Date of Hearing: April 23, 2026

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Alex Lee, Chair
AB 1579 (Ramos) – As Amended March 3, 2026

SUBJECT: Children's Crisis Continuum Pilot Program

SUMMARY: Expands authorization for use of grant funds designated for a children's crisis residential program (CCRP) to fund other components of the continuum of care for foster youth for purposes of the Children's Crisis Continuum Pilot Program. Specifically, **this bill**:

1) Authorizes a participating entity that does not have a CCRP but that has included in its continuum of care a comparable type of treatment component designed to serve children and youth experiencing the highest level of acute behavioral health needs in a residential setting, including, but not limited to, a short-term residential therapeutic program (STRTP), a psychiatric residential treatment facility (PRTF), or any other program type approved by the California Department of Social Services (CDSS), to utilize all awarded grant funds, including any funds specifically designated to fund a CCRP, to fund any other component of the continuum of care.

2) Authorizes CDSS, in consultation with the California Department of Health Care Services (DHCS) to extend the term of a grant agreement entered into pursuant to the pilot program. Specifies the extension shall only be approved if the participating entity demonstrates, in a manner determined by the CDSS, that both of the following are true:

    a) The participating entity has unexpended and available grant funds awarded pursuant to the pilot program; and,

    b) The extension is necessary to complete implementation or closeout activities, consistent with the purposes of the pilot program.

3) Requires an extension approved pursuant to 2) above, to be limited to the minimum amount of time necessary to complete activities authorized under the grant agreement and expend remaining grant funds, and prohibits the term of the extended grant agreement from continuing beyond July 1, 2030.

4) Specifies that these provisions do not require a participating entity that does not request an extension, or that has fully expended grant funds, to continue operating the pilot program beyond the end date specified in its grant agreement, except for reporting, audit, record retention, and other closeout requirements.

EXISTING LAW:

1) Requires CDSS, jointly with DHCS, to establish the Children's Crisis Continuum Pilot Program, designed in partnership with county child welfare departments, county probation departments, and county behavioral health plans to contract with county behavioral health plans for the provision of medically necessary mental health services, including specialty mental health services, through a defined continuum of care. (Welfare and Institutions Code [WIC] § 16550, § 16553(a)(1))

2) Provides that a CCRP shall be used only as a diversion to admittance to a psychiatric hospital and that the length of initial authorization for admission to a CCRP shall be limited to 10 consecutive days. (Welfare and Institutions Code [WIC] § 11462.011(c))

3) Requires participating entities to develop a highly integrated continuum of care for foster youth served in the pilot program. (WIC § 16553(b)(1))

4) Requires the continuum of care to include, at a minimum: a crisis stabilization unit; a children's crisis residential program; a psychiatric health facility; intensive services foster care homes with integrated specialty mental health services; and community-based supportive services. (WIC § 16553(b)(1)(A)–(E))

5) Requires the crisis stabilization unit to provide assessment and stabilization for up to 23 hours and 59 minutes for up to eight foster youth, to be licensed as a 24-hour health care facility or hospital-based outpatient program, and to be co-located with, or within 30 miles of, a psychiatric health facility or secure hospital alternative. (WIC § 16553(b)(1)(A)(i)–(ii))

6) Requires the CCRP to provide highly individualized stabilization services for foster youth who do not require inpatient treatment, to operate in accordance with applicable statutes and regulations, and to serve no more than four foster youth at a time. (WIC § 16553(b)(1)(B)(i)–(iii))

7) Requires the psychiatric health facility to be licensed by DHCS, to operate in a secure, therapeutic, hospital-like setting for foster youth requiring inpatient treatment, and to have no more than four beds. (WIC § 16553(b)(1)(C)(i)–(ii))

8) Requires participating entities to maintain at least twice the number of intensive services foster care (ISFC) homes in the pilot as the number of beds available in the crisis stabilization unit, crisis residential program, and psychiatric health facility combined, with 24/7 staffing and integrated specialty mental health services. (WIC § 16553(b)(1)(D)(i)–(ii))

9) Permits CDSS to consider a proposal that does not include a psychiatric health facility, or both a psychiatric health facility and a crisis stabilization unit. (WIC § 16553(b)(2)(A))

10) Requires the continuum of care to reflect, across all service settings, highly individualized and trauma-informed services; culturally and linguistically responsive treatment; alignment with the integrated core practice model; and coordinated assessment practices to support appropriate level-of-care determinations and transitions. (WIC § 16553(d)(1)–(4))

11) Requires participating entities to establish policies and procedures demonstrating compliance with the notification and due process requirements of the Lanterman-Petris-Short Act and other applicable laws pertaining to involuntary treatment. (WIC § 16553(e))

12) Requires CDSS, jointly with DHCS, to establish operational procedures, performance and evaluation standards, and utilization criteria for participating entities, developed in consultation with CDDS, the California Department of Education, the Judicial Council, county placing agencies, behavioral health plans, and other stakeholders. (WIC § 16553(f))

13) Requires the pilot program to be implemented for five years from the date grant recipients are selected. (WIC § 16551(f))

14) Requires CDSS, in collaboration with DHCS, to provide an evaluation report to the Legislature on the pilot program, including specified data elements on youth served, placement outcomes, utilization, and other measures of program effectiveness. (WIC § 16555)

FISCAL EFFECT: Unknown, this bill has not been analyzed by a fiscal committee.

COMMENTS:

Background: *The Children's Crisis Continuum Pilot Program* was established through the enactment of AB 153 (Committee on Budget) Chapter 86, Statutes of 2021, as a five-year pilot program in eight counties to provide foster youth with medically necessary mental health services. According to CDSS, one of the goals of the pilot is "to implement a network of services so that when a youth requires a higher or lower level of intervention, the movement within the levels of services and between levels of care is not disrupted or delayed by the need to arrange for provision of services and care or locate appropriate placements that include or can accommodate the provision of services and care."

The participating counties are Fresno, Los Angeles, Monterey, Riverside (regional collaborative with San Bernardino), San Diego, San Francisco (regional collaborative with Contra Costa, Marin, Solano, and Sonoma), San Luis Obispo (regional collaborative with Santa Barbara), and Stanislaus (regional collaborative with Merced and San Joaquin).

The Children's Crisis Continuum Pilot Program was designed in partnership with county child welfare departments, county probation departments, and county behavioral health plans to contract with a county behavioral health plan for the provision of medically necessary mental health services to foster youth, including specialty mental health services, through the continuum of care. The continuum of care was designed within current statutes and regulations for crisis stabilization units, CCRP, psychiatric health facilities, ISFC and other resource families, and STRTPs to permit the seamless transition for the appropriate treatment of the foster youth, between treatment settings and programs.

The pilot was designed to address a recognized gap in California's behavioral health system: the absence of a coordinated, least-restrictive crisis care infrastructure for foster youth experiencing acute psychiatric episodes. The premise of the pilot is that youth in crisis should be stabilized and treated within a highly integrated local continuum rather than defaulting to emergency departments, out-of-area placements, or psychiatric hospitalization.

The Legislature appropriated funding and authorized CDSS, in partnership with DHCS, to award competitive grants to participating entities to develop and operate that continuum. Grant recipients are required to build a system that includes five defined components operating in coordination with one another, with the goal of ensuring seamless transitions across levels of care. The pilot is designed to run for five years from the date grant recipients are selected, with CDSS and DHCS obligated to report to the Legislature on outcomes.

The Components of the Pilot Continuum. The pilot requires each participating entity to develop and operate five integrated components, each serving a distinct function in the crisis care continuum:

- Crisis Stabilization Unit (CSU): The CSU provides short-term assessment and stabilization for up to 23 hours and 59 minutes. It serves foster youth experiencing acute behavioral health crises who do not yet require a higher level of care or who are being assessed for placement. CSUs must be licensed as 24-hour health care facilities or hospital-based outpatient programs and are licensed and regulated under the California Code of Regulations by DHCS. The CSU must be co-located with, or within 30 miles of, a psychiatric health facility to facilitate rapid step-up when inpatient care is determined to be medically necessary.

- Children's Crisis Residential Program: The CCRP is a short-term, sub-acute residential component designed for foster youth who do not require inpatient hospitalization but need more intensive stabilization than a CSU can provide. CCRPs serve up to four foster youth at a time and must operate in accordance with applicable placement statutes and the Community Care Facilities Act. CCRPs fall within the community care licensing framework administered by CDSS. This component is the subject of the primary change proposed by *this bill*.

- Psychiatric Health Facility: The PHF is a licensed inpatient setting for foster youth who require the highest level of acute psychiatric care. PHFs are licensed by DHCS. Pilot PHFs are limited to four beds and must operate within a secure, therapeutic, hospital-like environment. Before any placement into a PHF, the participating entity must submit a written report describing the circumstances, assessments, prior services, anticipated duration, and barriers to a less restrictive placement.

- Intensive Services Foster Care Homes: ISFC homes serve foster youth stepping down from more acute settings or those who can be maintained in a family-based environment with intensive wraparound supports. Pilot ISFC homes are enhanced to include 24/7 in-home staffing, behavioral support, specialty mental health services, permanency services, and educational services. Participating entities must maintain at least twice as many ISFC homes as the total number of beds available in the CSU, CCRP, and PHF combined. ISFC is a placement type under the resource family framework and is subject to CDSS oversight.

- Community-Based Supportive Services: This component is intended to provide the connective tissue for the continuum by delivering intensive transition planning and aftercare for youth moving across settings. Services must be available 24/7 and include at least six months of aftercare for youth discharged from an STRTP to a family-based placement. The transition planning team must include, at a minimum, a licensed or license-eligible mental health professional, a support counselor, and a peer partner. This component is not a licensed facility but rather a service delivery model coordinated by the county child welfare agency, probation department, and mental health plan jointly.

The Children's Crisis Residential Program: No Programs Stood Up. As of the time of this analysis, no participating entity in the pilot has successfully established and operationalized a CCRP. This is a significant implementation gap given that the CCRP is a required component of the continuum and is intended to serve the critical sub-acute residential function between the CSU and the PHF. Stakeholders and advocates cite several structural barriers that have contributed to this outcome.

First, the CCRP is a relatively new licensure category without an established regulatory infrastructure that would allow for streamlined application and licensure. Providers report they

have encountered uncertainty about which licensing pathway applies and what physical plant, staffing, and operational standards govern the program. Second, the staffing model required for a CCRP, which is a highly individualized care for up to four youth with intensive clinical supports creates significant workforce and cost challenges, particularly in regions with behavioral health workforce shortages.[1] Third, the CCRP's small capacity (four beds) limits revenue potential, and stakeholders report that this makes it difficult to achieve financial sustainability without substantial and sustained grant funding. Fourth, the intersection of child welfare placement rules, the Community Care Facilities Act, and behavioral health service requirements creates a complex regulatory environment that has slowed provider interest and readiness.

Taken together, these factors have left participating counties without a functioning sub-acute residential option in their continuum, creating a gap between the CSU and PHF that the pilot was designed to bridge.

Pilot Grant Agreement Structure. Under existing law, grant agreements are structured around the specific components enumerated in statute that include the CCRP. Funds designated for a particular component, such as the CCRP, are tied to that component under the grant agreement. Because the grant period is fixed at five years from the date of grant recipient selection, participating entities that have been unable to stand up a CCRP report they cannot redirect designated CCRP funds to other components that are operational and serving youth, and they risk losing unspent funds at the end of the grant term without having been able to apply them to the crisis residential function the pilot intended to fill.

The provisions of *this bill* seek to address this constraint. On the fund flexibility side, *the bill* would allow a participating entity that substitutes a CCRP-equivalent alternative component, but subject to department review and approval, to redirect all grant funds, including funds specifically designated for the CCRP, to other continuum components. The sponsors allege this would allow counties to make productive use of grant funds that would otherwise sit idle pending a CCRP. *The bill* would also authorize CDSS to extend grant agreement terms, upon request, for entities that have unexpended funds and need additional time to complete implementation or closeout. Extensions would be capped at the minimum necessary time and could not extend past July 1, 2030.

Supporters of this approach argue that the fund-redirection provision preserves the spirit of the pilot by keeping resources within the continuum, while the extension provision gives counties a realistic window to complete implementation work that has been delayed by the same structural barriers that prevented CCRP standup. Opponents have raised concerns that the combined effect of these provisions, allowing a CCRP-equivalent to be satisfied by an existing program type, redirecting funds away from a crisis residential function, and extending grant timelines could reduce accountability for building the specific kind of program the Legislature envisioned.

Author's Statement: According to the Author, "Currently, WIC 16553 requires Pilot counties to open and operate a very specific model for 24-hour crisis programs for youth, the Children's Crisis Residential Program (CCRP). CCRPs have staffing requirements and funding challenges that make implementation challenging in many areas. There are other program types that could provide similar services to youth with the highest need that could be implemented successfully

[1] https://hcai.ca.gov/visualizations/supply-and-demand-modeling-for-californias-behavioral-health-workforce/

with approval from the California Department of Social Services (CDSS). This would allow Pilot counties to open and sustainably operate the 24-hour crisis program that most meets the needs of each county and its foster youth population."

Equity Implications: While current law provides a historic opportunity for counties to develop full continuums of care for foster youth, the interpretation of the residential crisis program requirements has created overly specific restrictions and unintended barriers to implementation. *This bill* seeks to address this in order to allow for existing and new program types that would meet the complex needs of youth in crisis.

Policy Considerations: Existing law requires CDSS, in collaboration with DHCS, to prepare and submit an evaluation report to the Legislature on the pilot program. That report must include specified data on the youth served, placement patterns, utilization of continuum components, transition outcomes, and other measures of program effectiveness. Participating entities are required to provide CDSS with any requested information to support the evaluation and the report.

Should this bill move forward, the Author may wish to consider an amendment to the existing reporting requirements in WIC Section 16555 to require CDSS and DHCS to specifically identify and report to the Legislature on implementation barriers to establishing CCRPS within the pilot. While this bill provides a near-term workaround for participating entities that have been unable to stand up a CCRP, the bill does not address the underlying reasons why no CCRP has been established, nor does it create a mechanism for the state to systematically identify and respond to those barriers.

Proposed Committee and Author Amendments:

The Committee proposes amendments to address policy considerations stated above to do the following:

- Require CDSS and DHCS to include in the pilot evaluation report an identification of the specific regulatory, workforce, financial, and operational barriers to CCRP implementation

Due to timing, the following amendments that originated from the Author, in agreement with the Committee, will be taken as Committee amendments:

- Require that any comparable treatment component, whether a STRTP, PRTF, or other department-approved program, provide short-term, intensive, and highly individualized crisis stabilization services, and require demonstration of enhanced direct care staffing ratios, increased clinical support, and strengthened system integration.

  According to the Author, this amendment responds to concerns raised in opposition that the bill would allow existing, unenhanced program types to substitute for the CCRP without any additional clinical requirements. The amendment clarifies what qualifies as a functional equivalent by specifying service intensity criteria rather than relying solely on program type designation.

- Require that the program statement submitted to CDSS, Community Care Licensing Division, or DHCS, as applicable, explicitly describe the level of clinical intensity required for the alternative component, including staffing ratios, clinical coverage, and service

delivery models sufficient to meet the needs of the population served. This creates a documented accountability mechanism tied to the licensing or approval process rather than relying solely on post-approval oversight.

- Require that CDSS affirmatively determine whether a proposed alternative component meets the statutory intent before it may be utilized as a CCRP equivalent.

  According to the Author, this amendment addresses the concern that the bill could allow substitutions to proceed without meaningful state-level review. With this amendment, CDSS' role shifts from recipient of information to an active role.

- Require that a participating entity utilizing an alternative component demonstrate that its full continuum of care remains intact, including all other required components, and that the alternative component fulfills a functionally equivalent role to crisis residential care within that continuum.

  According to the Author, this is intended to prevent piecemeal substitution from fragmenting the integrated system design that is the core premise of the pilot.

Arguments in Support: The California Alliance of Child and Family Services, a co-sponsor, writes, "The Children's Crisis Continuum Pilot Program was created to address the complex needs of foster youth in California through a highly integrated continuum of care. However, existing law has created overly specific restrictions and unintended barriers to implementation. Specifically, current law requires a Children's Crisis Residential Program (CCRP), which requires staffing and funding that make implementation challenging in many areas. Current law does not allow providers to serve youth through comparable services to CCRPs, which limits providers' ability to participate in the Children's Crisis Continuum Pilot and consequently limits care options for children and youth.

"[This bill] would seek to address these barriers by expanding the allowable program types for residential crisis treatment to include Psychiatric Residential Treatment Facilities (PRTFs), Crisis Stabilization Unit/Psychiatric Health Facility (CSU/PHF) combinations, Short Term Residential Therapeutic Programs (STRTPs), or other CDSS-approved residential crisis models. This expansion preserves the safety and overnight standards while giving counties the flexibility to build sustainable, access crisis care options for youth."

Arguments in Opposition: A coalition representing Disability Rights California, National Center for Youth Law, National Health Law Program, and Youth Law Center writes, "The bill's sponsors assert that the Children's Crisis Residential Program is not financially viable because the relevant payment rates from the state are too low. If financial viability is the barrier, then we should be discussing increasing funding, not decreasing safeguards. The state does not and should not establish a rate and then work backwards to a standard of care. CDSS set extensive regulations for what children's crisis programs need in order to be safe and effective; this bill asks us to disregard those requirements.

"We are also concerned about the fact that the current text of [this bill] seems to allow for the use of funds from the Children's Crisis Continuum Pilot Program to cover any component of the continuum of care at STRTPs or PRTFs, even beyond the crisis continuum the pilot was originally intended to fund. As such, the bill would effectively incentivize the establishment and

use of these facilities, including the higher and more intensive levels of care they typically provide, at the expense of true crisis services."

RELATED AND PRIOR LEGISLATION:

AB 2317 (Ramos), Chapter, 589, Statutes of 2022, required DHCS to license and establish regulations for PRTFs that provide inpatient psychiatric services to individuals under 21 years of age in a non-hospital setting.

AB 153 (Committee on Budget), Chapter 86, Statutes of 2021, established a five-year Children's Crisis Continuum Pilot Program to include a crisis stabilization unit, a crisis residential program for foster youth not requiring inpatient treatment, a psychiatric health facility, intensive services foster care homes with specialty mental health services, and 24/7 community-based support services to provide transition planning and an after-care plan.

AB 226 (Ramos) of 2021, would have reclassified CCRPs as PRTFs and transferred responsibility for licensing PRTFs from DSS to DHCS and would have required DHCS to begin the approval process for PRTFs. *AB 226 was vetoed by Governor Newsom, who stated in part: "AB 226 presents implementation challenges that cannot be overlooked or easily overcome."*

AB 808 (Stone) of 2021, would have made numerous changes to address the continuum of care needs of high acuity foster youth, including the creation of a of a Specialized Foster Home to provide 24-hour care for foster children that is in the residence of the foster parent with enhanced care and supervision provided by foster parent that have completed specialized training, as provided; and would have created a five year children's crisis continuum pilot program, as specified. *AB 808 was set to be heard by the Senate Health Committee, but the hearing was canceled at the request of the author.*

AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017, expanded the definition of a short-term residential treatment center (STRTC) to include a CCRC to be used as a diversion from psychiatric hospitalization and created a new facility licensure category for CCRCs. AB 501 also defined a CCRC as a facility licensed by DSS as a STRTC, and approved by DHCS, to which DHCS has delegated approval authority, to serve children experiencing mental health crises as an alternative to psychiatric hospitalization.

REGISTERED SUPPORT / OPPOSITION:

Support

Alliance for Community Advocacy dba Just Advocates (Co-Sponsor)
California Alliance of Child and Family Services (Co-Sponsor)
Alliance for Children's Rights
California Behavioral Health Association
City and County of San Francisco
County Behavioral Health Directors Association, (CBHDA)
County Welfare Directors Association of California
National Alliance on Mental Illness (NAMI-CA)

Opposition

Disability Rights California
National Center for Youth Law
National Health Law Program
Protection of the Educational Rights of Kids
One private citizen

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