Transcript

May 28, 2025, 8:31PM

Room 140 0:13
Both of you transcribing us.
Hey, Claudia.
An announcement for those in the room.
This meeting is being transcribed at home already now.
Thanks Claudia.
Hi everyone, it's Monica bankon.
Welcome to the family and social services cluster agenda for today, May 28th.
We'll be starting with introductions from the Board of Supervisors deputies, starting with SD111.
This is Anthony SD2.
Hi Lana SD3.
Anyone else from SC2 on?

Escobedo, Marina 0:53
Hey everyone, Marina's quado's also on joining virtually.

Room 140 0:53
Oh, OK.
Karina Lizzie Schuster with the third Donna Partillo.
Moral characteristic? I'm from the 4th and hi, I'm Monica.

Holden, Nick 1:05
Also, Nick Holden here with SD4 drawing online. Thank you.

Room 140 1:07
And Nicole, good.

Lim, Esther 1:09
Hi, I'm Esther from Esty 4.

Room 140 1:12
Wow, lots of representation in there today. I need as much.

Lim, Esther 1:15
Full house.
Full house.

Room 140 1:18
Upstairs, she didn't want to see us facing.
Right downstairs on the 1st floor. If you'd like to join Esther.
So anyway, we'll start with item.
Consent, consent and this is ISD. This is the aging into the Disabilities Department off Senior Center plumbing and repair restroom is someone who's.
Been up there.
This project has been muted for some time.
So do we have anyone that would like to hold this item?
Or you could just take my word.
Let's help with the demo.
Yeah, the the door actually doesn't open.
Yeah. For the seniors, the seniors. So. So thanks, Aya, Steve, for on this. Since we have no unfolding item 2A, we're gonna move to item three and the first one is St.
Three St. Four evolve St.
And redefining board priority around child protection.
Will someone from Street Street 30 thank you.
And we will give hand it over to SD3, unless you would like a department.
OK, so so first of all, apologies for the handout, the wrong version of the motion was posted to the EO, so the version you have as a handout is the correct version.
So it will be amended as such. Apologies.
This is my first time with this new process so apologies for messing it up.
Up on the 1st go and that I'm doing this right away.
So this motion is something that we I was working on before I went out on leave.

So that why the timing is the way it is and it's a follow up motion to a motion we did with 4th a year ago.
Looking at reimagining the OCP and I know min from OCP is and so in December.
The OCP.
He submitted their report back, which laid out.
Three priority areas. You can see them on the next page building a sustainable community pathway for services to services for families before they touch safety systems.
Strengthen coordination and collaboration across the child, Youth, Family system of care by focusing on joint strategies and solutions for shared clients and improving behavioral health and health priorities for children and youth, especially those.
And so they laid out the strategic road map and plans to bring to.
Do a full strategic planning process.
They just didn't have time with the last report back to do it and wanted to make sure that was in line with what the board wanted. And so this motion really calls on the OCP to move forward with the strategic planning work that they've already be on and.
Calls on them to come to this body, to our cluster on a quarterly basis until that plan is completed with updates.
So we can all make sure that we are engaged with the work moving forward.
It also calls for the strategic plan to include discussion of how the OCP could be more empowered to lead this work.
Could you know include office placement, reporting, structure, staffing needs, oversight, reporting, etcetera.
And then once the plan is complete, it crawls on the OCP to do a board presentation to the board and then the other part of this motion is to move that the board directed priority be redefined from child protection.
To be more inclusive for child, youth and family well-being, so it changes that child, that board priority, which I don't think has been updated since those who was created 10 years ago.
So that's.
This motion I I don't know if any men's here are questions.
We're all turned over you if you want to add anything as co-author.
Bring us the questions. Thank you.
Questions from the deputies on this item.

I.
I guess I have lunch and it's how this relates with the the larger picture of the different groups within the county that work on children Y prevention Y issues. Well, I think or is this just really focusing on?
What what's different about about this version?
I'll say than the one you got is it takes out mention of the ppscg because I didn't want to. We didn't want to include that without.
Talking to the second and having that conversation, and this felt like the right venue to have that vision and act friendly way.
And then I I mean my perspective is that this focuses on the OCP and through their strategic plan, it looks to the OCP to think about the collaboration and the prevention space and how all those tables work together.
I think I think with everything that we're encountering personally, measure G and budget cuts.
I just thought it would be really important.
I think from our from my vantage point, make sure we we also acknowledge as a board that the OCP has done good work in the last decade. The Blue Room Commission not only provided new recommendations, but also culled together hundreds if not thousands of previous recommendations made to.
Improve the welfare system. And so we've chipped away at it. But I think part of what we're missing, I think county wide is what we're doing with children, youth and families. And I think from time to time again, OCP and their convening power, I see them coordinating with.
Sapsi and DPH and just looking at the larger.
So part of it is to 2.0 version 1.0 version.
Now go do it or it still supports you four to five with OCP is doing.
It's evolved them.
And also families don't need protection.
Supports holistic supports, you know and I maybe that's sound too social working whenever I talk like that, Monica. So I will.
I will resend that recat that statement, but you know I think I think we, we we are evolving as as a system as well.
So I think that's what's.
Any additional questions from the deputies in the room or on the phone?
Thank you for the brief presentation.

And we look forward to seeing this June.
Thank you, sue. Over P for being here for that just in case.
Always helpful to have the department.
And I'll move on to the next motion for review.
This is a motion by Supervisor Robertson Mitchell, and this is implementing an innovative specialized child welfare program for young children.
Care handling it over again to SD3.
Thank you. And busy. When you came back, both of these were like in the works before I went out.
And so I think they were waiting for me to get back.
We were kind of busy with some stuff.
Yeah, not much happened.
So this motion, we're really excited about, really excited to partner with SC2 on it. As you all know.
Our young people, zero to five in care, need specialized.
And.
Services. We know that a third of the kids in the children DCFS care are zero to five.
Birth to three, and that the disproportionality we see across the system is very true in the zero to five population as well.
Dcfs has done great work around young kids, zero to five, and they about a year and a half ago created the young children in care birth to five program and they've been doing amazing work and the demand.
And has exceeded the capacity of that unit.
And so this motion calls on DCFS to do a couple things.
One to develop a proposal to fully.
Make sure the icica birth to five program is fully operational so that it can be accessible across the county and not just in 1/4 of the offices as it is now.
It calls on DCFS to work with first five LA the Commission units within DPH that are relevant.
The OCP and Laco and Community partners to prepare an analysis of current services and gaps to look at where we can strengthen supports for our youngest children in care and then it also calls on DCFS to convene those partners to develop a Community strengths and needs assessment frame.
And some of this work.
And like the other motion relates to the broader prevention work going on

throughout the county, but.
Know that this population.
We need specialized support and so it's calling out this population of young people and.
Yeah. I just, you know, in looking at it, I'm thinking it's it's very supported by like really compelling data.
It really aligns with best practices and it also helps to respond to critical gaps in child welfare system with scalable, collaborative and outcomes focused approach.
So I think that bringing all those things together.
They're really bolster this effort.
And first five in a tremendous partner, which surprised me. Shares in this work and so.
They are also eager to partner with us on this.
CFS is here if anyone has questions about the YCIC program.
Question to the deputies on this item or online.
I have one.
I guess maybe it's for you, although just 'cause I forgot there was a request from Brandon for a number of staffing positions in the budget and I'm not sure where that stands.
Then we got a letter from Brandon the staffing.
Has that been approved by CEO or?
Is would those positions be within additional staffing requirements for ocic think it would fall under before a future budget year?
Yeah, probably an unmet need.
I spoke to Brandon about this.
Thought we could find a cost neutral way to do it, so I don't know if it's moving other positions around.
Got it.
Yeah, we could do what?
What happened with that request from Brandon?
Yeah, I thought it was like 165 positions.
Ring a bell, Jerome?
I'm making us up.
No, no, no.
I think we'll move to the presentations that they provided, but a lot of those were

unmet needs.
OK.
Got it the way it was presented, that first slide made it seem like.
All of these were going to be asked, but in reality it was just dense between actual *** versus unmet needs.
And it was just wondering if this fit within that other.
Layer budget request for staffing.
Sounds like I don't think so.
Two different things exactly.
We'll figure it out.
Sounds like shipping things.
Cool additional questions from the deputies.
Honey.
On online? Nope. OK.
Thank you very much.
We'll move on to item 4A.
This is DPH substance abuse prevention and Control Bureau Youth Tay, a caregiver services presentation.
This is Sapsy presentation requested by this cluster, so we look forward to hearing more about Saab Si.
Yep.
Good afternoon, doctor Gary Sy, director at SAP C Control with Department of Public Health.
Today I'll be focusing on our Youth, Tay and caregiver services.
Adding an overview essentially of our services and addressing any questions that you all may have.
That's right.
So this is our network at a glance.
Sapsi contracts out all of our services, so we don't have directly operated services. On the left is essentially the drug medical, which is the specialty substance use system in California, has a number of different levels of care that are outlined in the smaller circles. And then in the.
Big Circle, yellow circle in the middle.
The types of services that are delivered within those levels of care.
And so you can see when it comes to the levels of care earlier mentioned services for

youth and young adults, outpatient services, there's intensive outpatient, which is essentially more hours of service within a given week. Residential services withdrawal management also known as detox and then opioid treatment program.
Also known as methadone clinics, as well as recovery services.
So those are all the levels of care. So essentially the settings and then within those settings are the services.
And the yellow arrow circle in the middle.
Which is individual counseling, group counseling, family therapy, medications for addiction treatment, otherwise known as mat.
Things like care coordination, linkages, peer support services, and recovery incentives.
The boxes on the right just give you a general sense of the size of our network.
So we contract out Youth Services with 30 agencies.
They're spread out across about 50 sites and you can see.
The site's broken out by levels of care.
Below that, we also provide field based Youth Services.
So there's 94 field based sites across the county and then you can see in the orange box below the blue box essentially where those field based services are.
Schools strtps some in home services and then other settings.
Next slide and then getting into the data.
Uh.
Two tables here or two graphs here on the left, or essentially the proportion of youth served within Sapsi system.
So across adults as well as youth. And so you can see our youth numbers essentially kind of dipping, particularly during the pandemic period and then coming back up amounting to around 5% or so of the total clients that we serve.
The solid red line, our individual youth clients.
The dotted line are admissions. You can see that they generally track one another, although it's not exactly the same because someone could be admitted.
Numerous times on the right table or graph is the primary substance of the youth that we serve when they come into the special Sud system. I do want to differentiate this from the prevalence, so this isn't how much you know cannabis use there is among youth in L.
This is of the proportion of people, youth who.
Come into our system.

These are the substances that they're reporting coming in for and you can see that cannabis is far and away #1 substance, and then you know all of the other substances.
Are less than 10%.
Slide.
A snapshot of our demographics and you can see.
So there's three bar charts here.
The blue represents the overall LA County youth population.
The green bar represents youth Sud clients served in our specialty Sud system.
So this just kinda gives you a sense of how it compares and so you can see across genders.
Generally kind of over represented.
In terms of males, underrepresented in terms of females, these are all youth with respect to ages. You can see kind of under represented among younger youth and then as you get to age 15 and above, then it tends to be kind of over represented within our system and.
Then when it comes to raising.
Latinx over represented as our black African American populations and then others are generally.
Underrepresented, so this just gives you a sense of who's coming into the special Sud system.
Just a clarifying question.
Thank you. Kira means young people under 17, right?
18 year old is considered adult. Yes, correct.
And next slide and then a little bit on TE.
We serve about 2800 K per year.
That's about 848 point, 4% of all of the clients that we serve, the majority of TE are male. As you can see here, as well as Latinx, about 70%.
When you look at the age ranges of that TE population, 25 is the most represented and then most of our tee that we serve in our system are unemployed.
Outpatient was the most utilized level of care to find this not. These are all this is county wide 18.4% of SAPSI receiving services.
Correct. 8.4% is every. Yeah, correct. OK.
Outpatient is typically the level of care that youth come into first.
Although you know for this situation, for Tay populations, residential does represent

a little bit under 30% and then almost half of people who are discharged from treatment take or discharged from treatment are discharged with positive compliance, meaning essentially that they're doing well in treatment services and you.
Can see the primary substances broken out here when you look at Tay populations, it's.
Less skewed to cannabis and more kind of.
Across various substances as people get older.
And see that cocaine?
Description drugs represent 40.
And the in terms of special populations, you can just see the breakdown of our Tay that are served within the specialty system according to those who are criminal justice involved, homeless, those with disabilities, LGBTQ as well as veterans.
Can I ask you another? I don't have a slide on this, but prevention. We're talking the 18 to 25.
How much prevention goes to this population?
Most of our prevention services so.
This presentation is primarily focused on treatment, but most of our prevention services are for.
Actually, a very small fraction of adults that were engaging in terms of our prevention services cause a lot of those services.
They're school based or they're community based and it's, you know, things that parks that tend to frequent more than else. The prevention work has helped decrease the number.
A entering. Yeah, absolutely.
I mean, when we look at the ROI of our prevention investments in general, it's $7.00 save for every dollar invested.
So we I definitely.
Definitely believe that it is.
Kind of lessening the treatment needs, although obviously it's not 100%.
I want to answer with this slide versus this slide two slides ago on primary substance abuse amongst youth patients, which showed mostly marijuana.
Am I understanding correctly that under the age of 17, the more popular drug is marijuana and as they age the age into some of these harder drugs?
Which is these ones on this slide.

Is that how I'm understanding it correct? And I would say it's not necessarily the use of the drug, but it's.
What causes people?
What triggers them actually accessing treatment?
Sometimes it's different using. If they don't enter to some sort of services, which means they're clearly having some sort of bad reaction or something, is that they're feeling I need to go in and I think one important take away of this is among youth underage 17 and under Cann.
Is a huge issue.
I I know it you know.
It is.
That's exactly right to get at.
So, but it's legal now.
But but the real research clearly did say that if you start, if you legalize is are gonna do it.
It sounds like that's what we're that's what we're seeing that these numbers have increased over the years that California has legalized marijuana amongst youth.
Yeah, and and among youth, I guess the the other important point.
Most instances when youth seek treatment, it's not because they individually are wanting it right. Normally, if they're being pushed in some way and so it it highlights that.
When it comes to cannabis, depending on who you're talking to, you're talking to parents.
There's probably a fair portion of parents that are concerned about cannabis, right?
But if you're talking to others around cannabis, you know it's maybe less.
You know it's legal.
You know, there's dispensaries.
Fairly common Los Angeles, so yeah.
I think.
You're seeing. I mean, yes, there are parents that obviously use cannabis themselves, and it's not a major issue in their minds, but we are seeing more and more evidence coming out and and I think this will only continue, right, whether it's perinatal use or whether it's, you know.
Impacts on developing brains, neurodevelopment, etc.
There's been a good amount of public health research on kind of the impact on

young people's brains, and if there's some sort of correlation with later on some sort of mental illness or severe mental illness as to Britain's developing.
Yeah, that's why the whole thing is a little concerning as a psychiatrist.
I think there's definitely associations with psychosis and.
You know, I think this is something that unfortunately we would just track with time, but I would not be surprised if we see rates of schizophrenia increasing over time.
Next slide.
So this just gets into some of the strategies around expanding services broke this out in the state and local level, although this isn't meant to be every single.
Cause there's a lot more right the state level. The main one that I wanted to highlight was CYBHI children and youth Behavioral Health initiative.
This is the fee schedule at schools that allows them to provide services via that fee schedule that would be funded through managed care.
We do have treatment providers that have relationships with schools and provide services in schools as well, right?
So this would be kind of this is separate in a part.
But it allows an additional way for schools to be offering these services in terms of local level strategies, some of which I'm going to spend a little bit of time talking about in more detail.
There's the reaching 95% initiative.
Which is covered in a board motion, so you may be familiar with it as a component of R-95 though.
We focus specifically on youth via this rise initiative, reimagining Youth Sud engagement, and I have a couple slides that will go through what that is.
We also have a caregiver and family engagement focused initiative called bridge stands for building relationships, inspiring development, growing engagement rolls right off the tongue. And this is really an effort.
Actually I have a slide where we'll talk a little bit more about that.
So I'll save that we've made an effort to expand mat services.
Medication services for youth, when it's needed and to ensure naloxone distribution widely, not just among SAP C treatment fighter network, but also as a part of the R-95 initiative.
You know, working with DCFS, OCP, DMH, DHS, etc.
The managed care plans to try to increase access to naloxone and just general Sud services.

Similar to the cybhi effort, there's been a lot more.
A lot more engagement around schools.
And I would say interest from schools to provide whether it's prevention or potentially some treatment services in school settings.
And then we are working with probation around expanding our Sud portfolio within juvenile halls and camps.
And there's been some recent progress on that that I'll talk about and then really expanding our Tay network of agencies that specialize in that population.
But to cover rise a little bit more in depth, this is really designed.
Let me take a step back. One of the reasons why we wanted to embark on this.
Because.
You know, when we look at our data, you know, I presented on some of it here.
We don't actually serve much youth treatment system.
There's a lot more need in the community than what we're seeing in our system, which tells us that we need to be engaging youth in a different, better, more effective way. And that's really what this initiative is focused on.
We're trying to leverage system design principles to really rethink how our providers outreach to and engage.
Youth, you know, this includes the environments that they're creating in their settings, really focusing on how do we ensure that our services, our SUV services, are developmentally appropriate. And then being informed by youth and by the providers that serve those youth around, you know what that looks like.
So we've convened on the next slide.
Listening sessions with both youth as well as providers.
Including Tay, just to hear their perspectives on things like, you know, do you generally prefer individual settings, right?
You know, there are boundaried approaches to Sud care where kind of you're setting limits, and that's the primary focus or, you know, kind of softer approaches, right.
The extent to which family are engaged in treatment so that we can shape our providers are thinking about this and we've been meeting with our providers.
Sharing what we're hearing from youth in these meetings.
Another key focus is around making youth centered infrastructure investments.
So this is funding our agencies to invest.
In making their settings more appealing, more welcoming, making deliberate investments in things like, you know, video games, audio equipment, charging

stations, we have some agencies that have like, full on podcast studios.
Because they have youth that.
Like that and then also investing in partnerships, whether it's mentorship, internships, financial literacy, that's a big one that we heard a lot from the youth that we engaged, job trainings or transportation support. But it's this is funding that we're going to be offering to agencies to make those.
Investments.
On the on the client facing side thinking about how we can provide nonmonetary incentives to try to enhance.
Engagement. This is similar to contingency management or incentives, which is providing incentives for people to engage in treatment. But you know, for youth, how do we tailor that specific to youth in ways that could be?
Likely to entice them to stick with care.
Building partnerships. I talked a little bit about, you know, and it even goes down to like we have some agencies who work with restaurants in their area that you know for the food that was uneaten that day. You know, they'll be able to distribute that right and then.
Lastly, expanding field based services.
For you, so that we're diversifying the settings in which we're delivering the services, I think that's one of the things that.
Very clear when we look at data around our residential Sud utilization, which is extraordinarily low.
Next slide please.
Yeah, over here for these questions.
All sound really great.
Are these the current budget or these budget asks from DPH?
Gph.
No, these are all these are.
This is your current.
These are all this sounds like extra stuff like provement or transportation. Or is that that work in terms of budget?
So all of these are things that are already being implemented, OK. I mean, I would say they're newer.
So bridge is, I think we started it maybe years ago.
Ryze we just launched it this year, so they're newer but.

They're budgeted for.
It's all through dmcods funding.
Not all of it.
Most of it.
So for example, things like field based services, we can build DMC, right? I think that.
There are potentially opportunities.
With things like opioid settlement or that that we could use to help support some of this work, but.
The the majority of it's funded through drug medical because I think it's important to to know the state sets a rate for counties.
And the county sets a rate for providers.
And so that difference is kind of a margin that we can use to reinvest in different ways. And so we've used that for the value based reimbursement approach that we're taking across our system, which includes youth. But we could also use those investments to invest in things like.
This.
How much of it is opioid settlement?
There's not that much opioids.
I don't know if this is the right time to ask the question, but I have so if it's not only it can it probably is.
Oh no.
How do young people.
Get connected to these services.
This is great, but like, how do they know?
Yeah, that's a good.
I think that's a can always be doing better in that space.
That's the reason why we're trying to expand out, right.
Whether it's schools, whether it's parent engagement, you know we do.
Participate in events like Parks and Rec.
Sometimes we'll have our spot events.
For example, we help to fund our spot. So we'll participate in those.
I would say, you know the managed care plans and pediatricians or primary care providers, right?
Like they're one way. I think one of the challenges we have is typically.
Don't access services until something bad happens.

Sprite or it gets flagged.
You know, grades are going down. Parents trying to figure out why and so.
It's really hard to engage upfront. I mean our that's what our prevention services are for, right.
Once it gets to the treatment side, it's about trying to earn as much of that interest and engagement those services as sticky as possible.
That's just gonna be a chronic challenge, I think.
Guess how?
Again, might not be the right time to ask this question.
Like for young people that are in DCFS care like.
Do they?
Is this stuff we talked about with resource parents?
Is it stuff that we train social workers on all the time when we're standing up this new?
AB12 unit.
But what's the new yes unit like? Is that are you working with them to think about that?
I'm just curious like how are we?
Those are basically our R-95 discussions with the 10 or so departments that include DCFS and OCP and others around how they can help us message around the resources that we have available to the population that they serve.
So that does include things like training social workers around motivational interviewing and what Sud Resources there are and naloxone distribution, all that stuff.
I just want to say because of family first Prevention Services act, all social workers and DCFS has been learning sites and they've expanded to do motivational interviewing.
I don't know if we're connecting the dots on that front.
So like for us, that's really helpful to know that that's a modality use.
On the child welfare side.
Because in theory, when it's gonna happen, Jenny, is everyone gonna be?
Am I like by 2027 or something?
Yeah, I think we're.
Too. We're in our second spa. I don't know if you if you knew that, but it's. I do. OK, see, when we were talking about that ffpsa. Yeah, I I think we had recommended that motivational interviewing be included in there because of how broadly applicable,

right. I just.
It's hard for, I think, for us as deputies, we hear so many different things and it's like sometimes I wonder who's weaving this all together.
Like even when you talked about workforce development or food recovery plan, your shop and doctor quote like right, they're doing amazing things in that space that's within DPH.
We have a whole department of Economic Opportunity with all these pipelines to jobs and employment.

VS **Veronica Sigala** 34:44
Do you want me to go down express and get you something? I got something from the hat. Food over there on that side of the room.
It's like I ate a sandwich.

R1 **Room 140** 34:52
Veronica, you're off mute.

VS **Veronica Sigala** 34:53
OK, but thank you.

R1 **Room 140** 34:55
Can hear you.
Yeah. I mean, I think that's so.
It's like my thing is like are we plugging and playing?
Not necessarily just for today, but also families and that kind of stuff with the thing infrastructures that exist and partnering.
Yeah, I mean, I could say we definitely do our best to try connect those dots, but if you're aware of dots, yeah, you know, you're thinking may not have been connected.
Feel free to just reach out and do that.
I know that in our rise discussions.
We did connect with like during those meetings, someone that.
Express some ideas around transportation, for example, so it does come up in these forms.
Yeah, like you know, we're talking about all this, and it made me think.
I don't know why it impacted me so much, but when we had the presentation on the

youth opioid response was the beginning of SD3's chairship and the and we're at the Vermont office.
And so something about like the that having hdhs, so CP and everyone at that table around the opiate response, kind of it's like.
We're in a crisis right now and I just I think there's these are great system thoughts and.
You know, but what's happening in the implementation right now to serve the needs of the Community and are are there gaps that exist? You would love to like, kinda like where? Where can I mean in this current school I'm at and with all the Medicaid cuts, this is.
All it's all up in the air right now. Ish, right?
But like, where can the board be supportive to like?
Age and and kind of help fill in some of those gaps, yeah.
I mean, for us rise to address some of the more fundamental gaps.
One of the things that we had wanted to pursue.
Higher to all the budgetary issues is the concept of recovery schools.
They have them like Boston, Colorado. They have in different states.
To our knowledge, we don't have any in California and so these are essentially funded first and foremost schools, but.
Free services for SUV are kind of woven into every aspect of that school, and most of the students there are in recovery themselves, right?
And so there's like documentaries on this on 16 recovering.
I don't know if you have seen that as a four part series.
It's great.
It is high cost, but it's something that I think provides another way for people to get services right because it's kind of the next level up to cyber hygiene.
Where you have a dedicated school and it would be the first in the state.
I mean, that's 11 gap. We we had some planning discussions with around that, but.
It is higher cost.
Could be editing existing.
Order like.
Space there.
And you're opening it with an idea, I don't know.
Just thinking of ideas, since we know that.
Specialized charter.

County is a little bit.
Yes.
Same.
Anything else before moving on to the bridge?
So this is the caregiver and family support services was launched last year. You can see in the boxes is basically the the the components of bridge and so things like family engagement services, family education outreach, family support groups, leadership and mentorship programs.
Family centered programming.
So these are things like parenting workshops.
These are the things that.
The the funding that we've provided, the agencies that have signed up for bridge with investing it and then you can see on the right are some of the the numbers, the data around how many families have been served nearly 1300, you know, different outreach events, family support.
Groups that were convened, et cetera. This one has gotten some good feedback from providers, although we are also looking for the numbers to go up like I think that we could be engaging.
Or caregivers in this program.
The FS caregiver, yes.
And and you know clinically there are sometimes it makes sense to engage family and caregivers and other times it's actually more therapeutic.
Next slide around addiction medications.
We have a map prescriber cost sharing initiative built in with an R-95 where essentially we're funding prescribers. One of the the reasons why.
Lack of Matt within the special HCD system as a whole, and I would say you know, particularly for youth, just because it's a specialized population and not all prescribers are comfortable with youth populations is because because of how underfunded the special SCD system has been.
They haven't even had the resources to hire prescribers, right?
So when I say prescribers, I mean physicians but also MP's and Pa's, that could as well.
And so this initiative essentially addresses what's been the the primary barrier, which is funding to help support.
Those prescribers, there's also a youth Mat learning collaborative. That means every

other week there's the opioid response that was mentioned or we're coordinating with other departments.
And then with respect to schools, we have school based field based services that I mentioned earlier to about 70 Mous across the county.
There's also different collaborations with LAUSD and specific schools via Mous and service delivery agreements, in order to provide early intervention and substance use treatment services across different school campuses.
With some of the tragic overdoses at some of the schools and the increased interest in naloxone across the schools, I think that's really opened up drist from schools.
That have been, you know, I think has been a very significant change for us in the past.
Have few schools reaching out, whereas once those things started happening a lot more interest.
I know for a couple years ago there was that motion that the Suvar Solis led, that you alluded to with respect to the overdoses at the schools and Sapsi went out partially go to the schools and the trainings.
Have those been ongoing or is with you saying districts are reaching out?
Yeah, those have been ongoing and I think it's it's just about deepening those those relationships.
I think the the next phase of it in my mind is also using those relationships to try to age some parents. I think that.
Relationships between school.
This is the school is not my world, but my sense in just feeling out some of the dynamics is like there are dynamics between parents and schools that the schools want to manage and you know, I think getting in to be able to engage parents in that way.
Would be helpful.
36 I know we have public health nurses like, oh, you're talking about the parents. And I was thinking about parents, but we have public health nurses. That DCFS are. We connecting the dots with Sap's, the WIP do with SAP C and just.
We have had conversations with DCFS about what the public health nurses at those DCFS sites could be doing, whether it's naloxone distribution or or other things families too, I would imagine.
Are they just focused on the kids?
I can check in I I don't know how much gauge with the families. I guess it depends on

level of engagement of the families, those centers to begin with. OK.
Is it a labor dispute or go out?
I mean they the phn's do joint visits with the social workers.
So they they're working with families.
That's what they do so.
Merely on a day-to-day basis, they're tend to mostly focus on the medical issues with the kid, not labor issue.
So I think it's maybe they'll might need a little bit more training. OK, I think it's similar to other areas of healthcare where it's kind of just a familiarity, comfort issue and it's.
It's variable, right?
Because there's gonna be some public health nurses that are more comfortable with.
Yeah, behavioral health issues and others that are less.
Training is a component. It feels like it's shooting fish in a barrel with this one. I better metaphor, but yes, yeah.
It might be.
I mean, it might be a option to just kinda.
How many public health nurses are collocated?
Kenny. Oh gosh, a lot we've got for the front end or.
And for continuing services, so.
Oh, so it's attainable.
Thank you.
OK.
Next slide.
And this is just focusing on some of our expansion and juvenile detention facilities, some good progress here.
Recent conversations with probation, we are expanding, so we provide Sud treatment services at Los Padrinos currently.
We're expanding education, so this is more prevention focused as well as early intervention and substance use treatment services at the various camps that are listed here. And this is for the general population, right, so it's.
Not not just for the Sytf secure youth facility.
T treatment facility, yeah.
And then.
Other justice involve initiatives for eligible youth and adults who are incarcerated.
This is the pre release program that we're coordinating with, dmh, DHS CEO on.

And this is slated to start September 2026 for youth.
Ask a question about the probation camps.
Within.
And to move the young people around, is there a way to make sure we add Kilpatrick here so that young women also can get this?
Yeah.
I'll follow up.
And next slide and this this is my last slide just in terms of goals for taste specific populations.
As mentioned, we are convening listening sessions with Tate, providers and other stakeholders. We do plan on expanding our taste specific network of agencies, continuing with cross departmental collaborations such as the Tay table and then establishing.
Partnerships with non Sud agencies to better support this kind of consistent with our so you know for example.
We know of some of our agencies that partner with banks that have people who are just interested in, you know, getting back to the Community and they'll have someone come in and provide financial literacy training, right? So.
Spontaneous partnerships like that to help support and diversify what they're able to offer.
That I will pause and see if there's any additional.
Issues. How is this discussion going with Dmh?
Discussion around.
A.
Children using fat like that.
Let's look at the families, children, youth.
Conversation 'cause. I know you're you're working closely with dmh on bhsa.
Yeah, we are.
Yeah, we're with multiple meetings every week about Bhsa.
That's spend the night together.
I mean, I think that there's there's interest in continuing to expand youth capacity across the board, particularly for Co occurring population youth with Co occurring.
Conditions. Is it really prevalent with use 18 to 25 is the most psychotic to psychotic breaks up in 20 to mid 20s right?
Yeah, I mean, it can happen in the in the later teens, but yeah, mostly in the kind of

more adult age, right?
Sorry I went.
I mean, there definitely are Co occurring conditions, I mean like.
Particular anxiety and you know, self medication, whether it's cannabis or alcohol, those are probably the most.
They tend not to be quite as severe as.
You know, we're dealing with different issues at that age group, similar to what you saw with the data around the substances that that people are coming in for.
It looks very different when you look at the younger age groups versus older.
But do you feel like when youth are gonna be a priority as we roll out bhsa?
Yeah, definitely.
I mean, there a priority population?
They have defined yes by the state, but I mean I think for a long time I've wanted to serve more youth.
Challenges they largely aren't interested in the services that we provide. So we have to figure out how to get them interested or.
That can help us get them interested, right?
So like our footprint in STRTPS, for example, right?
I think that's a good opportunity.
I think getting house managers in those settings and really in any other setting, including shelters to be familiar with motivational interviewing and what Sud resources there are and how to refer people in because it's those types of like just even if someone's walking by having conversation stop.
For a couple minutes, those types of things that they're able to do that others aren't because they have the most interaction with them, us bringing a counselor in.
Hour a week or 4 hours a week.
Isn't it a magnet effect where people like, oh, great, there's a counselor. Let me speak with you.
Right. We want that to happen, but it typically doesn't happen unless we have other well, like parents or others.
One of your first talk about the potential treatment centers, I think it said there's one.
But we've what I've heard. I'm not speaking about what I've heard again and again is that young person needs to be sober when they enter that when they enter a treatment center, and then that could be a barrier because if they're like, ready to go right, then get.

Them in but.
If they're not sober, then they don't.
So I'm just curious like.
Talk about that. What are the options?
To is like a central pillar of AR-95 initiative.
It's kind of. It's not saying that.
One can't be sober and enter in treatment, but it's saying that we don't want to establish that as a fundamental criteria because in the, you know, I've been traditionally agencies that, for example, would say, oh, we need someone to be sober for seven days and then after that.
Then they can enter in treatment and so R 95 is essentially trying to do away with that and saying listen if they're interested in services.
This isn't the condoned substance.
Use treat. Use in a treatment setting, right? It's to say that we want to open our doors wider and so that is an active discussion.
We're going out to individual agencies to have so for R-95, about 60% of our agencies have signed up to participate, meaning they've adopted that lower barrier admission policy right for the other 40%, we're doing individual leadership level engagements with them to try to expl.
Their hesitancy.
Is that one center that you listed on your slide agreed to lower standards residential?
Yeah. Yes, I would say so.
That one residential facility has 38 beds on a typical day, they're about half utilized, sure, with the BH sip opportunities. We're aware of other youth sites that were awarded right.
So I think we will expand.
The youth residential capacity, I think as part of that effort.
When we had conversations with agencies considering expansion, our recommendation was.
Build smaller sites because we we've had other sites like one a couple years ago that was like over 100 beds.
It was about 20% utilized and it closed after about two years because no one can operate off 20% utilization. And so it it's really about it's not that there isn't need for residential, it's you know smaller, more focused tailored services that can address those needs and.

Then us really building out other services outside of residential settings to address needs.
Other ways, because the reality is no one really wants to serve youth in institutional settings.
And they're trying to disincentivize that right at the same time, there are some youth that would benefit from residential care.
So we want to make sure that's an option, sure.
I guess I just wanted to hear from you that that barrier of needing like the R-95 that what that's working on is not an issue for the only residential treatment center we offer you.
No, I mean.
There are individual cases where.
The thing that comes across a lot sometimes.
Not not saying this is mainly for you because it's not.
It's actually more on the adult side.
It's what they call access to or personality disorders like there'll be instances where someone's admitted to a site numerous times, and at some point that site will say can't help you.
I'm not saying that's appropriate.
Sure. I'm saying there are.
There are.
There are times where they basically determine.
Like not sure this is what you really need, right and.
So it's not to say that there won't be any cases, but as a whole Tarzana treatment center, which is the center that operates those 38 beds, they've adopted R-95 and they're on board with lower barrier policies and they take genders, genders. You said they take.
All young people, all gendered young people. Yes, I mean, I would say that the the area that we need to build out is around Co occurring because there are other.
And this this kind of blends in with the daily disorder comment because there are instances where I've heard people try to refer in for Co occurring youth cases and they've been turned away because of the acuity of the psychiatric situation, right.
And sometimes the psychiatric situation.
Is kind of acting out in a way that it could be psychiatric. It could also be a personality disorder, which is, you know, different than I would differentiate that

from, like us, untreated schizophrenia case, right? Where if you just, you know, get some medications on board, you can.
Stabilize personality disorders are a little bit more difficult.
Long term, actually that's an area that I want our Sud system to own 'cause right now there aren't a lot of systems.
Handle personality disorders well, right?
And I think that our population very difficult.
Yes, you're right.
But you know.
They they're a lot of challenges resolved from treated personnel.
Rooted in trauma, so if we can, like, get traumatic event more often than not, so we get deeper and sooner and.
When you're doing these listening sessions, I've anecdotally, you know, I've carried a caseload, and I've been around for a while. But I've anecdotally heard that kids just don't want to go to Tarzana treatment.
Nair done that.
Yet near the sting sessions, as you kind of scope it out, I wonder if that's coming up. If the kids feel safe enough to say that I think as you look at maybe nontraditional modalities.
Or creative ways of treatment and not to throw shade at Tarzana treatment? I've, you know.
There have could there be alternatives as we scope it out?
You know what I mean?
Yeah. Well, I think the the BH sip was gonna fund you.
Talk about for residential settings.
Yeah. Yeah, the VH sip will fund some youth at other agencies. I would say that 'cause I I've heard sometimes that's the on the youth side. They haven't specifically mentioned Tarzana. They've mentioned not wanting to be in residential settings, right.
Typically because they wanna be able to do other things.
But I have heard.
You know, adults mention certain agencies, and I would say a lot of the times really talking about certain individuals at those agencies as opposed to like the agency as an institution, right?
And I think that's another thing that we're trying to influence with our N5 in terms of

being more tailored with the approach, like if someone with a trauma history, they likely aren't gonna do well with a boundaried approach. And we'll need a softer approach, right, whereas.
Someone with a?
Someone with a justice history, maybe they're accustomed to a boundary approach and that's.
What they drive in, right? But to be able to tailor our approaches to whatever an individual.
Respond to.
It's very difficult to do at A at scale.
That's where we look for systems change, but it really is an individual thing that levers are the mechanism too. And as a individual treatment is as much as.
Additional questions.
Questions from the deputies.
OK, right hand.
In that case, we'll now move to public comment for those in person or on the phone.
Either it's your hand or in person.
Just let me know.
I see Tina R has her hand up.
Have a question or comment from Tina R?
You have a minute.
Go ahead.

TR **Tina R** 56:50
OK.
Thank you.
My name is Tina Rios from reimagine Child safety coalition.
I just wanted to.

R1 **Room 140** 56:54
Papa.

TR **Tina R** 56:57
I just wanted to express my support of office and child protections, collaboration and partnership with us as community advocates for child and family Wellness, and it

would be wonderful to possibly be named in some of the reports as I feel like, you know, people at lived experience are.
Closer to the solutions and we want to keep.
That formula going for future, you know, I don't know people so they could know that we were very active in bringing forth the great results of less children entering and families entering into child welfare, almost miraculous reductions recently.
I also wanted to support the idea of recovery schools.
That's amazing.
I would love to see along with child Youth tee and caregiver.
Family unit supports groups, family unit housing and recovery centers.

R1 **Room 140** 57:55
OK.

TR **Tina R** 57:59
And also the maybe using an acknowledging peer support as an important part of Sud treatment and acknowledging the 5%, the 95% is that you know 5% is only being.
We know that is treatable.
I guess in that sense and so as we continue to look, we must be creative so we can further evolve how we treat and support families, especially the 95% that we haven't found appropriate treatment for them. We can't give up on those families and children. Thank.
You.

R1 **Room 140** 58:38
Thank you, Tina. We appreciate it.
Other questions online or in person?
Public comment this time.
I think there's a comment or a question in the chat.
Trying to make cloudier.
There's some information that.
That the others have. OK, got it. And we have some comments for those that want if you have questions, looks like related to the yes unit and some information on that in the chat.

So thank you everyone for that.

With that, we will adjourn the meeting and we'll see you next time this week.

◉ **Yadira Romero** stopped transcription