ASSEMBLY THIRD READING
AB 1579 (Ramos)
As Amended April 29, 2026
Majority vote

SUMMARY

Permits participating entities in the Children's Crisis Continuum Pilot Program (pilot program) to satisfy the requirement to have a children's crisis residential program (CCRP) by including a comparable residential treatment component, as determined by the California Department of Social Services (CDSS).

Major Provisions

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

   a) The participating entity has unexpended and available grant funds awarded; and,

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

2) Requires an approved extension 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.

3) Authorizes a participating entity that does not have a CCRP as a part of its continuum of care, to satisfy the requirement to have a CCRP by including in its continuum of care, a comparable residential treatment component designed to serve children and youth experiencing the highest level of acute behavioral health needs, including, but not limited to, a short-term residential therapeutic program (STRTP) or a psychiatric residential treatment facility.

4) Requires a comparable residential treatment component to provide short-term, intensive, and highly individualized services to stabilize youth in crisis and to demonstrate enhanced direct care staffing ratios, increased clinical support, and strengthened system integration necessary to safely serve youth who would otherwise require a more restrictive level of care.

5) Requires a program statement submitted to CDSS' Community Care Licensing Division, or to DHCS, as applicable, to describe the level of intensity required, including, but not limited to, staffing ratios, clinical coverage, and service delivery models sufficient to meet the needs of the population served. Specifies that CDSS shall determine whether a proposed component satisfies these requirements.

6) Requires a participating entity utilizing a comparable residential treatment component to demonstrate that its continuum of care remains fully integrated, includes the components described in the pilot program, and that the proposed comparable residential treatment component fulfills a functionally equivalent role to crisis residential care within that continuum.

7) Adds the following elements to the interim report to the Assembly and Senate Committees on Human Services required to be submitted by CDSS and DHCS no later than April 1, 2027:

   a) The specific reasons a CCRP has not yet been fully established or operationalized, including any regulatory, fiscal, workforce, facility, licensure, or interagency coordination barriers that have prevented or delayed implementation;

   b) The steps that CDSS and DHCS have taken, or are in the process of taking, to address the identified barriers; and,

   c) A plan for establishing a CCRP within the pilot program, including anticipated timelines, identified responsible parties, and any statutory, regulatory, or budgetary changes needed to achieve that goal.

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 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 program 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:

1) 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.

2) 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*.

3) 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.

4) 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.

5) 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.

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 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."

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."

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

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."

FISCAL COMMENTS

According to the Assembly Appropriations Committee on May 13, 2026, CDSS estimates minor and absorbable costs.

VOTES

ASM HUMAN SERVICES: 7-0-0
YES: Lee, Castillo, Calderon, Elhawary, Blanca Rubio, Ahrens, Tangipa

ASM APPROPRIATIONS: 15-0-0
YES: Wicks, Hoover, Bauer-Kahan, Calderon, Caloza, Ellis, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache, Ta, Tangipa

UPDATED

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