doesn't give analysis of impact. Then, I don't know how we are saying the one big beautiful bill, how are we pronouncing that? What is the impact of that. That's the analysis, obviously. Let's start with the state budget. It seems small in comparison.

>> So, the state, as we know the state budget is an issue just about every year. This year, we say that the governor, both in his January and in his May revise, basically proposed to solve at the time -- a \$12 billion budget hole with a series of fiscal and financial maneuvers, and with cuts to medical. The maneuvers are essentially internal borrowing. Borrowing from a variety of services, including BHSa funding sources. They are temporary, not long-term fixes. He argued or proposed under his budget to cut MediCal expenditures, and to do that by raising costs for a certain subsection of the medical population by creating monthly premiums for the first time for the population, and by doing the enrollment cap or enrollment freeze, and by reimplementing the asset test limits. The first two, monthly premiums and enrollment freeze impact those with

unsatisfactory immigration status. In short, those without legal documentation status. It's painful for many that care about that community, the advocates that spent years trying to specifically expand access and medical coverage to the population. The coverage for the population is paid entirely by the state. This is not a population for which the state receives any Federal dollars, so every dollar saved in cost on that side is savings for the state. In the end, the final legislative deal made, it will implement monthly premiums, \$30 a month. The governor originally proposed \$100 a month. In the end, they agreed \$30 a month and begin an enrollment freeze. There are two issues negotiated upon. One is that youth will not age out. The enrollment freeze is for adults, the final age range 19-54 -- 64? I forget exactly. 59? Is that what you said? Thank you. The concession that the governor made was that youth will not age out. If you are 15, 16 -- 17, you will not automatically be frozen out of the program. The second thing they did is created a six month re-enrollment period. If you fall off because you fail to redetermine, you have six months to get back on the program. You're asking for a financial impact. The reality is we don't have one at this point. For two reasons. One, we can estimate the number of people using projections from the state. We try to estimate the number of people who will eventually lose their insurance due to these two factors. How many people do we think will be kicked off because they fail to redetermine or they are not yet in the state only MediCal program and how many won't be able to afford the \$30 a month program. We tried to use the state projections and back into L.A. county numbers. Once fully implemented, over a hundred thousand L.A. county residents that would have MediCal today won't have it once this is fully implemented. Our projection, several thousand -- about 5,000, would be DMH clients. Of the 100,000 plus, about 500 of them experience SMI, putting them in the DMH system.

>> What about SAMC clients?

>> They might have their own calculation. I don't know.

>> My question is, under BHSA, they might be borrowing temporarily. What sources of BHSA are they borrowing from? I would imagine there would be delay or impact reduction service from where they borrowed from.

>> It's -- I don't remember exactly what sub fund BHSA they are borrowing, but there is not expected to be impact to dollars that come to L.A. county or event services. We are not even in BHSA yet. It's from a future funding prop that they allocated from the future. They are borrowing from it now. We are not impacting future impact. We are expecting the state will find a solution for that borrowing in the future. A lot of it is moving money around on paper without any expected actual service impact. That's on the borrowing and financial gimmick side. On the cuts to medical, there will be real impacts. One of the biggest areas of impact which we cannot determine is how many people are not DMH clients, mooning they don't currently have SMI, but would fall into mild to moderate but don't have access to mild to moderate services, therefore the

challenges are exacerbated, they won't get the proper treatment and they'll end up in our camp. This is one of the things we are looking at carefully, especially for aging out. A lot of clients that had psychotic breaks in the teens or 20s, we want to be sure they have coverage. The final budget deal keeps in place youth, which was a big win for our residents.

>> Is there an expectation that DMH will try to service people with mild to moderate -- I'm so old I remember when we serviced the population. Budget cuts there melted down, they pushed all of those people out and waited until they got -- and that's where they stayed, people already pushed to the service. I know what you are talking about budget cuts. I'm talking about expansion.

>> I think -- the answer is, we are considering it, but we don't know yet. There are two reasons. Part of the reason why the state purposely did the borrowing was because they didn't know what the exact would be at the Federal level. Some impact leaders straight up said that. They said we wanted to make temporary solutions so once we see what happens, especially with Trump's bill, they could then figure out how to address it at the state level. We have not spoken about the Federal bill yet, but we know the state is planning for a variety of contingencies. It's possible the cuts will be restored before implemented. We don't know. We are not counting on that, but it's a possibility. The other thing we are analyzing, and need legal assistance to analyze properly, what is our given the state budget and Federal bill, what are county department legal obligations to provide care to those who will now be uninsured? You may remember, the obligations from the mental health system are different from the other sections of the county. Like the mandate DHS operate under.

>> Thank you.

>> Commissioner Freidman.

>> I'm confused what you are saying. I think you said the cutoff is 19. TE goes to 21 or 24 depending upon who you are talking to. If you really are serious about that age 19, we have a lot of new people who are going to become homeless without health insurance. It's frightening to think what's going to happen to those people. Those are the people that we worry about the most because without any protection, they are going to be homeless.

>> Forgive me -- I don't always use the word TE as others do. I think of it as older youth and young adults. Forgive me in I misspoke and used an improper term. The main issue, if people are not enrolled in medical, once hitting age 19, they are no longer able to enroll if they are undocumented. Our main goal is to get everyone possible enrolled before these rules kick in. We have seen that. We have seen the county and the region embark on efforts like this before. We did it before Obama care was implemented. This is a brand new budget. I assume we'll see similar conversations regionally to figure out how everyone eligible is enrolled and keeps Medicaid. We share the same concern about people being unable in the future to access services.

>> Commissioner?

>> I love this topic. On bullet two where we are talking about the \$30 v. \$100, I think another confounding variable is who is going to seek services? Right now, we have seen a rapid decline in the number of people who feel comfortable coming out for services. That will need to be something factored into the budget issue also.

>> Yeah. I agree. I heard the conversation that you had with Dr. Wong earlier, and there was the question asked about what kind of impact we are seeing from the recent increases in ICE activity. It's a major concern, major question. One of the questions we have had internally with the department and colleagues with county departments is, are there going to be changes or flexibility for telecare. For those clients three months ago were comfortable coming in for in-person services, can we continue to serve them through a telecare model to address these issues. I don't know the answer yet. I don't know if there will be additional flexibility, but the county is advocating for this. So far, I don't think it will be a problem, but it will be a challenge to figure out.

>> How secure are the lines? Because right now, people are concerned about -- you know --

>> Anonymity.

>> Surveillance.

>> Right. Thank you. I appreciate you thinking about this. I get so many things sent to me what people should do, but they are always in English. I want to believe it's coming to me in English because I'm an English speaker, but I'm concerned that other than the department, it's not getting out as much as we hope it would be. Thank you.

>> Thank you, commissioner. Any other questions for Elan? Commissioner Stevens? We'll have an update after this as well.

>> Thank you. As I was listening, what came to mind, foster -- youth in foster care as well as detention centers. Then what came to mind was the silos. For instance, you are here. It's about the department of mental health. So, how are we as a county, and I'm hoping that cash is listening in the moment. Are we as a county looking at messaging and working together? Because this is unique. It's not -- you know, we did well with Covid, you know? People pulled in, and folks were touching folks that didn't belong to them. Just curious.

>> I can tell you that there's an agenda item coming before the board next week. Forgive me, I don't remember which board office authored it. It's on the agenda for next week asking for a wide variety of departments to report back to the board on the expected impact of the recent Federal bill. It's 900 pages. It impacts so many areas of our county delivery systems and our residents. I think what we'll see -- I know there are multiple requests for report backs from that motion, but one is a 30 day report back. I think it will kick start a conversation across departments. To be clear, we have been having conversations across the health department talking about how the various aspects of the Medicaid changes impact all of us. It's different for every department.

DHS will be challenged in a number of ways because the Federal bill will limit future funding streams for dish and direct service payments. It's different for every department.

>> Crystal, do you have something to add?

>> Commissioner? I hope that -- I'm looking at it at a different angle. It's really about -- you know, set aside your badges. You have a responsibility to the County of Los Angeles. I just want to encourage you and others to talk to each other about how do we really work together to make sure there is no stone left unturned, that regardless who you are serving and are not, we are messaging well and insuring that it's done together.

>> I appreciate that. I'll make one more comment, which is, I think, on the health side, it's not just about the county. It's not just about our delivery systems. In mental health, the bifurcation is very apparent. The managed care plans do the mild to moderate. We do the seriously mental ill. We have to work with managed care plans to address this. We are going to see not just a loss of insurance, but there are questions about the recent political environment issues, decrease utilization, not because people can't pay for it or don't have insurance, but because they are afraid. All of this impacts health status and overall health. We need to work with managed care plans in particular to address that. Right now, the Medicaid system in California splits us up in an artificial way. If you are a client, you want care. You don't care who is paying for it on the back end.

>> Thank you very much. If there are other questions, we have a legislative update from SAPSI? Was there something else? Thank you, Elon.

>> Good afternoon. My name is Daniel. I'm the finance chief for youth prevention and control. We have a legislative update for you all. First of all, thank you for the questions around HR-1, known as the one big beautiful bill. At the time that we submitted our slides, the bill had not been approved. We know it's been approved. Not major changes happened between then and now. Overall the bill is expected to reduce access to Medicaid programs. When we see any reduction in Medicaid, known as MediCal in California, when the general public is impacted just because mental health and SUD is an everyone problem, we know that at least a percentage of those folks are going to have an SUD. As Elon mentioned, they are anticipating 5%. We have done our numbers. We anticipate that in the general public, about 10% at any given time have an active substance abuse disorder. I think that's our working number. Specifically for the HR-1, there were provisions on there that we again know will impact MediCal enrollment at the state level, and then for a specifically drug MediCal enrollment. There will be an affect on reducing enrollment, but disorders were called out from that. They were not part of the final bill. When there's changes ambiguity, questions around a law or benefit, we know it impacts everyone. We anticipate adverse effects in enrollment. Eligibility, eligibility in retro active coverage. The provisions

tightened what constitutes eligibility requirements for improper payments, meaning if a provider excludes information, that would be considered an improper payment. We see recruitment otherwise a financial hit on the provider. Retro active coverage, right now, a patient can get retro active coverage up to the point of application. The new provisions state it goes back one to two months. The affect there is to see a hesitancy to enroll those not already provided. For immigrant eligibility, we saw a redefining by the timing, by prior groups eligible are no longer eligible for enrollment. Again, the overall theme, with more confusion, more restrictions, we'll see not just on the patient side, but also on the provider side, which we anticipate will reduce enrollment in this benefit.

>> There are doctors. Some of them mean well, but they took an oath. I don't know.

>> It's frustrating for sure, yes. Please, go on.

>> To your -- if I can add to your frustration, right, Dr. Von was asked what DMH was doing to -- in response to what's going on. I'll speak about what SAPSI has been doing. Slightly different network DMH has. For SAPSI, all of our services are contracted out. We are not a direct service provider. It's a -- it's a structure that ensures that the services -- the people being served are being served within the community by the community. Something that we have done at SAPSI, or one of the things we have done, we convene with our service providers and say what are you seeing? How can we support you? We saw a lot of what was mentioned, folks scared to leave home. These things started back in April and May when school was still in session. A lot of kids didn't go to graduation. Parents didn't see their kids graduate. Heartbreaking. There are two types of folks, lived experience. You are living with the disease of addiction or mental health or loved experience. You love someone and in both situations, we see the fear and struggle of folks who need care, but now have this barrier to access care. All right, I'll go on to the next slide. This is the legislative update at the state legislative update. We have AB-1037, SUD care modernization act. Essentially, what this does, it brings SUD care into current era by aligning language provisions with the current known field of SUD. It removes stigmatizing language. Some of these things go to the '60s. You do what you know and when you know better, you do better. We know better now. We want our language to align with that. It removes barriers to admissions for regulations that mandated both being drug free. We know some folks need additional health even if they are actively using. It streamlines the certification process and clarifies distribution. Moving to the next one. Yes, commissioner?

>> Are we looking at how right now could increase drug use? We have had success recently. Numbers dropped. Now this could potentially increase because of the fear and challenges people are facing. Can you speak a little to that?

>> I'll let the doctor, if I say something incomplete or incorrect. Whenever we reduce access to treatment, to services, folks with an active SUD, the disease is going

to resurface. When we add stressors, when we add fear, we'll see any disease resurface. Addiction is no different. We would, right, expect to see increases. We have not seen that in our data just yet. We are planning for that. We want to make sure that just like Dr. Jaun mentioned, we talked to the providers, be willing and check in with patients. Most of our providers have resources beyond their SAPSI contract, so they are able to offer services beyond SUD, which is great. We also want to have our providers rely on their network of service providers who can transportation, mental health, medical health.

>> Thank you.

>> And Dr. Hurley will be up here later. We were at hypodermic needles. What this does again, this aligns syringe service programs with other SUV programs. It's an arbitrary sun setting of the programs. It has full support. We know the syringe programs do a lot to address health in the community, not just drug use but HIV, hepatitis and other bloodborne pathogens. Commissioner?

>> I live in Santa Monica. We have a program in one of our parks that residents are very upset about. It was introduced by our assembly member. I'm wondering what you think is the chance of this actually being extended? I see the votes are there -- here, but it now is moving into professions, business and professions. Any idea how this is looking? Because -- and they always talk about crack pipes too. They hand out free crack pipes. I always say the problem they have in getting rid of them is it works. It saves lives. It's hard to argue that. Residents are combative about it. Do you think this will go through eventually, and we will be able to extend this? Does it save so many lives in our communities?

>> Based on current status, it seems to have broad support. I have a projection as to where we think this is, unless others do, but we can go back and get something for you.

>> Thank you.

>> We are hopeful and optimistic.

>> Thank you. One final bill you wanted to tell us about?

>> There we go. This is supportive recovery residence programs. This updates language to more align SUD with other disorders. It removes the requirement -- I'm sorry, what this does, it removes the timeframe for recovery residents, currently folks in recovery are limited in time. This removes that time limit. That's it for us.

>> Thank you very much. Any questions, comments from commissioners?

>> Thank you.

>> Thank you very much. Thanks for your report. Appreciate it.

>> Mr. Chairman, I move approval of 4-C.

>> We have a motion to approve item 4-C on the consent agenda. Do I have a second?

>> Second.

>> Second from commissioner Ostra. Further discussion on this? This is 4-C, DMH legislative updates we had. Any other discussion? Objection to the motion? That will be the order. 4C is approved and accepted by the commission. Moving to item 5, the AOT report. Let's wait for commissioner Austria. She requested the AOT report. Can we have Dr. Hurley give his report and we'll go back to item 5 if that's okay with the commission? Okay? Dr. Hurley, welcome.

>> Thank you. Good afternoon. Can you hear me okay? Great. I'm Bryan. I'm an addiction psychiatrist. I am the medical director for the director's report. We have a slide deck. We'll get the slide deck out. I want to talk about harm reduction programs in L.A. county and addiction programs. Those are two life-saving services that make a big impact in reducing the risk of death among people in L.A. county. That's what we are here to talk about. Next slide. I don't always know how long I have. I'll start with the end. In conclusion --

[Laughter]

>> In the worst overdose crisis in L.A. county history, everyone gets Naloxone. It reduces overdose. It can be purchased over county, prescribed and given at pharmacies. The words we use reflects how we think and how we think reflects how we act. When I talk about people that use drugs, people with the disease of addiction, I use those terms opposed to the terms addict or clean or sober. When you describe someone as clean or isn't, what are they? I use neutral terms to describe people and their relationship with substances. I don't think of someone with a non-abstinence role as less important. The DMH system serves more clients than our SAPSI system for treatment services. Often times, there is the assumption that we don't have enough treatment services. It is true that we need to expand treatment services. Let me be clear about that. We currently reach 5% of the people we need to be reach. We have launched the reaching the 95% program specifically to reach the people who are not currently engaged. The big driver, though, of the 95% who aren't in treatment is a lack of demand for services, not a lack of supply. There is a lack of demand for services. Many people who use substances are not ready to go to abstinence services. It's so important to connect to people. 95% of the people don't get treatment. We can't assume when someone shows up to treatment they are ready to start, committed to full sustained abstinence from alcohol and tobacco from the rest of their lives. We can't assume the goal of abstinence initially. Our bureau was part of a national guideline developed by the society of addiction medicine treatment for patient with absence of care. How do you work with people ready to stop using drugs, before they stop using. Last, one of the things I'll cover is how important it is to offer addiction medications. I use the word addiction medications, you may be familiar with medication assisted treatment. I'm referring to the same thing. The reason I use the word addiction medications, we don't refer to psychotherapy for depression. We don't refer to antihypertensives as diet and exercise so why do we refer to it as addiction assisted

medication. It's an odd term. It's a way of normalizing it. It goes back to language matters. If we are looking at the impact of addiction medication particularly for opioid use disorder, they have a tremendous effect of reducing the risk of overdose, so it's important to have them available before the person is committed to a treatment program or doing treatment services. I want people to have access to them that shouldn't gate keep behind enrollment processes, we should make sure they are available as soon as we can offer them to people. That is what I'm going to talk about for the next -- I have eight minutes left. We'll get through the rest of the content. Next slide. I'm going to talk about a segment of services called harm reduction services. That's in the yellow font in the slide. Harm reduction services don't make sense to talk about outside of the context. We are the health department, Department of Public Health. The best way to address substance use is start with early childhood emotional development to teach the skills of managing emotions without using drugs in the first place. It's a youth and family engagement process. That's where it starts. Harm reduction is a set of services whose engagement is where they don't want to stop using, necessarily. There is a lot that doesn't require them to commit to not using. Then there's change oriented treatment. Helping people change their relationship with substance abuse. People come into and out of treatment all the time. Harm reduction treatment exists in a continuum of people who are in remission, not in remission. It's important to have a full service to align with readiness. You are probably familiar with the term meet people where they are? I use the term align. If you get them into a residential program, watch how quickly they leave. If I have somebody that says this is it. I'm sick and tired of being sick and tired, I'm ready to stop using, you don't want to miss the opportunity to get the person into treatment when they are ready. It's not either/or. It's both/and. We put out information, epidemiology around overdose count, but harm reduction is not a stand alone program. It's a treatment and recovery service. Next slide. We have contracts, nonmedical contracts with harm reduction services programs. I joined SAPSI a little over four years ago. We had six harm reduction service programs. We are now up to 12. We are under active solicitation. We are looking at our harm reduction service program network. It's more than syringes, those they dramatically reduce rates. They are part of Naloxone distribution, being sure people have access to housing and services. There is a lot that the harm reduction programs do for people. Next slide. Because we have invested in a lot more services, we see lower HIV and hepatitis C transmission rates. People that use drugs are five times more likely to go to treatment than those that don't. They are three times more likely to stop injecting drugs than people who don't. They are change oriented services in the long-term. The only thing you need to recover is to be alive. These programs keep people alive. About 75% of the people that use drugs enter recovery within seven years. Overtime, people recover. They may not be ready right now to stop using. Recovery is possible in the will remember. Next slide. We have gone from 5,000 encounters a quarter to we are now over 35,000 encounters a

quarter a seven increase. These are encounters that do not require people have MediCal, give name or date of birth, you can deliver the services anonymously. What do you do when you reach more people who have been traditionally isolated from the rest of healthcare. You see a 22% reduction in overdose deaths. We saw 22-24 commensurate reduction. In Fentanyl deaths, it's the biggest drops in L.A. county. That should be celebrated, but you can only get to 22% when you were at 3,000 death to begin with. The drop in overdoses that is in part driven by the health programs was only possible because of how bad it got in the first place. These are our friends, neighbors, children, families, all impacted by overdose deaths. Next slide. I want to talk about addiction medications. People think methadone or another one. They are effective molecules, but we track others as well. I have had the privilege of working the program of mental health and department of mental services and the department of health to build capacity to prescribe the medications for opioid use disorder, alcohol use disorder and tobacco use disorder respectively. There are a lot of medications clinically effective not yet FDA approved. We use Valium, or Librium for alcohol withdrawal management. Those medications are approved for anxiety and insomnia not for withdrawal management but they are effective for those conditions. For stimulant use disorder, we have others. For cannabis use disorder, we have medications as well. Substance use disorder treatment, responds to medications counseling support not unlike mental health conditions. What is the treatment for depression disorder? Meds, counseling, support. Not every patient needs to be on meds, but everything needs to be available. That's what we are building with care. When I say the medications save lives, it lowers the rate of death for people with opioid use disorder over four fold. Having an opioid use disorder increases your risk of dying over six fold. Just the medication alone, even if you are not in a treatment program and even if you have not stopped using fentanyl or drugs, goes down four fold. They help people stick around treatment. Treatment retention without medications at one year is 10%. Most people go back to using. Most people do. Over time, more and more people recover, but it's like a 90% relapse within the first year. With medications, it increases to 50% of people stay in treatment and over time, decreasingly use the drugs they otherwise would be using. The evidence for methadone is stronger than this. We have clinically effective treatments. We need to make them available to people at the time they are ready to take them. To help with this, we got a one time allotment of money from the California behavioral services commission to actually install prescribing clinicians into SAPSI contractor treatment programs. Due to a long list of legacy reasons were typically concerned nonmedical. This is a contrast to behavioral health programs. It is not true with the SAPSI programs. They have medical directors but they didn't have to see clients. We want medical clinicians working at treatment programs seeing clients. If we just gave the money to treatment programs and didn't require billing, once the money went away the program would go away. We want to do a cost sharing method. We want to pay you for the time

it takes to onboard it but sustain it through medical billing. Next slide, we came up with a ratio of \$200,000.40 hours a week for medical clinician time. That was the start up funding. We reviewed implementation plans. Two fiscal years ago, 27 agencies committed to expanding a thousand hours a week of medical clinician time over all, over the entire network and onboarded 48 new medical clinician. In round two, we said, hey, do you need more start up funding. Up to 30 total agencies, and 90 agencies around two for expansion, so we are now at 70 new medical clinicians and just under 2,000 hours of additional medical clinician time. You might say that seems like a small number. Not every agency stakes advantage of this, but they are not equally sized. We have bigger agencies and smaller agencies. The 30 agencies are the biggest. 2/3 of the clients in the system are seen in the 30 agencies. The majority of clients are seen. We have round two coming up. We expect to speak to how to build medical capacity to make the services available to clients on demand. That's what we are building toward.

There is an entire guideline. Before I came to the county, I did a post doctoral fellowship on increasing mental health services. If you want a how to integrate therapy, it's online. Feel free to check it out. Next slide, the opposite of addiction is not sobriety. It's connection. With that, I'll end my update. Thank you for your time and attention.

>> We appreciate your presentation. Any questions from commissioners? Commissioner Weisman?

>> Thank you for being here and your presentation. Good over view of things. Questioned about guidance the department of bureau has for communities, impacted by decreases of harm reduction supplies available in our communities. We in Hollywood depend on a large steady supply of home reduction elements. Now we know we won't have as much access. Should we lean on DPHS SEPSI? How will we get by?

>> There is a harm reduction division. We have been fortunate to continue to expand our programs using non-state funding. We are looking at opioid settlement funding, used to be measure J. When there is a gap, please let us know. There is a whole number of contractors there. We continue to augment based on utilization. We work with the L.A. county harm reduction initiative to meet gaps. The state, California overdose prevention and reduction was refunded. The Sierra foundation is releasing its third round. Comp three is continuing, thankfully. The combination of state funding services are reasonably okay to augment services. We are poised for what happens with Medicaid eligibility. Rightfully so, but I wanted to reassure the group, we are funding with non-Federal funding. Thus far, we have expanded even against the head winds harm reduction programs. I can't promise it will continue that way. There are a lot of moving part, but I don't think there is a question the public health importance of the services.

>> Thank you very much. Any other questions or comments from the commission? Commissioner Keller?

>> Couple of things. Thank you for mentioning at the end that you are trying to get into the community mental health center. I'm wondering, first, what is your success rate at that? My experience with 35 or 40 years with community mental health, that's a new thing. I'm not seeing that happen on the ground. I'm going to go back to my community mental health centers. Hey, I heard from Dr. Hurley, did you know there was a tool kit?

>> I work closely with Jeremy Martinez. DMH associate director who is the person I work with closely on the DMH side. How well this actually plays out depends entirely on, do you have a local champion. I can point to dear colleagues of mine that work to implement the services at the contractor or directly operated programs. Since I moved to public health, I can't give you the current, what is today's boots on the ground list of who is providing the services and who isn't, but with medical no wrong door policy, there is a real flexibility in being able to offer the services under the especially mental health program for people with disorders. There is no criteria on the full range of services including medications, but the readiness of the clinic to do that is quite variable and we work closely with colleagues at DMH to advance it.

>> Maybe we can be the champion in the area. Thanks for that. The other question is, you mentioned harm reduction, and where you are going with kind of starting with youth, and I don't know how much you know about early childhood mental health consultation where you bring a mental health person into the preschool, help the administrators, teachers and parents with social/emotional barriers the kids might have that impact their ability to connect well socially when they reach kindergarten. There's lots of research that says if they do well in kindergarten, they'll be reading by age three, and that's when you read to learn. Those kids are going to be much more frequently not in gangs or drug addicted and that sort of thing. There is a lot of research, and we have done a lot of work in my area on that. At the same time, we are seeing head start cut. Not just elementary school but preschool, public and private preschools. I'm amazed. You can connect people to the regional center or our local mental health programs. It's an important prevention program that just kind of got cut recently because of prop 1. Do you have comment on that? Are you aware of that sort of thing? Can you keep that in mind talking about prevention.

>> My immediate reaction is, I agree with you. It sounds like an important program. We have been advocating for the Federal head start program to remain funded. Not even within SAPSI, but our department prioritizes early childhood development. Thank you for sharing how important it is -- I might suggest early as possible. One of the things that preschool and kindergarten have the advantage of is being structured. They are pretty early development education level. Early as we can get folk connected to healthy emotional development advances everything we are talking about.

>> They have 12 units or whatever, they don't have the skills sometimes -- they know, we have a problem with this kid, or maybe I'm not noticing you have a problem with the kid. Getting in early is important.

>> Thank you.

>> Okay. Thank you. Any other -- yes in Mr. Stevens?

>> Thank you for the presentation. I was looking at the harm reduction services, referrals needed, it says. I noticed you didn't touch much on that. Could you -- you know, describe what that looks like and how you remain engaged or connected to that participant?

>> When our harm reduction service providers connect with people, there are a few ways to do that. One way is drop in centers. There are a number that come in if you need syringes or other things. The harm reduction worker will say, do you need housing? If they don't want to talk about it, it's okay. We'll then connect them to their area housing -- whether it's loss of action says point, in skid row we have air traffic control that gets people to interim housing. There is also a number of inservice programs that go out with backpacks. They are not even on the road. You have to go away from the street to reach people who really are physically isolated from the rest of services. Often times, it's just building relationship. You are building relationship with the person until that person trusts you enough. You get a sense, is this somebody that needs mental health services. Is this someone that qualifies for home team to come out? Can they be connected to a local mental health resource. One of the programs in service planning area 6 working with a street medical team doing street based addiction medications. It doesn't require the person to come in for treatment. That's the connection for alcoholic needed referrals I'm talking about, using the relationship. The engagement becomes the platform for connecting the person to what they need.

>> Lastly, on the last slide, and I can appreciate this, that the opposite of addiction is not sobriety. The opposite is connection. I can't help but think of my own experience of my sobriety date is July 11, 1998. I have a birthday coming up. One day at a time.

>> Congratulations.

>> Here's the deal. There's nothing here around that connection to those who are abstinent. You don't have to respond. I won't take a lot of time here. I would like you to engage with me even if it's offline from here, about why we don't incorporate. I know one day at a time for almost 27 years. What I know works for me.

>> I think one of the things is importance of community self help, one day at a time. Abstinence based treatment can include abstinence.

>> In closing --

>> I would be happy to talk to you further offline.

>> I will say this, with the proposition 1 and BHSA, I just hope -- I just hope as one who has utilized services for many, many years and understand mental health and substance use based on my own personal experience, I hope we get to a place we begin to integrate and dance well together for the sake of the people and lives for which we can serve. I really do.

>> Thank you, commissioner. Any further questions from the commission? Seeing none, thank you very much. Dr. Hurley, appreciate it. Next item is -- we'll go to the MHS A/BHSA updates and then back to the AOT report.

>> Recently, June 26, the office of child protection posted a behavioral health convening on youth. We extended invites, but people were not available. This was co-hosted by the board offices, presenters including DHCS, CDSS, SAPSI, DCHS, all of the different agencies there. Also, we had participants from each board office, education, child welfare, managed care, statewide advocates. The reason for such a broad array of individuals, youth is a priority for the county. They wanted to have an intentional discussion with key stakeholders with this plethora of LA county initiatives coming at the same time. At the intersection of behavioral health, health and child welfare reform and how to prioritize children, youth and families. There's a big gathering. A lot of productive discussion and something to come from that end. The other thing we wanted to know is we are planning for specialty forums as part of the community planning process, we have done our best -- you have seen the list of stakeholders we are meant to incorporate. We have noted that some of the populations need special forums. One, being youth. Given the timing of the planning team meetings, we wanted to engage them in sessions designed specifically for them. We are looking at after hours or weekend instead of during the day in a format that makes sense to them. The other one is around housing. A big discussion given 30% of the BHSA budget that goes toward that. We are going to focus one of the community planning team meetings on housing, and we'll talk about that with the cities we need to partner with. That's in terms of the upcoming events. Then we have community planning team meeting updates as well. In the recent meetings that we have had, we talked about the statewide behavioral health goals, review of data in the last few meetings, and we have talked about LA county data to supplement that. We had a walk through. I don't know if you are familiar with portrait of LA, conducted by measured America. We went through more determinants of health, income, things like that. There is an offer available if you would like to go through a data walk. It's quite comprehensive. Doesn't include behavioral health in this iteration, but it's a focus for later. We have a lot of state updates. We have a long awaited California Department of Public Health population prevention approach. They have released phase one. It's a long title, prevention program guide. It is available online. We have provided the link in the update we shared. This guide is high level. We know what we can do as a county and how to relay the information to providers working in the prevention space. The other thing we would like to share is the student loan repayment program. BHS has opened and is available to professionals of all levels who serve or will serve. The applications are open until August 15th. There are a phi webinars with more information. Welcome to share that information with anyone that might be interested, and we have provided the link. Some more updates, I promise, we are getting close to

the end. On the DMHS side they continue to work on internal planning and identified capacity at needed areas of care. They are looking at combining planning happening at the same time to make sure the efforts align. On the SAPSI side, we are onboarding for a few months. We are focused on the integrative plan, narrative and budget which we plan to present to the team later this year, September, that timeframe. Another update we wanted to provide is we work with a request for housing funds. That's a work in progress. That's it.

>> Thank you. Any questions or comments? Commissioner Freidman?

>> Thank you very much for all of this. Sounds like you are very busy. We have looked at youth that have the draw and working with them on the venue, for example. We have talked to LACO and we have reached out to other providers in the network and to see if we could pull from their networks. There are individuals that we identified that work with youth interested and engaged in these type of initiative. We pulled to think through the proper venue to think about the design of the specific session. The three hour meetings we usually run probably wouldn't work for this audience, but if anyone is interested in the topic, we would be open to collaborating.

>> When you say you have talked to LACO -- they have 85 school districts or something. Every school in the district has to be notified.

>> Yeah. That was a preliminary discussion FYI. I don't have more information beyond that right now, but noted regarding how much the breadth it covers.

>> Thank you. Commissioner Weisman?

>> Thank you for being here. Question, this is big picture and food for the future conversation. How is the department SEPSI/DMH affected by the budget related -- what is the split? When will we hear? Can we put that on the docket for the future conversation?

>> That's probably as far as I'll get right now, but noted that we should have a response for that as planned.

>> Can I piggyback off of that? I'll ask Kenia and the team if we could have Sarah and the appropriate staff to present to the commission to share an update on how the collaboration integration is working.

>> That will be great. Thank you, Tyler. Appreciate that.

>> Thank you so much.

>> Thank you. All right. Now, we are going to go back to the AOT report. Yes? Oh, okay. Great. Thank you.

>> Good afternoon, commissioners. Thank you for having me. I understand we have a short amount of time, so I'll get through this report quickly as possible and find that the slides are descriptive. It has the information on it as far as the budget amounts that were spent and in the percentage spent in each category. I'll give highlights from each service area. If there are questions, I'm happy to take them. The first slide, these are the budget allocations within each budget, clergy engagement 10,000,

neighborhoods, 12,500. Salt budget for the past fiscal year 24-25, \$100,000 moving to the 25-6 fiscal year, going back to its pre-Covid allocation of \$50,000. You can see the remaining budgets are community resource budget. Next slide, please. The amounts previously reported at an early commissioner meeting, you will see differences because we used a different reporting source. The E-cap, electronic countywide accounting and purchasing, I believe, services, and that is a much more accurate report. You will see a slight reduction in numbers in the amount of expenditures, but this report is much more accurate. Next slide, please. 23-24 fiscal year served as the baseline year as mentioned before. Party with a purpose basically means we want to bring the community out. We want to create a memorable time but we want to draw them back to mental health services and let them know what is available to them. That's what we focused on in the past fiscal year. Having intentional outreach and raising awareness of service also all with the goal of strengthening our community. Next slide, please. Here are our expenditures. You can see from service area one, they are leading the pack with \$108,000 to serve \$108,000 in spending, all the way down to service area eight with \$4,500 in spending. That is not to say service area eight is not active. We'll get into that later about how money is being spent and spent intentionally. Here is our expenditure comparison fiscal year 23-24 to fiscal year 24-25. 23-24 fiscal year, I believe it's in blue if I'm seeing that correctly and 25 is in red. So, as you can see, it reflects -- 24-25 fiscal year reflects increased spending in service areas one and two. I want to include in the service area, six and eight and it's aligning with the goals of party with a purpose. We are going to put that on a tee shirt, I promise you, one day. Next slide, please. This is a breakdown in percentages. You see the differences in spending between 23-24 and this past fiscal year, and what you will notice, you will see a slight increase in activations, and to define activations, that is activities we engage our community in, anything that really creates a memorable experience for our consumers and impact. You see us starting to creep up a bit, a couple of percentage points, but you will see a shift from promotional items to having events that are impactful. Next slide, please. This is the service area one breakdown. They had 47 events and events includes meetings. Just a quick note on service area one, service area one does an incredible job with bringing out the community with catering, so you will notice as you go through the slides, and you can go to the next slide, please, they know how to bring out a big crowd and engage the unique population. They have a commuter population, and they know how to engage the population. A lot of things take place after hours, or late in the afternoon so they can capture the attention of the community and make sure that they are bringing out as many people as possible. The slides are descriptive. If you have questions, please stop me. Next slide, please. This is their salt and community collaborative budget. Next slide, please. This is a listing of events and meetings they have had throughout the year. Next slide. So, they have had quite a few. Service area one very active. Massive jump from the 23-24 fiscal year to 24-25. They have getting

the community engaged and doing a wonderful job of it. Next slide, please. Service area two. Service area two had a total of ten events. They have spent roughly \$57,000 in their budget. Service area two is activation focused. They had amazing events in the past fiscal year that made an impact. It goes to show, it doesn't matter how many events you have but the type of events you have. The type of events that left an impact on the community, they had a community warning event, a trunk or treat event which was huge and that was bumped up to the event and an Armenian remembrance event. A lot of those that came out were immigrants to the country and didn't know the services existed. While they didn't have 50 events, they maximized what they had and did the most with their events. We can go to the next slide. You can take a look at where spending -- where they spent in the spending categories. Next slide, please? We'll keep going through the slides. We'll get to service area three and a list of their events. Service area three, unique in that they tend to focus on education, and they promote connectivity within the community. We can go to their next slide. They are also one of the higher spending service areas. Again, not a ton of events, but when they have an event, they really engage the community. It's something incredibly meaningful to the community. We can go to their next slide. Great events that are focused on bringing the community together. We can go to the next slide. If there are no questions on this, go to service area four. This is a list of their events. They are doing a pretty amazing job. Service area 4 please, thank you so much. Service area four is focused on creating experiences, and they also -- experiences within every category. They are doing a fantastic job with the community collaboration efforts. We'll see that they not only collaborate to get in-kind services but other service areas. We can go to the next slide. Just stop me if you have questions. Time is short. We are going to go to service area five.

>> Seven.

>> We are going to get to seven. Service area five did a fantastic job this year with community collaboration. They seem to grasp that you piggyback on to larger events and spend less money that way, but you also create a greater impact. They had wonderful events this year with suicide prevention. They had a visit to the holocaust museum, sharing stories with the older generation, aging and passing the stories down to younger generations. They maximized their community KHRAB. They also collaborated with service area six and four. Next slide, we can go through to service area six. Service area six, they have high levels of community involvement. Impactful PRC events. As you heard Mr. Hamilton speak earlier, there are about 89 salt members. I have been to the meeting. Very active membership. They are great advocates within the community. We can go through the slides. As you can see, huge events. Service area seven. One of the things I love about service area seven, service area one, three, six and seven, they are all high spenders and they are creative. They get incredibly creative with activations. They are bringing stuff to the community that

the community hasn't seen before and exposing them to new experiences, so service area seven, they do a really great job on focusing not only on community, but networking in the community. They have enkind services, amazing things donated. They have an incredible podcast I can't stop talking about, amend they also -- I'll leave it there. They do a lot with men's mental health which I think is fantastic. We see the department moving in that direction. We can go through the slides to service area eight unless there are questions? Service area agent, there is a jump in services, events they provided this year. They are doing a fantastic job as well. Service area eight this last year focused on maternal health. They take advantage of cultural events. When we talked about service area agent earlier, it didn't look like they spent a lot. They had a Cambodia day parade. A unique, small minority group within the community. They were able to engage those folks, and they really maximized their efforts within the community. Next slide, please. We can go through service area eight slides unless someone has question. The total PO and expenditures, as you can see -- the slide before that one. Those are the amounts spent in each budget for the total county, and the final slide -- so, 25-26, we are going to continue to focus on partying with a purpose, but we are going to increase focus on engagement. We'll increase focus on activations, creating memorable experiences for the community and the stakeholder group. Wow.

>> That was great. I don't think you took a breath the whole time.

[Laughing]

>> Thank you for having me if there are no questions?

>> Thank you very much. I know this is a lot of work. I would like to see this be a -- at least a quarterly report. It shows what our community is doing. That's a major mission of our mission here.

>> Absolutely.

>> Commission.

>> Yes, thank you for the feedback.

>> Commissioner?

>> I wanted to thank you very much. This was really exciting. I'm sorry I have missed all of these events. That leads me to, if we could as a commission know about these events, I know some of them send them to me directly -- it would be great. I think some of the commissioners would be able to come out and table at an event. I would love to know beforehand.

>> We would love that support as well.

>> Thank you for being here and being patient.

>> Jamie walker. Appreciate it. Thank you so much. Thank you for being cognizant of our time limitations. I appreciate that. Now we go back to item 7, public comment. This is public comment only on items five or six.

>> I'm sorry, we have the AOT report.

>> I'm sorry. I have been gone. Do you want a report? I know you have been pushed off. I don't want to push you off anymore. You are here. You waited the whole meeting. Do you want to take a few minutes to hear the report, and I have a comment if you do?

>> You might have questions. Still need support in my opinion. I'm not sure that it should be chaired by the commission. I want to find a home for it so the group can continue to meet. There are a couple of community stakeholders who attend who each have their own community they report to. Given what's going on with prop one, the budget and state, questions or a quick statement. You have been there from the beginning.

>> Britney has been there from the first.

>> I want to say thank you for your work. It's critical.

>> So, Melinda Byrd from disability rights has been a constant member. Mark Gale has been a constant number. Before Covid, it was a bigger group of folks who did attend -- participants who attended all the time. Some of the comments, this is Venus, the program manager. I'm over care court now. They are similar. There is a lot that's together and connected. Both of them felt very much like the committee -- oversight committee should continue. There was discussion about having public defender, county council, judges, which we had before Covid, public defenders, counsel, LAPD, a lot of folks we feel are integral to the program and meeting were in attendance. I think it's a little more difficult to get the judges now because AOT care are in the LPS court and the judges have hearings in the afternoons. At one point judge did attend. Everyone was vocal. Mark and Melinda's comments, which you read in the report, very much think that we should integrate AOT and care. We want to be sure AOT still has a place. We don't want to be absorbed by care. They are similar but different. We feel strongly that both have a place in the department. With that --

>> My thought -- I don't want it to end right here as a decision of the commission on what we do with it, maybe since time is short, refer back to the executive committee to have them come up with suggestions. One, it needs to be reinvigorated which we have been talking about for a long time. It's mostly staff, wonderful staff. And informative. How do we make sure they don't get lost in the shuffle which is critical because there is a shuffle going on. I don't want them to be lost in the shuffle and to the budget.

>> One of the things I was interested in are the numbers deemed to be ineligible and what happens with those folks. I'm not asking you for it right now. I appreciated that you included that in your report. They are not being treated doesn't mean they don't need to be treated. Thank you for including the numbers.

>> We put together a report quarterly and yearly, but Miss Ny put that together.

>> Congratulations on taking the program this far. I'm just reflecting, as we sit about the meetings and things that took place over the years. Going back to Dr. Southern, anyhow, keeping something afloat with eyes on AOT, is there anyway the care court

motion going before the board for county reconsideration of improvement, is there anyway to make an ad hoc committee element under that or does it not make sense to conflate the programs in that way. I wonder if in improvement, there could be a sub ad hoc oversight report backs etc., as part of the care court motion or if it wouldn't integrate well at all. I'm trying to feed two birds with one meal, as they say now.

>> We can take that back to the program head as well as the author of the motion to see if that's something that is feasible and something the board office would also want --

>> It may be too complicated. If that is the case, I wonder if staff would make a recommendation to us on where it should be placed and how it should be monitored or managed or demobilized from your perspective?

>> Maybe that's something we can discuss in the executive discussion?

>> I think that's where your commission is going with this.

>> I would hope it would continue. Where it would fit and how it would fit is maybe above us, but definitely, and there's been a lot of conversation about having it be care and AOT together. There are similarities. We work closely together, so we want the populations are similar. The criteria is different. Some that don't fit for care fit for AOT. People who don't fit AOT fit care. Primarily private insurance. The law states for care people must -- private insurance must pay. That doesn't happen in other places in our department, so we work closely. It would be great to have it continue.

>> That's what we have been doing for the last year. As a committee meeting, we have been combining. As reports from both, separate but under the same court jurisdiction, I thought they belonged together myself.

>> Sounds like we could -- let's put that on the executive committee agenda, and we'll consider that at our next executive committee meeting. Thank you for sticking around and being patient and providing the report. Thank you, commissioner Austria.

>> Thank you for staff and Linda especially. You have been my main contact and you have kept it afloat during some times. Wonderful staff. Mark and --

>> I hate to --

>> Thank you.

>> I hate to interrupt, but we have lost our quorum, which means -- I shouldn't put it that way. We have been talking so positively today, so we have to stop here and adjourn the meeting. Thank you so much.