CFCI ADVISORY COMMITTEE MEETING

CART Transcript

April 18, 2024

LA County Care First and Community Investment Advisory Committee

Date: 4/18/24

CFCI advisory committee meeting

3:45-5:00 section

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>> CART PROVIDER: Standing by.

>> Hello this is Leo, Spanish interpreter.

>> I want to go ahead and call the meeting to order. Welcome everybody. We've got a tight agenda today. Let's go ahead and review the meeting disclosures.

>> Thank you. I will now read the meeting disclosures. This meeting is being recorded for the purpose of the meeting minutes. By remaining in this meeting you consent to being recorded. This is a public meeting and subject to the Brown act. Since conversations and statements on the chat are not visible to people on the telephone and who are unable to participate, the chat function is limited to technical assistance. There will be no response nor forwarding of any public comments to the advisory committee members. If members of the public would like to provide comment, please do so either during the public comment period for that specific agenda item or during the general public comment period.

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For closed caption assistance CART services are available. You may access these services by clicking on the Streamtext link that will be provided in the chat after the reading of the disclosures.

When accessing Zoom through a computer browser or smartphone Zoom app scroll to reactions at the bottom tab and you will see the raise hand feature. When accessing Zoom through the smartphone browser scroll to more at the bottom tab there should be three buttons above more and you will see the drop town feature with the raise hand feature [interruption].

>> For anyone experiencing online technical difficulties, telephone dial in information will also be provided in the chat. During public comment telephone participants may press star nine to raise your hand, star 6 to unmute. For Spanish interpretation please click on the globe icon for Spanish. Written public comments are to be submitted to JCOD at LA county.gov. For written public comments to be reviewed by the committee members prior to the meeting by the 5 p.m. submitted by 5 p.m. the day before the meeting. These public comments will be shared with the advisory committee members prior to the meeting and will be -- lost sound.

>> CART PROVIDER: It is no sound. We have lost audio. I believe the room has been muted.

>> I would like for us to acknowledge the Gabrieleno Tongva people, the Fernandeno Tatavium tribe and the Ventureno Chumash people. These native peoples understand and respect the land connected and respected the four-legged creatures who once roamed the earth freely; the winged ones and everything in the ocean. Their hearts told them never to take more than they could use and always

give back to mother earth. These amazing people are still here today living and breathing among us and still giving back to the community that surrounds us.

Aheehe, thank you to our ancestors.

>> Also, most U.S. institutions at the foundation of this nation in vast and he can equitable wealth. We respectfully acknowledge our debt to these people primarily of African descent who labor and suffering built and grew the economy and infrastructure of a nation that refused to recognize their humanity. While the 14th amendment of the institution technically ended slavery in the U.S. we know slavery's ongoing impacts are felt by countless people forced through violence, threats and coercion to work in the U.S. we recognize our debt to exploited workers past and present whose labor was and continues to be stolen through unjust practices. We acknowledge our collective debt to the indigenous peoples of this land whose labor was forced and exploited. The Chinese immigrants who built railroads that allow for westward American development. Japanese Americans while incarcerated and migrate workers from the Philippines, Mexico, central and South America who worked Pacific Northwest farms. We recognize immigrant and American born workers of Africa, Asian whose labor remains hidden in the shadows but still contributes to the well-being of our collective community. We recognize that our economy continues to rely on the exploited labor of incarcerated people largely people of color who earn pennies an hour while generating billions of goods and services each year. And we know that there are many other people too numerous to mention who are prevented from reaping the true value of their labor by unjust systems and cruel practices. They mourn their

loss of life, liberty and opportunity. We acknowledge that the theft of labor is the theft of generational progress nearly all people of color have been robbed of the opportunity and wealth that their ancestors might otherwise have passed onto them. Please call the roll.

>> Wilt conduct the roll call. We ask all advisory committee members to be ready with the microphone before your name is called so you can be ready to announce your attendance promptly. If you are unable to unmute yourself please raise your hand on the Zoom platform so we can assign cohost privileges to you. If you are calling in on your phone you can unmute yourself by pressing star 6. You can raise your hand with star 9. We will now begin the roll call by last name alphabetically when your name is called please say present. Judge Armstead or alternate.

>> Present.

>> Member Carbajal or alternate.

>> Present.

>> Member Castillo or alternate. Member Contreras or alternate.

>> Present.

>> Member Crunk or alternate.

>> Present.

>> Member Cyrus-Franklin or alternate.

>> Present.

>> Member Earley or alternate. Member Ferrer or alternate.

>> Dr. CY was just here.

>> Mr. Fuentes-Miranda or alternate.

>> Present.

>> Member Garcia or alternate.

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>> Present.

>> Member Ghaly or alternate.

>> Present.

>> Member Lewis or alternate.

>> Present.

>> Mr. LoBianco or alternate.

>> Present.

>> Member Nishiyama or alternate.

>> Member O'Brien or alternate. Member Schoonover or alternate.

>> Alternate present.

>> Member Scorza or alternate.

>> Present.

>> Member Soto or alternate.

>> Present.

>> Member Steele or alternate.

>> Present.

>> Member Stevens or alternate.

>> Present.

>> Member Eakins or alternate. Member Williams or alternate.

>> Here, present.

>> Member Wong or alternate.

>> Thank you this meeting has reached a quorum.

>> Let us please go over the CFCI community agreements we'll pull them up. We can read them together I'll start. Be respectful of the diverse voices being represented and remain open-minded.

>> Be mindful of power dynamics in this space as well as the historical disenfranchisement of Black and indigenous communities.

Accordingly prioritize and defer to community throughout this process.

>> Be mindful of the diverse audience you're representing to and make sure you speak with clarity.

>> Be collaborative.

>> Assume best intentions.

>> Challenge the idea, not the person.

>> Remember why we're here, to center the Black, Brown and indigenous communities and other communities that have been most impacted by the carceral system, low income communities, trans and gender nonconforming folks, et cetera.

>> Defer to community.

>> Transparency and follow-through.

>> Be intentional about hearing and allowing space for additional voices to be uplifted.

>> Be active participant and try to be succinct in your thoughts and contributions.

>> Let equity lead the way.

>> Make space for youth voices.

>> Review community agreements before every meeting and amend them as needed.

>> As much as possible allow community members to finish their sentences through and during public comment.

>> Begin CFCI advisory committees with the land acknowledgement statement recognizing and respecting the indigenous peoples of the land we now call Los Angeles County. Thank you very much everyone moving onto item 7 the review of the minutes from our last meeting March 21st. There are attachments if you want

to review them. Could we get a motion?

>> I'll move to approve the minutes.

>> I'll second.

>> DEREK STEELE: Motion to move the minutes was made and seconded is there any readiness or anything to add, anything missing, any changes to make note of? Hearing none can we please go to public comment.

>> This commences the public comment period of the agenda. The public comment period during the meetings will be one minute per person. For those online who would like to provide public comment, please use the raise hand feature now. We will call on you in in the order your hand is raised. Please state your full name for the minutes before beginning your public comment. Your hand will be lowered once you have completed your public comment. For those on the telephone please dial star 9 to raise your hand we will say your name or the last digits of your telephone number when it is your turn. Dial star 6 to unmute yourself. When accessing Zoom through a computer browser or smartphone Zoom app scroll to reactions at the bottom and you will see the raise hand feature. We will now begin public comment for approval of the meeting minutes for the March 21st, 2024 meeting. Do we have any public comments in the room? Seeing no hands in the room, we would like to go online.

>> There are no hands online.

>> Thank you. Seeing no hands raised this concludes the public comment period. As a reminder and in advance of our next public meeting, if you would like to submit a written public comment please send an email to JCOD at LA county.gov by 5 p.m. the day before the

meeting. Back to you chair Steele.

>> Chair Steele: Let's vote.

>> We will now conduct the vote for this motion and we will be using a similar process as the roll call. Again, we ask all committee members to be ready with the microphone before your name is called. When I call on your name please indicate your vote of yes, no or abstain.

>> Member Carbajal.

>> Aye.

>> Member Castillo.

>> Member Contreras.

>> Aye.

>> Member Crunk.

>> Aye.

>> Member Cyrus-Franklin.

>> Aye.

>> Member Earley.

>> Member Tsai.

>> Member Fuentes-Miranda.

>> Aye.

>> Member Garcia.

>> Aye.

>> Member Hong.

>> Aye.

>> Member Lewis.

>> Aye.

>> Member LoBianco.

>> Aye.

>> Member Nishiyama. Memo O'Brian. Member Knight.

>> Aye.

>> Member Scorza.

>> Abstain.

>> Member Soto.

>> Aye.

>> Member Steele.

>> Aye.

>> Member Stevens.

>> Aye.

>> Member Eakins. Member Williams.

>> Aye.

>> Member Wong or alternate.

>> The motion passes.

>> Thank you very much want to acknowledge member Wong just walked in as well.

>> Thank you.

>> So exciting we actually had another presentation that I think folks are really interested in and prepared for. We have been talking about this presentation to provide some space and time for preparation and decided to bring it forward. We're going to have a presentation for DPS and DHS to discuss harm reduction expansion, the syringe exchange programs, recovery bridge programs, diversion program so a lot to bring further. Without further ado I want to turn it over to our presenters today. Please.

>> Thank you. And I'm just setting up, pulling up my information.

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Give me one second. All right. So maybe I'll begin with introductions. My name is Yanira Lima with the Department of health substance abuse prevention and control. We are providing updates on some of the aspects we have utilizing CFCI funds. I will be covering the benefits or contracted services for SAPC for recovery bridge housing and SUD court-based diversion. I will pass this presentation over to my colleagues on the DHS and Dr. Hurry, Shoshanna, Veronica and Richard. Who will cover elements related to the expansion of harm reduction services. Next slide, please. So I'll start with just covering elements regarding recovery bridge housing and I'll discuss specifically how the funding received through CFCI really supports this housing setting.

Next slide, please. All right. So I think maybe I'll start with saying that we know from clinical experience as well as research that safe and stable living environments are critical. Not only to achieving and maintaining a person's SUD, but recovery from SUD's. So in brief, the recovery bridge housing benefit is interim housing. It's recovery oriented, peer supported and really aimed at individuals that are homeless as a primary criteria.

I should say that this is SAPC's at this point only housing setting. Individuals that are housed in recovery bridge housing are also required to be concurrently enrolled in an outpatient type treatment service, such as outpatient counseling services or intensive outpatient counseling services.

Now, the benefit offers 180 days of housing within a 12 month period. However, SAPC has incorporated the ability for individuals to request extensions for recovery bridge housing. Really aimed at

ensuring we are not discharging people back into the streets. The current capacity for recovery bridge housing is at 1354 beds. They are co-located or sites are all across the districts as well as service planning areas. Of the 1354, 100 of these beds are specific supported with CFCI funds.

Now, in speaking maybe just very briefly, the contractual structure, all of our beds and all of our capacity is contracted to the community, so SAPC does not maintain any direct service provision so all of the funds that have been allocated by CFCI specifically for this benefit are of course invested in the community. At this point, we have 23 agencies that operate across 131 sites. In reference to maybe expansion and growth, SAPC as I'll show in the process of expanding, adding an additional 400 beds to this current capacity. We anticipate being at 1600 beds by the end of either this fiscal year or the first quarter of fiscal year 24-25. This expansion is made through a grant that both the Department of Mental Health as well as DPH applied for through the state under the behavioral health bridge housing. We will also please introducing as part of this grant a new benefit known as recovery housing which will add an additional 12 months of housing for individuals that have potentially completed treatment and need a stable place to reside.

So those benefits will be forthcoming in the next fiscal year. Next slide, please. So in speaking about the way that funding is utilized as I stated in the previous slide, we utilized 2 million dollars really to support the 100 beds in the RBH system. Funding affords the ability for us to reimburse beds at a rate of 55 per night. However, all services in treatment are paid for through the Medi-Cal program it's a

way to leverage funding. Anything related to recovery bridge housing is not supported through Medi-Cal so we rely on secondary funding sources such as CFCI, measure H funding we get through DPSS programs, maybe some of our SAPC block grants. I think because of the grant that we received in addition to the 2 million dollars investment from CFCI, we will be also introducing housing navigation services as well as participant assistance funds through the BHBH grant. All of those services will be wrapped around individuals participating in treatment services and of course housed in recovery bridge housing.

I think these are added benefits for individuals that are receiving services within the SAPC or SCD system.

Next slide, please. All right.

And I should maybe make a note on this slide, because the outcomes presented are not just specifically overall in our recovery bridge housing program, it applies specifically to outcomes related to the funding connected to CFCI. Based on this we see in fiscal year 22-23 a total of 919 participants received services to recovery bridge housing. 51 of those also received services during this first quarter of this fiscal year. Total number exiting recovery bridge housing that was 814 in fiscal year 22-23 which represented a 23% of individuals moving into permitted housing settings.

For fiscal year 23-24, I think we're seeing a trend upwards. Of course it's, we're only looking at one quarter. So it's to be seen if this current trend kind of continues to move upwards.

All right so next slide, please. So I think it's important when we really attribute human element to some of the services that we

provide. And I think these are just different stories we've collected at least over the last several quarters. I think, I'm now going to go through all of them, but I will touch a bit on the story from Ralph. I was the one that was most impactful for me.

This is a gentleman with 40 years of addiction, many, many years in prison, many struggles with treatment. Issues with maintaining employment and mentioned how the union of treatment and having safe housing really ensured his road to recovery. So I congratulate Ralph with all the work that he's done, and very excited he's moving into rebuilding his family relationships.

I'm going to move into the SCD court diversion but before I do that, should I pause for questions?

>> Member Steele: Let's pause for questions. I'll start. What is, what happened to the other, do we know where the other folks actually went the ones that were not moved into permanent housing.

>> So some of them might have maybe moved either left prematurely from services, maybe moved into other interim housing, environments, maybe moved back with family or some of them maybe necessitated being back into a higher level of care such as residential treatment services.

>> Member Steele: These are, the 34% and 45% are not, are they representative of people who may have needed services more than one time or is it just unduplicated.

>> I want to say they are unduplicated, however, because we have two fiscal years, you could have individuals coming in in one year.

>> Member Steele: That's what I'm asking do we know if it's

unduplicated or not.

>> I think I want to say there might be some duplicates.

>> Member Steele: There might be, cool. Go for it, please.

>> I was just wondering about the recovery bridge housing program outcomes number also where last year it was 273 out of 814 and the first quarter is out of 137. So is it have that more people come later in the year or it just goes up and down?

>> I think it's more of a data lag for quarter one because we tend to go through a blackout period for billing, so I think sometimes it also affects data submission. So it's more of a data lag.

>> Thank you.

>> Thank you for this. Wesley Crunk. A few slides ago I was looking at it and it said that you had 1300 plus beds and that soon you will be at 1600 plus beds. Is that correct?

>> That's correct. The goal is to be at 1600 beds at least by the first quarter of fiscal year 24-25.

>> Member Crunk: Last year you serviced 919 people and this year you're on pace for serving 1004 give or take whether it picks up or not. For this to be, for such a very needy group or group that needs attention when we're talking about housing and reentry, why aren't those or other beds being filled or what is the criteria to qualify, so I'm just if that's making sense what question I'm asking. 1300 something beds.

>> And you might be referencing the 919 number, correct.

>> Member Crunk: Right.

>> 919 were specific individuals that participated in recovery housing through CFCI funding. Total universe of individuals that

participated in recovery bridge housing for fiscal year 22-23 was over 3300.

>> Member Steele: Do that question, it's not the whole housing programs outcome it's just specific to the 100 beds that were CFCI these are the numbers just for the 100 beds.

>> Yes.

>> Member Crunk: Thank you.

>> Thank you for that question.

>> My turn. Thank you for your presentation. I know that not all housing is equal. We're talking about quality affordable and safe housing. There was a situation where there were some native housing and folks were getting, got closed down they were getting sent out to hotels, places that weren't safe and it was counted as being put into a safe place. So I guess my question is two part, what type of housing are these folks being transitioned to, is it like the king Edward hotel downtown or is it like something that's, we would live in ourselves personally. And two, is there any stats you have based on race how folks are getting served, whether they are Black or Native American, American Alaska native and different data sets.

>> Yeah. We do have data maybe to your last question, data in reference to I guess the demographics. We could make that information available. But I might have some of the stats.

>> When I say king Edward I think folks are probably familiar with that it's an SRO it's not really appropriate housing. Yeah.

>> So I think in reference to demographics specifically for this project, of course I think the majority were male. Female was the smallest or smaller number. I think age range, hold on just one second

because it might be easier to do percentages and I only have numbers. It might be easier for us to submit that information to this group if needed.

>> I only ask that question because this committee is committed to Black and indigenous populations and people of color and I want to see how it makes sense the investment that this committee has made into this housing to see how it's reflecting in those numbers who is being served.

>> Most definitely. I will tell you, I will say this. In reference to when we look at all of our criminal justice population, and I'm just talking in general, population coming into our programs, 75% are male. 23% of them are female. In reference to ethnicity or race, Latinx makes up 61% of the population. Followed by white at 18.3. Black or African-American at 17.4 and the remainder Asian Pacific Islander and so forth. American Indian, Alaska native .6%. And this is just criminal justice involved populations these stats are from fiscal year 22-23.

>> Member Steele: Reba, Member Stevens.

>> Member Stevens: I've a few questions it would have been helpful to have that particular data you just spoke of. But on page 2, I'm real curious and interested in knowing where are these beds. You used the language 1354 and although I get it's 100 beds from CFCI, but I would like to know in what spot service planning area, supervisorial district and that would be helpful. You don't necessarily have to respond it would be nice for us to have the information.

>> Okay.

>> Member Stevens: To see the full picture. Although there is 100

beds funded by way of CFCI, I think it would behoove you for us to see the broader picture so as we are looking at future funding or how we can support the advancement and the success of the program, it would be helpful to see it all.

The other is on I think page 3, it would be helpful, I did say it would be -- and thank you so much for sharing the success stories. I think success stories are critically important and then I'm hoping that there's some way in which you are able to follow folks for awhile to see just how successful they are, you know, like perhaps over the span of five years. I don't know how much that would cost but I think it's necessary because alcohol and drug addiction, it happens today but a situation and circumstance can happen tomorrow and, you know, I don't have the will powerful if you feel to maintain or sustain my, sobriety. How you are getting funding because you can't bill Medi-Cal, it brought to mind where we are today. We have proposition 1 that passed I hope we could advocate for some of those funding dollars to support. It has to be a continuum in our communities. Thank you.

>> Thank you.

>> Member Steele: Member Crunk.

>> Member Crunk: I had one more question this question in a lot of different forms it baffles me how so I mean I was incarcerated before I know the numbers are a little different, but not that much. So I'm looking at something right now that says LA county has 55% Latino inmate and 30% African-American and then 13% white. But when I heard your percentages of who gets servicing, the Latino was 61, white was higher than the African-American, and the African-American was 17%. So my question is, you know I heard

Medi-Cal you couldn't be on Medi-Cal, so I know a lot of less fortunate African-Americans are on Medi-Cal but I'm trying to figure out how is it promoted to people and how is that, that help being jumped over what are we missing.

>> Chair Steele: Great question. When Julia asked for the number how are we doing the outreach to make sure it is representative effectively.

>> And the data that I mentioned is specific to criminal justice involved. So it's a portion of individuals coming into our system maybe about 20, 25% that make up the whole universe of individuals that access SUD. I think we can look globally to see if there's a change.

>> Quick follow-up to that. American Indian Alaska natives there's more here in LA county than anywhere in the United States borders. There's 1 million. And the statistics I've gotten is that we have the highest suicide rates, highest incarceration rates and police brutality race per capita. There being a million natives in LA county, .06% being served there feels like a disparity if they have the highest incarceration per capita. There is obviously I feel like a gap and my brother Wesley lifted up to is that, as a whole, this committee, we're committed to that. That's why we voted to put these dollars into affordable housing. I guess I think the challenges when I say how do we improve this and how do we do better not calling out but like how do we call it in and improve it.

>> Chair Steele: I would add I got you member Contreras not it, call it what it is there's a disparity we need to fix it. Because that's problematic for sure. I'm glad we are serving people but we want to make sure again in the underscore of the emphasis on Black,

indigenous, people of color and that's what these funds are for so these beds should definitely have that priority for sure. Member Contreras.

>> Member Contreras: Thank you, for the presentation, Jackie Contreras DPSS. I know you're reporting on the 100 that are CFCI funded but that leaves 1254 that are not and the populations that we're talking about there's no reason why they wouldn't be served with the rest of that funding, is that correct?

>> That's correct.

>> Member Contreras: It would be helpful to see the data on the hopeful so we can sort of get a better understanding of the disparities and where services are going.

>> Chair Steele: I think member Stevens asked for the same thing we want to make sure we get that data so we can take, you know, take that into account. But even with that being the case, again, the emphasis for these 100 beds when we're looking at the numbers, it should be the opposite of just the natural functioning of things. When we're thinking about the placement for how these dollars are being used for those different spaces we should be thinking about BIPOC communities have the priority for these spaces. I agree. Real good point where those beds are for these dollars as well.

>> Is the committee looking for maybe a map or just kind of a classifying where all of the beds are for recovery bridge housing inclusive of the 100 beds made available through CFCI because that gives you a global picture.

>> Global map maybe have two different colors so you can see which ones are which and where they are and also the delineation of

the data that was asked for today with the specificity of who is utilizing these beds, how and why. Thank you.

Got a note just be mindful there was an error in the transfer of the slides to the agenda so not all slides are in the packet. But they are in the presentation so there may be some in the presentation that may not be in our packet just be mindful of that.

Let's continue on. Let's just make sure we get the update added so and also to the public so they have it as well. Please continue on any other questions? Cool. Let's continue on.

>> I'll move on to the second project that's funded through CFCI and this is actually a project that's two fold. The SUD court based diversion dollars are utilized to support the client engagement and navigation services. But also supports the cost of room and board for justice involved individuals in residential treatment at Martin Luther King or the behavioral health center so I'll cover both of those projects.

Maybe just to level set the client engagement and navigation services is one entry point for the SUD system. There's others such as the substance abuse services help line which is a 24/7/365 day help line. The core centers which are kind of in maybe health centers and also the individual to go directly to providers for services. So really kind of like a no wrong door approach.

The CENS are also community-based providers. There are eight, there's one CENS situated in each service planning area. Although they have an area office in each of their SPA's, the model for CENS has always been that we are taking services to locations where we are needed at. So what that means is we have over 130 locations where

we're serving. Am these could be courts, these could be probation offices, these could be permanent supportive housing sites, family solution centers, health clinics, et cetera.

The CENS staff are SUD certified and/or registered counselors. They provide face-to-face services really to ensure that they are facilitating not only engagement, connections, screenings but actual linkages to treatment services.

Some of the activities as noted in the slide include outreach and engagement. Really focusing on these very hard to reach populations who may require maybe some closer engagement. Such as those that are in encampments. They offer a lot of education and training such as early intervention or specific training or education to individuals who are probably not ready to engage in services.

They do a lot of screening, appointment reminders and so forth, follow-up to ensure that individuals who have been encountered are actually connecting to services.

There's of course the service navigation element and that's kind of to ensure that it's not just, say, connection to SUD treatment services if an individual would require services, say, maybe in health services or so forth that individual would be connected.

All right. Next slide, please.

[Captioner change 4:59 PM]

>> JOE WILLIAMS: American Indians Alaska Natives, there's more here than anywhere in the United States borders. There's 1 million and the

statistics I have gotten is that we have the highest suicide rates and police brutality rates per capita. It feels like there's a disparity. If they have the highest incarceration per capita, there's obviously, I feel like, a gap. And especially my brother Wesley lifted up, too, is as a whole, you know, this committee, we're committed to that. That's why we voted to put these dollars in premier affordable housing. The challenge is how do we improve this and do better? Not about calling out but how do we call it in and improve it.

>> DEREK STEELE: I got you, Member Contreras. People of color, that is what these funds are for so these beds should definitely have that priority. Member Contreras.

>> JACKIE CONTRERAS: Thank you for the presentation. I know you're recording on the ten CFCI funds and that leaves --

>> That's correct.

>> JACKIE CONTRERAS: It’s helpful to see the data on the whole so we can get a better understanding of the disparities and where services are going.

>> DEREK STEELE: I think Member Stevens asked for the same thing. We want to make sure we get that data so we can take that into account. But even with that, that being the case, again, the emphasis for these hundred beds, like, when we're looking at the numbers, it should be the opposite of just the natural functioning of things.

That's what we're looking for. Where those beds are for these dollars as well.

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>> Is the Committee looking for maybe a map or a classifying where all of the beds are for Recovery Bridge Housing, inclusive of the 100 beds made available through CFCI?

>> DEREK STEELE: Maybe a global map with two different colors so you can see which ones are write and where they are and also the delineation of the data that was asked for today with the specificity of who is utilizing these beds and how and why. Thank you.

Got a note. Just to be mindful there was an error in the transcript for the slides.

Let's continue on. Let's just make sure we get the update added. Okay. So and also to the public so that they have it as well. Continue on. Any other questions on that? Cool let's continue on.

>> I'll move onto the second project that's a project that's two-fold. The SUD Court-Based Diversion donors on utilized to support the Client Engagement and Navigation Services but also supports there's others such as the substance abuse services help line which is a 24/7, 365-day help line of the core centers which are in maybe health centers and also the ability to individuals to go directly to providers for services so really kind of like a no prong door approach. The CENS Staff are SUD certified and/or registered counselors and they provide face-to-face services to ensure they are facilitating not only engagement connection screening but actual linkages to treatment services. Some activities are noted on the slide include outreach and engage. Really focusing on these hard-to-reach populations who may require closer engagement such as those that are in encampments. They offer a lot of education and training such as urban intervention such as

specific training and education to individuals who are probably not ready to engage in services.

We do a lot of screening appointment reminders and so forth. Follow up to up sure that individuals who have been encountered are actually connecting to services.

Next slide, please. So how is the be CENS I guess connected within the CFCI funds? So under diversion we receive two million dollars. Only $300,000 of the 2 million are specifically allocated to the CENS program. It was really incorporated to support the Rapid Diversion Program and really supports the three courthouses kind of listed on here. So the Antelope Valley, CCB, and Van Nuys; however, the table on here, I think kind of shows the total number of RDP clients that have been referred to our CENS providers for fiscal year it 22/23 and 23/24. The CENS with co-locations, if there is a justice involved individual in need of a connection screening linkage or navigation services the CENS providers or counselors will activate and assist these individuals.

Initially the funding was just to support RDB but as we progress with the implementation of these projects and the funds of CFCI, the funds has been extended to service other justification involved individuals.

On here for fiscal year 2/23 we see that a total of 444 individuals were connected, screens and connected to services and of course 268 connect and screened to services. Next slide, please.

Again, as I think I mentioned earlier, this is the human element. This is the important piece of the work that we do. For me, I think Joe's example of having ten years of alcohol abuse that results in having a domestic violence case, he was referred through RDP and engaged by CENS and connected to

treatment. Also connected to other services, maybe as ancillary services offered through mental health services, anger management. And as noted here, eventually we see a modification to his restraining order, allowing him to reenter his family. These are the success stories we look at. An element we tend to do is with the providers and allows us an opportunity to really be on the ground.

Anyhow, this is I think the project for CENS. Now the last piece and this is in reference to the secondary program. And earlier I mentioned that out of the 2 million about 1.7 million is dedicated specifically to support room and Board for justice involved patients. That room and Board supports the residential services, residential withdrawal management, again, at the Behavioral Health Center. The cost of treatment, as I mentioned earlier, that is, of course, covered through Medi-Cal or drug Medi-Cal. And, again, maybe another project where we're kind of like braiding funding to ensure the individuals are receiving the services that they so need.

And on here -- oh, I'm sorry. I'm sorry. Next slide.

>> DEREK STEELE: Really quickly, though. So 130 different places, that's where you're co-locating for the services?

>> If you are referring to the slide in reference to CENS?

>> DEREK STEELE: Yeah.

>> The CENS program we have over 130 colocations. Three of those are funded through CFCI.

>> DEREK STEELE: Okay. I missed the three. So how are you using the money? 300,000 for 130 different colocations, what? Got it. That's wild. But a question of where are they, that's a good question. Member Stevens.

Again, we want to know where these are. I think you know the SPAs or the districts, have I the knowledge of where we're being intentional about the placement and also the services provided and who is getting those services is really important to the work we're doing.

>> All righty and is this -- my apologies.

>> DEREK STEELE: That's okay. Go ahead.

>> Is that request in reference to trying to understand the entire CENS program, where the colocations are?

>> DEREK STEELE: Yes but for the CFCI dollars, I just want to underscore for the way that these funds are supposed to be utilized, there's an emphasis from an equity perspective to make sure those who are being serviced not only just by location but even just the individuals themselves being serviced by this are BIPOC focused, right? Because universally, yes, you have to care for the entire County.

But for the utilization of CFCI funds, there's a specificity tied to this. Member Stevens?

>> REBA STEVENS: I just want to add that I think, I want to set aside dollars because I understand this is about the CFCI dollars by this is also about life. And I think that it would be helpful to see the broader picture so that we understand where the needs are. Who is being served, how people are being served. There could be -- and I want to believe there will be -- opportunity to fund for more and we will better understand now where the needs are. It's really about unmet needs in the communities across the County of Los Angeles. It would be helpful to see a full picture of all presentations moving forward.

>> DEREK STEELE: I agree. Many.

>> Maybe to your question the CFCI dollars support the Antelope Valley Courthouse in SPA one and SPA4 and Van Nuys SPA2.

>> But the places come from all over the place, right?

>> DEREK STEELE: Thank you for that Member Crunk the percentage of those for criminal -- so if I know nothing else from when I was young, growing up in LA -- 70s and 80s -- yes, the population of African-Americans in the County has went way down. But the one base.

>> WESLEY CRUNK: We haven't gone that far down is the justice system and homelessness. When she's talking about that number of beds, that's supposed to be for that community and the numbers are still lower. That's what struck my ear. The Hispanic percentage of inmates was 55. The inmates being serviced of that hundred was 61. That's close.

The percentage of whites I think was 16 or something and it was 13. That's close. It was 30% African-American but 17% -- and I'm not saying it's done purposely. I'm saying maybe the outreach or whatever the qualification is maybe going over. I don't understand it but just the math. The math just jumps out to me.

>> DEREK STEELE: The ain't math'ing. I get it. Thanks. The last question I have on this is partnership with community-based organizations as a part of the work because I think the culturally relevant practices that exist in these organizations might be helpful to this so that some of the blind spots that the County may have because the macro picture for the program itself, the specificity that might be there because of the practices for team-based organizations being involved might be helpful. I know $300,000 might make

that difficult to do. You might have one organization to work with versus the two million but it's something to consider. Even if from an advisory standpoint and maying advisors to help you with your thinking about how you can track those. Interest different ways to go about it. But yeah.

>> And I should say that 100% of all of our services are within the community. Okay?

>> DEREK STEELE: Please continue.

>> All right. So I think just to with a number of Items in references to last slide, I did mention it that of the $2 million that's allocated through CPI, 1.7 is specifically dedicated to support the Martin Luther King Behavioral Health Center. Really supports number of, I want to say 33 specific beds that are designated for criminal justice involved individuals. It really supports the room and Board component. The Medi-Cal piece really supports the treatment service element.

The -- based on this and this is for the data for fiscal year, this current fiscal year, 23/24 to date or maybe through March, residential services has served approximately 278 patients and individuals that have gone through residential withdrawal management. That total was three hundred 18. The table showcases average lengths of stay for some of these individuals.

I think as has been questioned in the other projects that we presented. We could also offer maybe some demographic information in reference as to who these individuals are.

>> REBA STEVENS: May I ask a question about the numbers you just raised? Did I hear you say 1.7 million to serve 33 participants? Or 33 beds?

>> 33 beds.

>> REBA STEVENS: And that is for how long? What's the period?

>> A bed is funded on an annual basis and that bed could potentially turn over multiple times. If the average length of stay is 90, then potentially the bed is turning over four times.

>> DEREK STEELE: 288 is the number of patients, right?

>> Yes, that's my understanding.

>> DEREK STEELE: Got you. All right. Any other questions? Thoughts? Let's move on.

>> Okay. I'll turn it over to my esteemed colleagues here.

>> Good evening everyone. Can you hear me okay? We are transitioning --

>> DEREK STEELE: Use the Mike because we need to have it for the community Members.

>> Brian Hurley medical director -- and joined by -- CFCI has funded a number of harm reduction programs and public health and health services work together to make those programs effective in the community. So we're doing a joint presentation about CFCI funded harm reduction programs. And to help demonstrate how harm reduction programs connect to the mission of CFCI to mechanic sure care is available to the community where it's needed most, I'm going to invite Dr. Bluthenthal up to the podium.

>> Good evening. Professor in the Department of Public Health sciences at the Keck School of Medicine. For 35 years I have been ducted community-based research with people who use drugs in Los Angeles, California and elsewhere.

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I'm going to try and keep my comments brief but let me give you the three highlights of what I'm going to share with you today.

The health problems of the population of people being unhoused has resulted in multiple health epidemics that continue to get worse. That's the first point.

The second is that approaches emphasizing abolition and harm reduction are effective means. And then I'll just conclude with some thoughts about the importance of engagement with these populations that are at risk in terms of actively being involved in creating programs for both people with lived and living experience to help us be efficient and create programs that are sustained.

Okay so this first chart shows you the situation with overdose deaths in Los Angeles County. Something that jumps out as somebody who studies these programs is that we have really gotten off lightly, also a thousand people a year is awful. But things have picked up in the recent years, driven by the purpose the Fentanyl related deaths and there's no evidence that's going to stop.

Next slide, please. I think this is under reported and under discusses is the ongoing Hepatitis C epidemic. This is California data and it just shows this cohort difference. There was a cohort of people that were really vulnerable to Hepatitis C born in the 50s and 60s and came to maturity in the 60s and 70s and now we have a new one that's been driven initially by the prescription opiate problem that has now become one about heroin and Fentanyl and there's no signs of that stopping and this is a national phenomenon.

Next slide, please. These are data about other health cancer consequences related to chronic substance use including bacterial infections. These data from the West Coast and part for the national study. I like to show under reported health problems having significant impacts on our health system and with bacterial infections within injecting drugs and chaotic drug use patterns.

Next slide, please. Finally, to close the gap on this, all of these health problems are exacerbated by the economic and social business end of our incarceration system and inadequate public health response. When people are unhoused they are more vulnerable to HIV and Hepatitis C.

Although we don't track a lot of these carefully, we have science that reports clearly if you have an ongoing homeless crisis which we do in this county and you're not addressing it adequately you can expect to see HIV outbreaks and continuing hepatitis problems. Next slide, please.

>> DEREK STEELE: Briefly. Thank you for the content. But in order to bite size it for community. Rates of opioid and Fentanyl deaths are going up and it has jumped after COVID and after. HC is a generational problem. Folks who are using are dealing with bacterial infections in a very real way. The homelessness issue is drawing up the numbers in infections and exposures as well. Correct?

>> Correct.

>> DEREK STEELE: I got you.

>> We can skip the slide I just covered this.

Our response to a lot of the health problems of minoritized people and low-income folks is often incarceration. We know and there are international

studies that document that incarceration increases the risk of overdose death dramatically. So in the two weeks after release from incarceration, there's something like 10, 20 times increased chance of loss of life.

We all know that felony convictions are carried on people's resumes and their work history for the rest of their lives and result in them having difficulties obtaining employment, getting access to public services, and education and training opportunities. People don't go to jail or prison to heal.

Next slide. This response comes out of a political response of Black empowerment in particular beginning with the Nixon administration and this well-known quote about the War on Drugs. Next slide.

Punishment and retribution do not create safety. We know when people are incarcerated they are isolated from individuals that would be normally part of their social support. They lose housing and social relationships and they lose opportunities for educational growth. It's just a big fat negative and the result of the people coming out of those systems are placed in circumstances that make it difficult for them to obtain the responsible living situations that we would want people to do. And of course, it undermines community clout. They don't get to vote. The residence is the Counties that they are in and not the Counties they come from which further disempower our folks. Next slide.

The solution of what we have endorsed in this County is care. Creating these community resources that divert people and building alternatives that help heal and repair the traumas that people have experienced. At the same time always invest in increasing political power for communities. Next slide.

Harm reduction is a great example of this. In the United States it really began in the late 80s and early 90s and it came out of the HIV epidemic and our nonresponse to the political help and systems. I was in Oakland and helped start the needle exchange program in 1990s and it's driven by these basic principles – client directed, not judgmental and nonpunitive and practical. These strategies are low threshold and sustainable with a focus on people who use drugs, considering their experience to help us figure out what's the best way to help them. Ask them what's the best way to help them rather than telling them.

Next slide. Syringe service programs began in the 80s. We got Naloxone distribution thanks to Dan Biggs. Proven in multiple studies to be very effective in preventing overdose deaths. There are things we are now contemplating like overdose prevention sites. There are hundreds in Canada and thousands throughout the world and these are to empower people with health challenges to act on their wellness. With he know now when we give them the resources they need, they will use them the way we intend to improve their well-being and sustain their lives.

Next slide, please. These are examples of the kinds of interventions that we can contemplate and their relationship to direct or indirect influences to health problems people face. Next slide.

So working directly with drug user unions. There are stong ones in the County. There’s a national drug union that has sort of emerged. There’s a lot happening in LA County slowly, sort of more slowly than I would like. But I think one of the important points is that through engagement with the people who faces challenges, that's where we find the solutions and he need to do more of that moving forward. Next slide, please.

This is a synthesis when you think about abolition and harm reduction. They have things in common and things that are different. You end up designing programs than nonjudgmental and invest in people and address some of the structural determinants that lead to poor health and well-being in our populations and more importantly, building alternatives to a system that has not worked for 50, 60 years.

Let me repeat this. The alternative to harm reduction and abolition is death and suffering, right? We know, if you could arrival time your way out of any of these problems, God knows we would have already done it. It's really imperative to continue the process you have done in investing in the people and our communities that have these struggles.

>> DEREK STEELE: The idea of folks with lived experience and the thinking about right now, these are the solutions that we have. Are we creating spaces for more or at least creative or envisioning spaces for other alternatives that can be brought to the table as well or are we leaning into the ones in front of us?

>> I think we need more. I have a Ph.D. and I have been doing this a long time. I know nothing. Everything I know is because I talk to people who have problems and listen carefully with them and try to work with them to come up with things that actually work.

>> REBA STEVENS: Hi doctor Ricky. How are you? It's really good to experience you in person.

>> Thank you.

>> REBA STEVENS: Reba Stevens.

>> Great. Good to see you.

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>> REBA STEVENS: Couple of things. One is, I was looking at page seven. Fentanyl and I think I need to read this really slow. Fentanyl and other opiates continue to drive overdose deaths in Los Angeles County. That's a powerful statement and it's a reality of where we are and I'm just hoping that we all sit with that for a moment because when I look at this graph and how it continues to rise -- my question that I have written is -- I made a statement. We must do better and why are people turning to drugs?

My question is for you, in one of your slides you mentioned health challenges. And I was curious if when you're talking about health, are you only speaking of physical health or are you also considering or including mental health as a result of people continuously using drugs to die? That's one. And then the other is, in reference to utilizing people with lived experience that have been there but also creating the space for the authentic experience and the authentic voice in order to weigh in. So I see an opportunity for more research. Because we researchers. I see an opportunity for research in this to really do more studies and I don't know if that could be funded. Look at this graph. It keeps getting worse, never better.

>> Mental health is a part of health. Spiritual health, community health. If you're in a circumstance where everyone around you is doing better, you're likely to do better and that's one thing to think about. I'm a researcher and so I do research. We know how to help a lot of the people in these circumstances but what we don't have the way necessarily is the political will to do so. The.

This wasn't in my talk but I'll just talk about it because it's been on my mind lately. There are universal basic income pilots, hundreds, thousands.

They kind of work. So when you have a circumstance, when you look at the populations who are unhoused in LA, many of whom are receiving genre leaf which is 270? 221 and hasn't changed since 1986. That's not a surprise that people are then struggling with food insecurity, with securing housing, with finding restrooms and shower facilities. These are all obvious consequences of not giving people the resources they need.

So I would also include money and I think -- we can do research -- but I think we kind of know the solutions in some of these things which is giving the people the resource they need. There's this housing 2.0 program going on in Hollywood which is mental health focused which is also promising approach which brings resources and flexibility to case managers and people with props so they can work through hey, what's going to get you to a better space. I want to refer back to the earlier comment.

I guess she's gone. One of the things when you look at the case studies, you see people saying consistently, reconnecting with family. Our system doesn't help facilitate that, right? Because family may mean traveling out of state or it may mean bringing them here or maybe going down to San Diego. So having that capacity to help people find their wellness in a flexible way with reasonable resources including money is important.

>> Thank you for your presentation. I would have to disagree on that the system is broken. I think it's working perfectly the way it was designed as the War on Drugs and poor people.

>> JOE WILLIAMS: As someone who has experienced being taken away from my Native American mother at seven years old in Kern County. We live in a police state and whether it's the LAPD or the US Calgary. When you talk about the political will, the Mayor of Los Angeles put a million, billion dollars

into the LAPD and no one has called her on that. You all are working against. Do we play identity Politics and give her a pass or manufacture the will to hold her accountability. I know if it was Antonio Villaraigosa people would be pissed off, they'd would be at city hall, holding him accountable and so would I. Whether it's Karen Bass or Antonio Villaraigosa or this Board here we have to look at the root cause and it's the police state and we have to have the political will. Cause all of the good work we're doing could be trumped -- no pun there -- by the politicians. Thank you for the research and the work you're doing but I just wanted to lift that up.

>> Thank you for your comments.

>> Chair Steele, if we can talk about the CFCI investments.

>> DEREK STEELE: Quickly. Thank you.

>> I just wanted to start by introducing myself because I don't know many of you. I will talk more -- there you go. Is that right. My name is Shoshanna and my background is I have spent 25 years working with people who use drugs and particularly those who are affected by in harm reduction programs or connected our services. I came to LA County for the opportunity to work with the version reentry and diversion for people who use drugs and also to scale up our overdose prevention efforts as we were watching the Fentanyl, on the uptick from the outside on the County. I am so thankful to CFCI and Measure J to help make the difference you're about to see.

>> BRIAN HURLEY: Addiction psychiatrist, Brian Hurley. We're going to be talking about harm reduction programs but I want to make sure it's known where these fit into the County ecosystem. Some of the most impactful programs we have are youth development and promotion programs. I want

to highlight there are positive youth development program that's support children and Families with healthy emotional development and there's more generalized substance abuse messaging. Harm reduction works with poem who use drugs in between the substance use prevention and treatment sectors.

We do and I work assertively to make sure treatment and recovery services are broadly available to Los Angeles County and all of our residents and we work on surveillance. This is where harm reduction fits into a continuum of health services.

>> The approach we have taken is that in order to meet some of the needs of the underserved populations like people who use drugs in Los Angeles County, we needed to do two things. It was a very under resources sector and we needed to help stabilize and help them establish themselves and meet people where they are. We had to address the fact that people using drugs are touching our healthcare system and reentry system: Having harm reduction as a separate thing, six programs up until last year, it was not adequate. When we looked at incarceration and what we needed to do on that front, there are reasons why all of this effort came together.

I'll tell you the thing that makes me the saddest is the number one cause of death of people leaving incarceration is overdose of opioid and it happens within the first two weeks and often within the first couple of days. A lot of this is making sure the person leaving can connect with a case manager, counselor, that we would have more opportunities to help that person stay alive, to give them valuable information to help them understand strategies they can use to protect themselves. Naloxone exists and give them the tools they need to stay alive and save their community Members.

In terms of strategy we took the CFCI funding opportunity and put it into doing the two things. Stabilizing and enhancing the existing system and working across all of these other partners and sectors: So in CFCI round one we received $6 million. This is DPH and DHS. That was for a range of programs. And round two for drop-in centers throughout the County. The expansion has meant that we've gone from those 6 original programs to 20 including two new drop in spaces. We have been able to use this justice reform momentum to identify other justice related funding opportunities with both AB109 has been a key funder with this and SAMHSA, CDC, Department Health care Service, and California Department of Health have all come together to support the momentum of harm reduction expansion.

>> The point has been made why now? Why is harm reduction such an important service to invest in now? Overdose number one cause of death of people from reentry. Reducing incarceration means more people leaving jail and the only requirement to be in recovery is that you're alive.

We have to keep people alive in order to support people's health and wellness.

>> DEREK STEELE: Right.

>> Next slide.

>> So this is what's happened since the investment has happened. There have been over 92,000 people served through these programs. Those are outreached short interventions and some longer sitting with a case manager at one of the drop-in centers. That's unique individuals is the 92.

The total number of events -- and it's hard to tell exactly because sometimes we don't keep records in a way that's easy to cross reference but

these are the two big numbers about the scale of outreach and engagement efforts.

So far there's been 25,514 overdose reversals in the community. Some are stamp some are people in treatment centers and doctors and these are people saving each other. That's who is on site when somebody overdoses. Family, loved one, whatever. This is just true community power and $25,000. The Naloxone is that we have been able to distribute, we have distributed 621,000 doses over the last -- we started at the very end of 2019 and actually, if you go to the next slide -- you'll see the over dose slide in a bit. Do you mind going -- never mind it will screw it all up and I'll just tell you.

>> DEREK STEELE: In the essence of time, any highlights, I think you have about five or six more slides. Give me the highlights.

>> Then let's do these are the programs that you guys funded. Drop-in centers, engagement, syringe service programs and outreach and overdose outreach team on skid row and they have government carts and roll around with oxygen and identify people down on the ground and whose breathing is compromised and take out the oxygen and sit with them and wait with them until they get better and wait with them there or take them to services if they want to or wait with them until they are all right and this is remarkable.

>> This gives you an idea of the harm reduction. 2022 there was a huge expansion in response to CFCI invest Tolman next slide.

>> Do you want to do this one?

>> DEREK STEELE: I like the pictures.

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>> Some of them are from the LA times and some outreach and the second is the golf cart from downtown and the one on the right is the memorial project made by clients at the overdose awareness day. Just, again, your investment means less death in vulnerable communities. There's nothing more you can do with this world. It's amazing. This is the distribution of Naloxone. We put the vending machines in LA County jails at the exit and they distribute over a how a month.

These are people themselves at high risk of overdose death and we mapped where they are going back to and they are going walk to communities deeply affected by overdoses and the 25,000 reversals come from this and services.

>> Thank God that much Narcan is out in the community. Think about where we would be if we had not saturated the community with Naloxone.

>> This one is important to share. There are a couple of ways that we have been making sure that people with lived experience are part of the growth here. Set up a ton of overdose prevention trainings but we did a workforce needs assessment for this growing field and set up three trainings. Direct service Staff, supervisors, job seekers. We have three different graduating classes from job seekers. We are from communities that are impacted. Sex work, homelessness, incarceration. Offer the opportunity we pay them while they go through the program and we have started moving some of the folks from the program to jobs at the drop-in centers and SAPC did a parallel or partner program.

>> We have invested in the workforce and the agency. We did an agency leadership training on how to build organization capacity to carry out these.

>> The number of full-time jobs were 66. 36 part-time jobs created as a result of this that continue to be funded by the CFCI program.

>> In direct response to CFCI funding.

>> In terms of community engagement and being partners with people who use drugs and others with lived experience -- combination of community Members and providers and advocates and researchers and folks like us. We talk about what are the critical community needs and how are we responding to it and how can we do better? We modify what we're doing depending on the response in the room.

>> On the left.

>> We found the meetings themselves was challenging for community Members to come to, particularly people who continued to use drugs, who are actively using and we set up listening sessions with the harm reduction providers and went into their cohost listening sessions at the outreach centers and in different parts of the County and the red dots are places where we have held listening sessions with people who use drugs in the communities.

>> Next slide.

>> When you said five-minutes, we should have handed to Veronica.

>> Let's go ahead and do that.

>> Just so you know the slides not printed outline is a table of funding to all people receiving funding and these are all the programs: This is going to be sent out to you again so if you want to see in more depth. I know you had questions about where and how and who. We'll make sure this is available.

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>> Veronica, next slide.

>> I'll be quick. But I think you understand what's happening on the ground. We're one of several organizations doing this work but essentially, you know, we have been a part of the multidiscipline ay team process and we have the second largest number of area of teams in the County. Oscar our program manager, our teams got tired of seeing people dying so before this money came along, we literally just began, Oscar began to get in kind donations and when the resources came along we significant really grew our program. So our work involves all the things you see there: What are we doing? We're going to over 40 different encampments doing street-based harm reduction. Taking clean supplies and collecting used supplies and giving out Narcan. Wraparound of harm reduction supports. People would previously not talk to outreach teams. They would take the food and resource and not talk to us.

Harm reduction has allowed us to engage with people who would not speak with us. Before we were trying to save their lives in a nonjudgmental way and we are now meeting where they are. We opened a harm reduction drop-in center.

We are going to be adding to just I think Brian told me less than four of these machines but we are about a month away from having a drug checker machine. You hear about all of these drugs being laced with all of these different things and this money has allowed us to add to one of the fee in the County. That what means is we're going to be testing drugs and being able to say this is what's in it. This is what we're seeing this week. This is what the drugs are laced with. Be careful so people know what to do. We're giving outstrips and you know there's limitations and it doesn't try every

drug. We're restoring a sense of humanity. There's a lot of demonization and judgment with folks using drugs and we're just trying to save people's lives. We are the community we serve.

The lived experience and lived expertise came up and everyone on this project is on their own different journey. Really our team understands the lingo and know the slang and they know what's going on. It's relevant. This is not just a program. I heard somebody say yesterday, people that are closest to the problem are closest to the solution and that is literally a motto and we are excited about having a space for people who wished they had the services Oscar says to be able to provide support and educate people and stop people from dying.

Here are numbers and I'm not going to cover all of them. In the last three years we've had over 28,000 encounters and CFCI makes up close to 4% of the dollars we are operating with. We have distributed over 24,000 boxes of Narcan and carps removal over 25,000. Fentanyl test strips over $34,000. And we have saved 732 lives. We communicated and he had clarity and distributed and trusted the community to support themselves and reversals happened.

Other things happening, before we had the harm reduction teams, lots of folks would not talk to us. Not only are they engaging with us, we are educating them how to use drugs in a more safe way which they're very grateful for. But it also allows us to an entry into them being willing to discuss housing supports, other physical health supports, mental supports. Part of what we're doing, in addition to what I've mentioned is we are partnering and doing a lot of street medicine things which includes screenings.

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You can see this is an entry for us to be able to help people in all facets of their life. Next slide.

I'll share a couple of stories. And the one thing I want to say is we are a harms reduction provider. We are the gateway. We're intensive outpatient treatment provider. We're recovery bridge housing provider. So harm reduction is one of the ways we serve people but we understand we're going to meet people wherever they are.

A couple of stories for you. Just to uplift the importance of harm reduction. These are made up names. I will tell you about Sandy who was living on the street for over two years and her drugs of choice were heroin and Fentanyl. When we engaged her and we gave her supplies and Naloxone. She really understood the importance of helping save lives. She's still living on the street in an inoperable R.V.. But she has essentially become a de facto safe consumption site. People know to come use drugs and we're in Sandy's R.V. and she has a box outside her R.V. with Narcan and the community know she is a safe space and a champion. She is still using herself but she creates safe spaces so that she can prevent other people from dying or having other consequences.

Jane has been homeless for more than 3 years as well. Her drug of choice is Meth. Overtime, she began to get services, but the story is: Oscar was walking through our building about three weeks ago, a month ago. He saw a lady that looked familiar. She said, "You guys helped me. I was living outdoors. I was using drugs." She's no longer using drugs, she's now house and employed. She happens to be employed in out building, but she's moved forward on her journey.

The last story I'll tell is Joan. So, Joan asked for treatment and she had multiple bouts of treatment. She's been going in and out of treatment for 5 years and disconnected from her son. She's recently completed inpatient treatment. She's now in recover bridge housing and our team is helping her get her reunify with her son and get back on her feet. There are lots of different stories and there's lots of people still actively using but you know what? We save their lives. As long as you're living and breathing, our job is to save your lives. That was a quick rapid fire but thank you for listening and open to question at this time.

>> DEREK STEELE: Thank you for the work. Seriously, it's not easy work I can. It's very, very difficult. And I want to lift up and although least underscore one of the things you said.

There's a stigma for the folks who are going through this about what their lives looks like outside looking in and I think the War on Drugs has not helped that and I think the work that the County and HOPICS are doing, in order to change the hearts and minds of people going through it about their situation as well as helping with the family, that's amazing.

I just want to throw some numbers out there real quick. Looking at the people serviced, 92,680 for $6.9 million. About $75 per person. Right? Roughly. Right?

We're talking about for the Narcan, if you breakdown the numbers to that, you know, the resources are being utilized in several different ways and I think the jump out by all the services rendered by 2022 and continuing on from there, when you look at the reversals by year, I think it's amazing. Do you know what I mean? So great work. Good on you all for all of this. Any questions? Please. Member Stevens.

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>> REBA STEVENS: Let me thank you for the presentation. I do have a few questions around, just curious about the I don't know, Narcan or whatever, this keep you alive substance.

>> It's an antidote to opioid poisoning. Reverses opioid overdose.

>> REBA STEVENS: I'm curious about the human body. The way I use drugs, I would probably be using a lot of that, you know. Reversal substance. Which makes me wonder, what is the long-term effect of such? And then the other is, as I listen to you -- and I worked really hard to listen with an open mind -- I never heard or rarely did I hear or was convinced that there was the opposite of abstinence. And I did hear it so it was mention and Veronica Lewis, you definitely shared stories. And the encouragement to do something different or use other options which makes me wonder.

If it has anything to do with bed availability or having enough of that type of resource in order to really begin to divert folks to treatment beds versus the Norcan. The last thing I'm going to say because I can say a whole lot but I'm going to try to be kind today.

If, as a drug user, as a dope fiend -- and I've been in jail for let's say 30, 60 days. You know, so now the fog has lifted and I'm going to be exiting jail. I am in a sober state of mind but as I'm exiting, what are you offering me? You're offering me another substance or what could be a trigger. I'm just saying. Could be a trigger for me to go and use, that reminds me before I can even get out the door.

I just think we need to look at timing and where we're placing things. But also appreciating the fact that your desire is to save lives. I truly believe

the life that we save is more so without the substances and I just hope that we would do a lot more about encouraging folks to not use.

But could you answer just that one question about the long-term effects of using that particular medication?

>> Sure. Brian, I'm a physician and I'm happy to speak to it. As I understand, the question is if somebody gets repeated doses of Naloxone, what is the long-term effects of that? Narcan and Naloxone all it does it block the opioid receptors in the brain affected by opioid. It acts briefly, maybe 20 minutes and in and out of your system quickly. It has virtually no long-term effects because it's in your body so briefly. Its biggest effect is to reverse an opioid overdose. Someone not breathing because their brain is saturated with opioid, it reverses that temporarily. The Naloxone does not have long-term effects because it's in your body for such a short-term. Lack of it is why we're focused on community accessibility.

>> DEREK STEELE: I hear what you're saying. What are the other ways other than using another substance that could be a trigger that could cannot the substance use. I think the narrative changing for the people who are in this space, then giving space for them -- particularly those who do move away from it -- having the ability to give more ideation around what else can we do? Or what else is needed, right? Because, again, the people who have the solutions are the people closest to the problem.

>> REBA STEVENS: I just want to touch that real quickly from my own personal lived experience: I drank and used drugs for 21 years of my life and I was in and out of treatment facilities and I know they don't always work if I'm not ready or if my need is not met.

What I will say is what changes the course for me is cognitive behavioral therapy and it was when I began to really trust someone and really know -- and not only that because I'm glad that Lisa Wong was here. It wasn't only the cognitive therapy it was the fact that this person stayed with me. I wasn't transferred to another caseload. I think the connection and relationships are critically important. I would like to see us look more deeply at the braiding or however you all like to talk about this integration of services that would include mental health. Because we don't know what the situation or circumstance was that positioned the person to begin to use in the first place.

The other is the big book of alcoholics anonymous that talks about the phenomenon of crave and going how I'm bodily different than my fellows and it's a lot of things I think we should look at. Thank you for the present approximation.

>> VERONICA LEWIS: Treating the system that could lead to death are not mutually exclusive. It hasn't been publicly released but the morbidity report related to people experiencing homelessness will show not that overdoses have plateaued but the fatalities have plateaued. Addressing the root cause, treating the symptom both are going to have to happen at the same time. The reason I listed the things that we do is because we have to meet people where they are and we don't want people to die simply because we don't feel like they should be using drugs or they shouldn't be helped until they are ready to come indoors. I know that's not what you're saying Reba.

I'm saying both things are needed and both things are needed, period. We'll stop.

>> DEREK STEELE: Indeed.

>> OSCAR: I'm the program manager. Congratulations on your recovery. You mentioned that you had a connection and went through a couple of phases and it was not a linear process. For a person in harm reduction, that's the same kind of autonomy we provide to them. We're client centered and meet them where they are at. When they relapse and go back, we are there and when they get to the decision that is their right to have, we're there for them.

>> DEREK STEELE: Year two funds when we were talking about the 24-hour Mental Health Facility need in certain areas as well to the point that you're making, this is connecting and weaving together all of these things. You're absolutely right. Anyone else on this?

>> I want to thank you for the presentation and I just want to highlight for us on the County sides is one of the things we don't do well is engage the community and. In my mind in the space I work in which is housing injustice, this is one of the examples. It's not perfect yet and there's a lot more we can do but it's one of the examples where I think we have invited the community in to the table and the table of decision making and allocating resources and I wanted to highlight that point which I think came out but maybe not as much as it could have.

>> I would like to speak to --

>> REBA STEVENS: Before you do, with you include the weekends? Are you providing services on the weekends?

>> I want to add what Clemens was talking about in terms of engagement. We have been building as we go. In the last couple of years the opioid settlement dollars have been coming in and based on the feedback from the group we asked everybody to come in and give budgeting advice. We heard

what they had to say and we reported back to them and we are now doing programming based on their guide spans my hope is in the future with CFCI funds that we are do this and it is been interesting to see how people are able to allocate.

>> Operating on the weekends and even with more funding we would be able to operate more hours. I'm not saying that we're totally full of funds and we don't need anymore. In fact this is an area in need of ongoing investment one of the reasons it was important to show these photo -- harm reduction services is about Naloxone and supplies but fundamentally about connection and bringing people together and particularly because of how stigmatized people are who use drugs, it's the isolation that is the most, the biggest threat to health of the.

You know, other things but it's really that isolation and harm reduction is a direct response to that. Of bringing connection in response to isolation.

>> VERONICA LEWIS: I didn't say this because I was rushing. Besides the encampment engagement. We have hundreds we are responsible for. If you don't know a lot of times when people are housed, because they are in isolation and no longer surrounded by people. So In addition to encampment work on the street we do a lot of work for people in moments, isolation and prevent overdoses for people indoors as well.

>> DEREK STEELE: Yes.

>> This goes a comment on how we think about funding these kinds of initiatives. I think some of you know that I worked on skid row for 23 years much I know one person that I worked with who struggled with addiction. I stayed with him for almost ten years before we saw sobriety. We had to do a lot of harm reduction to keep him alive all of that time but he did achieve

abstinence and he reunited with family and there are so many steps along the way and I want us to not give up on the valuable programs that we fund because we might not see an outcome that we're expecting overnight but to realize these are long trajectories sometimes.

>> DEREK STEELE: I want to ask quickly -- then I got you. I'm sorry about that. I got you. Okay. Got you.

92,680. What is the population though. These are the folks who are served but the larger number of the population of folks. Do we have a macro number of folks we're trying to reach.

>> I think there's a number of reasons that we don't know the number.

>> DEREK STEELE: I just wanted to know.

>> Since we started doing this work I have wanted to know are we getting there? Those targets are complicated by the fact that this stuff is totally illegal. There's been a lot of research in the last years but we don't have the -- at least on my side of the universe, we don't have that number.

I'm wondering if that's on your data side, that you have a better number?

>> There are a number of national survey tools, the national survey on drug use which is a household survey and it's difficult to take that data and broadcast it. We have a homelessness count and we don't have a completely precise number of how many of those people are using drugs. So in other words we can come up with models and estimates but we don't have a precise count. One of the things I have learned is when you don't have a perfect count, start with the priority populations. Who is leaving

custody and who is experiencing homelessness. You use principle models to get there because that's how you get to the people you need.

>> DEREK STEELE: Member Soto and then we'll crap it up.

>> WESLEY CRUNK: My statement is I never had an introduction addiction program but I've contributed in other ways. I apologize but my biggest addiction was the gang thing. And I equate that to this. The only person who is going to help a gang member in the height of it when he believes that all is there and family even goes away is an angel. There's only going to be an angel in the hell of bullets. After ten years and they are looking for some way to get out or before they get in it. But there's not too many groups willing to be in the trenches at the time to help and I equate that to help. Somebody has to be there when they are not quite ready to stop and don't know how to do did but to get them to live to that point and I think it's very important. I appreciate it.

>> Our peers are very passionate about the work they do and they are on recovery as well and they are looking to do work in the world that is lifesaving work.

>> ROSA SOTO: I just want to thank you for the life changing work you're doing and just is to see the impact that has already been made and also to know about the additional work we have been doing at LA general and the foundation. The question about when this happens, the good news about working with us is we have been able to able to support with having an expanded team that goes into the weekends and has vending machines available and we're really developing that program so that people can come even when there isn't someone there.

I have also seen firsthand the relationship between the case managers and their clients. And you know, it is just not replaceable, right? It's not the same experience as what you have when you are in a busy emergency room but yet our collaborations have yielded being able to be at the emergency room or the outpatient center or within skid row. And I just wanted to thank you for the comprehensive presentation and the incredible work. The partnership we have is with private foundations and who else can help and how we can help and it's been nimble and fast and responsive and just congratulations.

>> VERONICA LEWIS: Thirty seconds and I'm going to wrap this up in a bow. We're serving folks on all parts of the spectrum. Because of Reba, for example, our vending machines that have just been delivered, had she not told her perspective about being triggered, they are packaged in a way they're so discreet you wouldn't know what they were. I believe harm reduction will stop and we have to be mindful of everybody on the journey of recovery and we appreciate all perspectives and consider all perspectives. Thank you.

>> DEREK STEELE: Amazing presentation today. We are going to table, again, the last piece of the agenda. For the sake of the community we'll go to general Public Comment and then we'll get ready to wrap up the meeting.

>> As a reminder, the Public Comment period is one minute per person. Telephone users dial star nine for raise hand and star six to unmute yourself. Computer users, scroll to "Reactions" on the bottom tab to find the "Raise Hand" feature. Smart Phone users, scroll to "More" on the bottom tab and select "Raise Hand" feature from the drop-down menu. We will call you in the order your hand was raised. Please remember to state your full name.

CFCI ADVISORY COMMITTEE MEETING

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Seeing no hands raised in the room -- there are a few hands raised online.

>> HOLLY DEVI ALSOP: Thank you hi I'm Reverend Holly Devi Alsop. I will speak to a few things. I am a person with lived experience and a person in recovery and I will say relapse trigger is disconnection. What I have heard tonight gives me so much hope and my question to the advisory Board is how can we scale this to meet the need that is obviously unmet in Los Angeles and it's not just in SPA6. It's in every single service district across our County and I am hoping that this can be a leverage to get more funds because like HOPICS and Department of Health care services and mental health services, I have been a recipient of this and it has given me the leverage I need and I have been able to be reunited with my family but if I didn't have the help and connection of one person with my case manager that I have had a healthy and loving relationship with, I'm not sure I would be speaking with you here today and thank you so much to the organizations that presented and the work you've been doing and when you need me, I will come and talk to the supervisors ever Los Angeles County and tell them 88 million is just not justify. I'm an example and the peers that work for that organization is examples of people who can contribute to our society in a meaningful and beautiful way. Thank you so much.

>> Byron, go ahead, please.

>> BYRON: Good afternoon. This is Byron with the Trans-Latina Coalition. Thank you for showcasing interdepartmental collaborations while also ensuring the funds are directed toward the community investment and service providers. Thank you.

>> Thank you so much. There are no other hands online.

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>> This concludes the Public Comment period. Back to you, Chairman Steele.

>> DEREK STEELE: I want to end by saying I know that HOPICS has been -- y'all have been in the trenches for a lot of different things. So this presentation today matched with the boom from the last one. The trajectory that we're on how these resources are being utilized and how many lives are being touched I think is a very, very big deal. Amazing work to Veronica and your team and the County funders who are stewarding these dollars in effective ways as well. My love to all of that.

Any announcements or anything else to anyone else?

>> VERONICA LEWIS: I want to recognize our Chair. I was at an event last night and four people were honored and our own Chair Derek Steele was honored as the change maker award. He wasn't going to say anything but his speech was amazing and he didn't even talk about his self and he talked about folks and a call to action. I appreciate him.

>> DEREK STEELE: Thank you. I appreciate that, Veronica. Hopefully they put out the speech and that they put it out. It's important to lock arms. We've been talking about this for a very long time and have locked arms. Meeting adjourned. Thank you, Veronica.

[Meeting concludes]