Date of Hearing: June 20, 2023

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Corey A. Jackson, Chair
SB 408 (Ashby) – As Amended May 18, 2023

SENATE VOTE: 40-0

SUBJECT: Foster youth with complex needs: regional health teams

SUMMARY: Requires the Department of Health Care Services (DHCS), in consultation with the California Department of Social Services (CDSS), to establish up to 10 regional health teams (RHTs) throughout the state to serve foster youth and youth who may be at risk of entering foster care, at a facility or through mobile services in home or other community-based settings. Specifically, **this bill**:

1) Requires DHCS, in consultation with CDSS, to establish up to 10 RHTs throughout the state to serve foster youth, and youth who may be at risk of entering foster care.

2) Requires RHTs to be physician led and composed of, at a minimum, the following members: a physician; a licensed clinical social worker; a public health nurse; a nutritionist or dietitian; an occupational therapist; a community health worker; a peer support specialist; a training coordinator; and, additional behavioral health staff as appropriate.

3) Requires RHTs to be available to children and youth and any adult caregivers or other adults connected with the child or youth under 26 years of age, who are experiencing severe mental illness, emotional disturbance, substance use, intellectual or developmental disability, or special health care needs or chronic health issues, or any combination of the listed conditions, and subject to identification and referral as described in 6) below.

4) Defines, for purposes of these provisions, "severe mental illness and emotional disturbance" to mean an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior, that seriously limits a person's capacity to function in primary aspects of daily living, such as personal relations, living arrangements, work, school, and recreation.

5) Requires screening and referral for RHT services to be determined pursuant to guidelines developed by the local system of care team, as established in current law, in the county or counties served by the RHT, with priority to current foster youth and those at risk of entering foster care.

6) Requires RHTs to perform the following activities, which may be delivered at a facility or through mobile services in home or other community-based settings where the youth and family are located:

    a) Receive and respond to referrals received from staff from county child welfare, county probation departments, regional centers, and others as deemed appropriate by the local county system of care;

b) Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services;

c) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

d) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;

e) Coordinate and provide access to mental health and substance abuse services;

f) Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings, which is defined as appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;

g) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;

h) Coordinate and provide access to individual and family supports, including linkage to community, social support, and recovery services;

i) Coordinate and provide access to long-term care supports and services;

j) Promote evidence-based medicine and utilize patient engagement strategies in the implementation of client plans;

k) Develop a person-centered care plan for each individual that coordinates and integrates all of their clinical and nonclinical, health care-related needs and services;

l) Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, as well as the placing agency, and provide feedback regarding practices, as feasible and appropriate;

m) Establish a continuous quality improvement program, and collect and report on data that permit an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience-of-care outcomes, and quality-of-care outcomes at the population level; and,

n) Conduct staff training within the RHT and with other service providers to improve direct care and patient outcomes.

7) Requires DHCS to coordinate with CDSS and the California Department of Developmental Services (DDS) and to convene and engage stakeholders, including, but not limited to, the County Welfare Directors Association of California, the Chief Probation Officers of California, the County Behavioral Health Directors Association of California, the Association of Regional Center Agencies, interested counties, and other stakeholders, as deemed appropriate, to develop the RHTs.

8) Requires all team members to be responsible for ensuring that care is person centered, culturally competent, and linguistically capable.

9) Requires DHCS, in establishing the RHTs, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services (CMS) no later than July 1, 2024, to implement the Medicaid Health Home State Plan Option.

10) Requires DHCS to fund up to 10 health teams to be geographically situated to support access to services equitably throughout the state pursuant to a competitive procurement process and requires eligible entities to include county behavioral health plans, community health centers, hospital-based physician groups, or others as determined by DHCS.

11) Requires DHCS, in consultation with the stakeholders identified in 7) above, to establish performance and outcome measures to be tracked by RHTs and the intervals at which these teams are required to report information related to those measures to DHCS. Further requires DHCS to post the results of these performance and outcome measures on its internet website on at least an annual basis.

12) Makes findings and declarations related to the crisis counties are experiencing of foster youth with severe trauma and complex, unmet needs who are simply overwhelming county child welfare and probation agencies, regional centers, schools, and behavioral health providers.

13) Further declares that services to this population are currently delayed, lacking, and disjointed, resulting in foster youth often experiencing frequent placement changes because no single provider or entity can meet their needs. This results in a cycle of multiple placement moves, frequent changes in service providers and caregivers, and unnecessary stays in hospital settings and unlicensed settings. These experiences lead to poor outcomes for youth and exacerbate their trauma.

14) States legislative intent that the health home state plan option established pursuant to these provisions begin no later than December 1, 2024, subject to the receipt of any required federal approvals or waivers.

EXISTING LAW:

1) Establishes a state and local system of child welfare services, including foster care, for children who have been adjudged by the court to be at risk of abuse and neglect or to have been abused or neglected, as specified. (Welfare and Institutions Code Section [WIC] 202)

2) States that the purpose of foster care law is to provide maximum safety and protection for children who are currently being physically, sexually, emotionally abused, neglected, or exploited, and to ensure the safety, protection, and physical and emotional well-being of children who are at risk of harm. (WIC 300.2)

3) Defines a “child and family team” as a group of individuals who are convened by the placing agency and who are engaged through a variety of team-based processes to identify the strengths and needs of the child or youth and their family, and to help achieve positive outcomes for safety, permanency, and well-being. (WIC 16501(a)(4))

4) Authorizes a county to establish a child abuse multidisciplinary personnel team within that county to allow provider agencies to share confidential information in order for provider agencies to investigate reports of suspected child abuse or neglect. Defines a "child abuse multidisciplinary personnel team" to mean a team of two or more persons who are trained in the prevention, identification, or treatment of child abuse and neglect cases and who are qualified to provide a broad range of services related to child abuse. (WIC 18961.7)

5) Defines "intensive services foster care" as a licensed foster family agency model or public delivery model of home-based family care for eligible children whose needs for safety, permanency, and well-being require specially trained resource parents and intensive professional and paraprofessional services and supports in order to remain in a home-based setting, or to avoid or exit congregate care in a short-term residential therapeutic program (STRTP), group home, or out-of-state residential center. (WIC 18360(c))

6) Requires, in order to ensure that coordinated, timely, and trauma-informed services are provided to children and youth in foster care who have experienced severe trauma, each county to develop and implement a memorandum of understanding (MOU) setting forth the roles and responsibilities of agencies and other entities that serve children and youth in foster care who have experienced severe trauma. (WIC 16521.6(a))

7) Requires the Secretary of California Health and Human Services and the Superintendent of Public Instruction to establish a Joint Interagency Resolution Team (IRT) consisting of representatives from CDSS, DHCS, DDS, and the State Department of Education (CDE). Provides that the primary roles of the IRT are to develop guidance to counties, county offices of education, and regional centers with regard to developing MOUs and the implementation of those MOUs to facilitate the treatment and service provision across departments to high needs children and youth in foster care. (WIC 16521.6)

8) Requires county mental health departments to provide children served by county social services and probation departments, who meet the definition of medical necessity, with mental health screening, assessment, participation in multidisciplinary placement teams and specialty mental health treatment. (WIC 5867.5)

9) Requires each local mental health plan to establish a procedure to ensure access to outpatient specialty mental health services, as required by Early Periodic Screening and Diagnostic Treatment program standards, for any child in foster care who has been placed outside their county of adjudication. (WIC 14716)

10) Requires each county child welfare agency, probation department, and mental health plan, in consultation with the local Interagency Leadership Team (ILT) established pursuant to 6) above, to jointly provide, arrange for, or ensure the provision of, at least six months of aftercare services for youth who are discharged to a family-based setting. (WIC 4096.6(b))

FISCAL EFFECT: According to the Senate Appropriations Committee analysis on May 18, 2023:

- Unknown, ongoing costs (General Fund and federal funds) to support regional health teams.

- Unknown, ongoing costs for DHCS for state administration to implement the provisions.

COMMENTS:

Background: *Child Welfare Services (CWS).* California's CWS system was established with the goal of protecting youth from abuse and neglect and is designed to provide for the safety, health, and overall well-being of children. When a child is identified as being at risk of abuse or neglect, reports can be made to either law enforcement or a county child welfare agency. Often, these reports are submitted by mandated reporters who are legally required to report suspicion of child abuse or neglect due to their profession, such as a teacher or physician. When a mandated reporter submits a report to either law enforcement or the county child welfare agency, a social worker determines whether the allegation is of suspected abuse, neglect, or exploitation. The child's social worker and the court collaborate to evaluate and review the circumstances of each case, seeking either reunification or placement outside of the home as a way for the child to achieve permanency.

California's CWS programs are administered by the 58 individual counties with each county organizing and operating its own program of child protection based on local needs while adhering to state and federal regulations. When a child welfare case is open, counties are the primary governmental entity interacting with children and families when addressing issues of child abuse and neglect and are responsible, either directly or through providers, for obtaining or providing the interventions and relevant services to protect children and assist families with issues related to child abuse and neglect.

CDSS secures federal funding to support CWS programs, provides statewide best practices training for social workers, and conducts program regulatory oversight and administration, and is responsible for the development of policy while also providing direct services such as adoption placements.

As of January 1, 2023, there were 52,265 youth between the ages of 0 and 21 in foster care in California.

Continuum of Care Reform (CCR). In response to data showing that congregate care for foster youth experience poorer outcomes than youth placed in family settings, the Legislature enacted reforms to the CWS system to improve placement and treatment options for youth in foster care, which became known as the Continuum of Care Reform, and most is often referred to as CCR. AB 403 (Stone), Chapter 773, Statutes of 2015, was enacted followed by series of bills (see prior and related legislation below) that helped with the overall implementation of this concept. AB 403, sponsored by CDSS, sought to improve outcomes for youth served by the CWS system by working to ensure that foster youth have their day-to-day physical, mental, and emotional needs met, that they have the opportunity to grow up in permanent and supportive homes, and have the opportunities necessary to become self-sufficient and successful adults.

Think of Us, a research and design lab for the social sector, conducted a 2021 study entitled *Away From Home* which surveyed youth with recent lived experiences that found institutional placements:

- Failed to meet the mandate of child welfare of safety, permanency, and well-being.
- Were prison-like and punitive.
- Were traumatic and unfit for healthy child and adolescent development.

- Shielded youth from building relationships that would get them out of institutions.
- Were environments in which youth felt like they didn't have a way out.

Casey Family Programs has also assembled data confirming that youth who experience group placements have poorer educational outcomes than youth in family foster care, including lower test scores in basic English and math, are less likely to graduate high school, when compared to youth in family foster care, are at risk of physical abuse when they are placed in group settings, and lack opportunities to develop critical life skills and positive relationships.

Another component of CCR focuses on incorporating child and family teams when providing services to children in care and their families. When youth enter foster care, social workers use a variety of strategies to engage with the youth and their family to identify their strengths, and family's concerns, and most importantly, to develop a plan to help achieve positive outcomes for safety, permanency, and well-being. According to CDSS, this strengths-based approach to practice recognizes that families are experts in their own lives, and they can achieve success when they have an active role in creating and implementing solutions.

Systems of Care. Foster youth with complex care needs are often served by multiple programs that are delivered by multiple departments. These services include CWS, specialty mental health services, rehabilitation services, special education services, foster youth services, as well as services offered through regional centers. Often these services and programs have different eligibility guidelines, different appeal processes, variations in how information is shared, and how referrals are made. As a result, foster youth and caregivers have reported that access to coordinated and timely services has been challenging.

In recognition of a need to break down these siloed processes and shift to providing services that are person-centered rather than program-centered, AB 2083 (Cooley), Chapter 815, Statutes of 2018, was enacted which established a process to ensure that coordinated, timely, and trauma-informed services are provided to children and youth in foster care who have experienced severe trauma.

Each county is required to develop and implement an MOU setting forth the roles and responsibilities of agencies and other entities that serve children and youth in foster care who have experienced severe trauma. Participants in the development and implementation of the MOU include county child welfare, probation, and behavioral health departments, along with the county office of education and regional centers serving children and youth with developmental disabilities. Also included are foster care or other child welfare advocacy groups, as deemed appropriate by the organizations that will be parties to the MOU, serving in an advisory capacity.

The goal of the MOUs is to address systemic barriers to the traditional provision of interagency services and to create a service plan that defines how they work together as an administrative team, with collaborative authority over the interrelated child welfare, juvenile justice, education, developmental, and mental health children's services.

The MOUs are required to include, at a minimum, provisions addressing all of the following:

- Establishment and operation of an ILT and an interagency placement committee.
- Commitment to implementation of an integrated core practice model.

- Processes for screening, assessment, and entry to care.
- Processes for child and family teaming and universal service planning.
- Alignment and coordination of transportation and other foster youth services.
- Recruitment and management of resource families and delivery of therapeutic foster care services.
- Information and data sharing agreements.
- Staff recruitment, training, and coaching.
- Financial resource management and cost sharing.
- Dispute resolution.
- Processes, as developed through tribal consultation with the federally recognized tribes within each county, for engaging and coordinating with these tribes in the ongoing implementation of the MOUs.

As required by AB 2083, the Secretary of California Health and Human Services and the Superintendent of Public Instruction established a joint IRT consisting of representatives from CDSS, DHCS, DDS, and CDE. The primary role of the IRT is to develop guidance to counties, county offices of education, and regional centers with regard to developing the MOUs, to support the implementation of those MOUs, and to provide technical assistance to counties to identify and secure the appropriate level of services to meet the needs of children and youth in foster care who have experienced severe trauma. Additionally, the agencies are required to ensure that a process is developed for counties and partner agencies that are parties to the MOUs to request interdepartmental technical assistance from the joint IRT.

The ILT serves as the governing and coordinating body of this collaborative and includes leaders from programs and departments that interact with children such as the Chief Probation Officer, the Director of Mental Health, the Director of CDSS or the Health and Human Services Agency, the Superintendent of the County Office of Education, and Regional Center leadership, or designee. Members of the ILT are required to establish a process to provide, arrange for, or ensure the provision of, at least six months of family-based aftercare service to children and youth and acknowledgment that federal financial participation under the Medi-Cal program is only available if all state and federal requirements are met and the service is medically necessary.

To the extent permitted by federal law, members of the ILT are permitted to disclose to, and exchange with one another, information or a writing that may be designated as confidential under state law, if the member of the team having that information or writing reasonably believes it is generally relevant to the identification, reduction, or elimination of barriers to services for, or to placement of, children and youth in foster care or to improve provision of those services or those placements. Additionally, any discussion concerning the disclosed or exchanged information or writing during a team meeting is considered to be confidential and is not open to public inspection.

When members of an interagency placement committee, child abuse multidisciplinary personnel team, or child and family team, convene for the purpose of implementing the provisions of the MOUs as described above, they are required to comply with applicable statutory confidentiality provisions and to comply with applicable records retention policies for their respective agencies or programs.

As part of the requirements of AB 2083, the IRT, in consultation with county agencies, service providers, and advocates for children and resource families, reviewed the placement and service options available for youth in foster care who have experienced severe trauma and developed and submitted recommendations to the Legislature addressing any identified gaps in placement types or availability, needed services to resource families, and any other identified issues. The IRT was required to take into account the specific needs and characteristics of youth with unplanned discharges from STRTPs and youth for whom counties were unable to, or have difficulty with, securing placements and providing trauma-informed services, including, youth impacted by commercial sexual exploitation, youth with acute behavioral needs, and youth with intellectual or developmental disabilities. The recommendations also articulated a statewide plan for any additional development needed for a trauma-informed, therapeutic continuum of care to support youth in-state in the least restrictive setting.

The IRT, in consultation with county agencies, service providers, behavioral health professionals, schools of social work, and advocates for children and resource families, also developed a multiyear plan for increasing the capacity and delivery of trauma-informed care to children and youth in foster care served by STRTPs and other foster care and behavioral health providers. The IRT is also required to track and report de-identified information of youth in foster care who have been assisted to preserve, or secure new, intensive therapeutic options. This information is posted on the California Health and Human Services Agency website and updated annually, to include the number of children and nonminor dependents served through its technical assistance process, characteristics of individuals served, and, as applicable, local and statewide systemic issues identified by the team.

This bill would require screening and referral for RHT services to be determined pursuant to guidelines developed by the local system of care team, as established by AB 2083, in the county or counties served by the RHT, with priority to current foster youth and those at risk of entering foster care.

Enhanced Care Management (ECM) is a statewide Medi-Cal benefit as of January 1, 2022, and was created to provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need members enrolled in Medi-Cal managed care. ECM is a component of a new Medi-Cal program called California Advancing and Innovating Medi-Cal, which is also known as CalAIM. ECM beneficiaries have a single Lead Care Manager who is responsible for coordinating care and services among the physical, behavioral, dental, developmental, and social services delivery systems.

Children and youth in foster care who receive federal Social Security Act Title IV-E payments are categorically eligible for Medicaid in every state. In California, children and youth are enrolled into foster care-linked Medi-Cal subject to the court's custody determination. According to DHCS, as of March 2020, children and youth with Adoption/Foster Care aid codes represent 0.014% (176,734) of all certified Medi-Cal eligible individuals in the state (12.4 million) and 0.034 % of all certified Medi-Cal eligible children under age 21 in the state (5.1 million).

Children in foster care are not required to enroll in a Medi-Cal Managed Care Plan (MCP), unless they reside in a county with a County Organized Health System (COHS), where enrollment in a Medi-Cal MCP is mandatory. As a result, many foster youth in California receive services through the Medi-Cal fee-for-service (FFS) system. According to DHCS, approximately 55% of children in an out-of-home child welfare or probation placement are enrolled in an MCP and 45% receive services from the FFS system. Foster youth are permitted to be voluntarily enrolled in an MCP only when the county child welfare agency with responsibility for the care and placement of the child, in consultation with the foster youth's caregiver, determines that it is in the best interest of the child to do so and DHCS determines that enrollment is available.

ECM is exclusively for MCP members, which means that foster youth who receive care through the FFS delivery system are required to enroll in an MCP in order to receive ECM services.

This bill seeks to create parity between foster youth enrolled in Medi-Cal MCP and FFS in terms of the added layer of support ECM enrollees are provided.

Author's statement: According to the Author, "Some foster youth, especially those either going through a crisis or with complex trauma and significant, co-occurring needs across multiple child-serving systems, continue to lack the intensive, specialized and coordinated services they need. These foster youth often have intensive psychological, health, and developmental needs that have not been properly identified nor assessed, leading to ineffective treatment and services that do not address their underlying needs. Additionally, such assessments and treatment planning are often siloed and lack coordination across child and family-serving systems. 46% of foster youth under CalAIM will not be enrolled in managed care and instead will be served by the fee-for-service system, thereby these youth will not have access to enhanced care management (ECM) and community supports.

"[This bill] seeks to address gaps in the service planning and care management for foster youth and ensure that foster youth have access to a trauma-informed, supportive and therapeutic environment when needed by establishing ten Regional Health Teams (RHTs) across the state for diagnostic assessment, direct care, and support for youth in crisis and their families. The RHT will bring together professionals and peer supports to provide trauma-informed coordinated care and services, under a single umbrella, in coordination with other service providers (i.e. wraparound, regional centers, education and others), to prevent the separation of youth from their family caregivers and to reduce incidence of youth going into institutional settings (i.e. hospitals and congregate care)."

Need for this bill: The provisions of this bill seek to create specialized teams to meet the needs of foster youth in crisis. The author contends these youth lack access to intensive, specialized and coordinated services and that by establishing 10 RHTs across the state for diagnostic assessment, direct care, and support for youth in crisis and their families, foster youth will be better served. Additionally, this bill seeks to create parity in the types of services available to foster youth enrolled in Medi-Cal FFS plans who are therefore not eligible for the extra services from a dedicated ECM provider.

Equity Implications: This bill seeks to address foster youth who are experiencing severe mental illness, emotional disturbance, substance use, intellectual or developmental disability, or special health care needs or chronic health issues, or any combination of the listed conditions by establishing regional health teams throughout the state to coordinate their care. By definition, foster youth have experienced trauma simply by having to be removed from their home.

According to the National Conference of State Legislatures, up to 80% of foster youth have significant mental health issues, compared to approximately 18-22% of the general population.

When it comes to employment, educational attainment, financial independence, criminal justice involvement, and overall physical and mental health, foster youth fare poorly when compared to their non-foster youth peers. In addition to the trauma these youth experience by being removed from their home due to either abuse or neglect or a combination of both, only 53% of foster youth in California graduate high school compared to 83% for non-foster youth. Compounding these factors, research indicates that as many as 38% of foster youth experience homelessness, a figure much higher than the general population. The Legislative Analyst's Office (LAO) released an analysis in March of 2022 that stated foster youth are disproportionately low-income, Black, and Native American and that the proportions of Black and Native American youth in foster care are around four times larger than the proportions of Black and Native American youth in California overall.

Recent research also suggests that LGBTQ+ youth are overrepresented in unstable housing and foster care and face poorer treatment while in the system and lower rates of achieving permanency, as well as bleaker outcomes after they age out, including lower educational attainment and higher odds of homelessness and financial instability.

Foster youth represent one of the most vulnerable and academically at-risk student groups, according to CDE and suffer poorer educational outcomes with higher rates of suspension and lower rates of graduation. According to the LAO, in California, the populations reflected in foster care are predominantly youth of color as 21% are Black and 50% are Latino. Further highlighting the disproportionality comprising the foster youth population, the number of Black and Native American youth in foster care are four times larger than the number of the general population of Black and Native American youth in California. The LAO also states that racial disproportionalities and disparities are present within initial allegations and persist at all levels of the system—becoming the most pronounced for youth in care. Additionally, LGBTQ+ youth are also overrepresented in foster care, according to the UCLA Williams Institute, with 13.6 % of foster youth identifying as lesbian, gay, bisexual, or questioning, and 5.6% identifying as transgender, compared to 10.3% of California's students in public middle and high schools identifying as LGBTQ+.

Because foster youth are typically at a disadvantage when compared to their non-foster youth peers, this bill seeks to create parity for foster youth experiencing crises by establishing additional supports and services to allow for better access to the care they need to be able to attain stability and self-sufficiency.

Policy Considerations: This bill has several components that fall outside the jurisdiction of the Assembly Human Services Committee, and the below considerations only reflect the issues within the jurisdiction of the Assembly Human Services Committee:

This bill names a list of required professionals to be a part of the RHT, but does not include representatives from the foster youth's local educational agency.

> *Should this bill move forward, to better support a foster youth in crisis, the author may wish to consider adding a member of the foster youth's educational team to the RHT structure.*

Beyond the geographical, multi-county approach, it is unclear how would the RHTs differ in practice from how the AB 2083 interagency MOU structure currently operates.

The author may wish to clarify the differences between these two structures.

The bill requires RHTs to receive and respond to referrals received from staff from child welfare, probation, regional centers, and others, but as it written, the RHTs do not have any requirements placed on them for how soon after a referral is made that the youth will be provided services or whether there will be an approval or denial process upon referral.

The author may wish to consider adding more details to this process including a timeframe.

The bill requires screening and referral for RHT services to be determined pursuant to guidelines developed by the local system of care team served by the RHT, with priority given to foster youth and those at risk of entering foster care.

The author may wish to clarify how this priority would be established in light of other Medi-Cal recipients.

The bill requires RHTs to facilitate communication among team members and between the health team and individual and family caregivers, as well as the placing agency.

The author may wish to provide considerations for youth who do not wish to have their information shared with their caregivers.

Double referral: This bill will be referred to the Assembly Health Committee should it pass out of this Committee.

PRIOR AND RELATED LEGISLATION:

AB 2317 (Ramos), Chapter 589, Statutes of 2022, required DHCS to license and establish regulations for psychiatric residential treatment facilities (PRTFs). Further required DHCS' regulations and certifications to be consistent with federal Medicaid regulations governing PRTFs, in order to maximize federal financial participation. Added inpatient psychiatric services to individuals under 21 years of age provided in a licensed children's crisis PRTF as mental health services provided under the Medi-Cal Program.

AB 808 (Stone) of 2021, would have proposed 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 in the residence of the foster parent with enhanced care and supervision provided by foster parent that have completed specialized training; would have placed additional responsibilities on the IRT to include making specified recommendations to the Legislature; and would have created a five year children's crisis continuum pilot program; among other provisions. *The policy of AB 808 was included in a budget trailer bill.*

AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017, expanded the definition of STRTP to include a CCRP to be used as diversion from psychiatric hospitalization and creates a new facility licensure category for CCRPs, and made related changes.

AB 741 (Williams) of 2016, would have expanded the definition of a short-term residential treatment center to include a children's crisis residential center to be used as a diversion from psychiatric hospitalization, and would have limited the stay to 10 consecutive days and no more than 20 total days within a six-month period. *AB 741 was vetoed by Governor Brown.*

AB 403 (Stone), Chapter 773, Statutes of 2015; AB 1997 (Stone), Chapter 612, Statutes of 2016; AB 404 (Stone), Chapter 732, Statutes of 2017; AB 1930 (Stone), Chapter 910, Statutes of 2018; AB 819 (Stone), Chapter 777, Statutes of 2019; and ***AB 2944 (Stone), Chapter 104, Statutes of 2020,*** implemented CCR to better serve children and youth in California's CWS system.

SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, established the "Investment in Mental Health Wellness Act of 2013", which authorized the California Health Facilities Financing Authority to administer a local grant program to increase capacity for crisis support programs.

SB 1013 (Committee on Budget and Fiscal Review), Chapter 35, Statutes of 2012, required CDSS to establish a working group to develop recommended revisions to the current rate-setting system, resulting in the CCR effort.

REGISTERED SUPPORT / OPPOSITION:

Support

Chief Probation Officers' of California (CPOC) (Co-Sponsor)
County Welfare Directors Association of California (CWDA) (Co-Sponsor)
City and County of San Francisco
City and County of San Francisco Human Services Agency
County of Los Angeles Board of Supervisors
County of Santa Clara
Kern County Board of Supervisors

Opposition

None on file

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