Comments from the Editor

With this second issue of the *Children's Regulatory Law Reporter* (Children's Reporter), we continue to report on the California regulatory process as it affects children. Although the *Children's Reporter* approaches the process from a legal perspective, we strive to present summaries that will be useful to policymakers, child advocates, community organizations, parents and all other interested parties.

This issue covers new regulations which were published or filed from January 1 through June 30, 1998, and includes follow-up actions through August 31, 1998. Additionally, this issue includes updates on regulations that had not completed the regulatory process in the time period of the last issue.

During the first six months of 1998, the decisions of the Managed Risk Medical Insurance Board (MRMIB) had a major impact on children's lives. MRMIB has the charge of designing and implementing California's new health insurance program, Healthy Families, for children whose family income falls between 100% and 200% of the federal poverty line. Because of the importance of this new program, we have featured an in-depth overview of that regulatory process beginning on this page.

In addition, the Department of Social Services (DSS) is now proposing rules to implement the state’s CalWORKs welfare reform statute of 1997. Although DSS adopted or noticed most of these rules after the June 30 cutoff for this issue, because of their importance, we have included them in a special insert in this issue. Many of these rules are immediately effective on an “emergency” basis while their formal consideration for permanent adoption proceedings. As to each of these pending rules – as with all rules under the Administrative Procedure Act, public comments must be considered by the adopting agency within the time period prescribed by law. As to those rules which have been permanently adopted, California law allows any person to propose a new rule, amendment, or repeal of an existing rule, to the agency for possible further rulemaking proceedings. The opportunity for public involvement is great – and child advocates must ensure that adopted rules reflect the needs of children who cannot speak for themselves.

Margaret A. Dalton, Editor

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family income is up to the federal poverty level (SB 503) (Lee) (Chap. 624, Statutes of 1997). (Regulations relating to the expansion of Medi-Cal are the responsibility of the Department of Health Services (DHS) and are covered in the Child Health section of this Children's Reporter.)

As required by CHIP, California submitted its Healthy Families plan to the federal Health Care Financing Administration (HCFA). On March 24, 1998, HCFA approved both the mandated plan for expansion of Medi-Cal and the Healthy Families plan, designed to expand coverage to children through age 18 whose family income is up to 200% of the federal poverty level. (Note the federal statute's allowance for coverage up to 200% to 300% of the poverty line for some of California's children; see also later discussion of Governor Wilson's retraction of coverage for many children living below 200% of the poverty line through a revised definition of income.)

Healthy Families provides subsidized health insurance coverage (not health services, per se) for children in families with incomes between 100% and 200% of the federal poverty level (between $13,650 and $27,300 per year for a family of three). Parents have a choice of plans, including coverage for dental, vision care, hearing loss, and physical health services. Monthly premiums range from $47.45 per child (up to $14 per family for families between 100% and 150% of the federal poverty line) to $46.92 per child (up to $27 per family for families between 150% and 200% of the federal poverty line). In addition, co-payments are set at $5 per visit and per prescription; no co-payments may be charged for designated preventive services.

In California, the Managed Risk Medical Insurance Board (MRMIB) is the state agency responsible for drafting regulations for the implementation of Healthy Families. On February 20, 1998, MRMIB published notice of its intent to adopt new sections 2699.6500 through 2699.6813 Title 10 of the California Code of Regulations (CCR), on an emergency basis, to implement the Healthy Families program. The regulations became effective on the same date. On March 13, 1998, MRMIB published notice of its intent to permanently adopt the regulations. MRMIB accepted public comment on the proposal until April 29, 1998, and held a series of eight public hearings throughout the state. MRMIB revised the proposed regulations and submitted them to OAL on June 5, 1998. OAL approved them on July 15, 1998, and they became effective on the same date (15 days after Healthy Families became operational).

The regulations, as permanently adopted, are divided into four articles: Article 1, Definitions; Article 2, Eligibility, Application, and Enrollment; Article 3, Health, Dental, and Vision Benefits; and Article 4, Risk Categories and Family Contributions. For the purpose of easy reference, each Article is considered in order below.

Article 1, Definitions, includes one of the most controversial portions of the regulations, "income deductions" allowances (§ 2699.6400(b)(1)). As originally proposed in the emergency regulations, families qualified for certain income deductions in determining the gross family income for eligibility purposes. These deductions included work expenses of up to $90 per month for each working family member; child care expenses (up to $200 per month per child) for each child under age two and up to $175 for each child over age two and for any disabled, dependent); the amount paid by a family member per month for any court-ordered alimony or child support; child support payments received up to $50 for each applicable family member; and alimony payments received up to $50 for each applicable family member. HCFA had approved these income deductions as part of the federal government's approval of the Healthy Families plan. However, in early April 1998, Governor Pete Wilson proposed eliminating the income deductions from the regulations and requested HCFA to approve a corresponding amendment to the state's plan — a plan originally submitted to the administration's DHS. At its April 20 meeting and at the Governor's request, MRMIB approved the regulatory change (on a 3-2 vote) and removed the income deduction from the regulations — vigorously opposed by child and health advocates — raises the total family income for consideration of eligibility, and thus denies health coverage to qualified families of children on the grounds of previously-qualified children. It also complicates the ability of families to shift from Medi-Cal to Healthy Families as family income rises, or to qualify for coverage for children who have already been covered as Medi-Cal beneficiaries. The regulations rules no longer are consistent with Medi-Cal rules, which allow the deductions in computing family income. The poverty line assumes no child care costs, calculating minimum income necessary to house, clothe and feed a family in a typical state. Expenses apart from these necessities, required to earn income, are properly disregarded as disposable income for public medical coverage purposes in other programs. Hence, child care costs to allow employment, et al, should not be included in determining eligibility for Healthy Families. Advocates also argued that failing to disregard such expenses discriminates against children in many families with the same disposable income but who must pay for child care or other expenses. Finally, critics of the Governor's plan pointed out that more than enough federal funds have been provided to cover all of these children — and many more — and that exclusion would lead to a California give-back of substantial federal funds for distribution to other states. Nevertheless, HCFA subsequently approved the State Plan Amendment, eliminating the use of income disregards for eligibility determination and temporarily ending the discussion.

Other changes in Article 1 include an expanded definition of the "Family Value Package" (§ 2699.6500(c)) — one of two options families may choose. The comprehensive application process is another bar to participation in the program. Sections 2699.6600-2699.6650 contain over fifty rules applying to families attempting to qualify for Healthy Families coverage. The application itself, designed to be visually appealing and user-friendly, nevertheless requires a painstaking determination — using a three-page application of which family members qualify for Medi-Cal, Healthy Families, or neither; a five-page Healthy Families application form including ten declarations which must be individually initialed (and copied made if applicable for more than three children); proof of each child applicant's alien or citizenship status; proof of income; and an initial family contribution payment of at least one month. Applicants who pay in advance, the amount of three months of family contributions shall receive the fourth consecutive month of coverage with no family contribution required (§ 2699.6500(b)). In the emergency regulations, the rules allowed for payment only by cashiers check or money order. This barrier to participation was adjusted somewhat in the permanent rules, which now allow applicants to submit the second or later family contribution payment by personal check, cashiers check, money order, credit card, or a
tronic fund transfer. In an attempt to encourage enrollment, the state has offered training for individuals who work with community-based organizations to participate and assist families in the application process, A person who receives training is certified, and the organization will receive a $25 for each successfully completed application when pregnant women or children are enrolled in the program (§ 2699.6629). Even with that assistance, the enrollment process is complex, and the organization effectively serves as a bar deterring all but the most motivated parents.

Enrollment includes an annual requalification based on income (§ 2699.6625), which compels applicants to requalify on an annual basis by providing to the program all information required to initially enroll. The program will automatically withdraw the child from the enrollment program if the family fails to requalify within the time allotted, and the family must be given advance notice of the disenrollment criteria, open enrollment (for changing from one health plan to another), and additional or transfer enrollments.
copayment requirement for any of these services out-of-patient professional (medical) and mental health, home health care, outpatient alcohol and drug services, and rehabilitative therapy. There is also a similar copayment for most prescription drugs. Preventive services as defined do not require a copayment. The share of cost requirement for outpatient services has a $250 ceiling in a benefit year. Child and health advocates have expressed serious concern with this high copayment cap, since otherwise qualifying families—some of whom may be just over the poverty line—may pay up to $250 per year to access medical care for illness or injury, in addition to the price of premiums. This barrier to treatment, particularly for families whose incomes are already at the lowest levels, is one which child advocates believe will make the program most prohibitive for many of the very families it was theoretically designed to help.

Article 4. Risk Categories and Financial Assistance: 4.1.2.1 Rate restrictions for participating health plans as well as premium costs for families. Allowable rates are based on the geographic regions of other counties similar to the rates of other private health insurance companies. Section 2699.6805 gives MRMB the authority to designate a Community Provider Plan in each county and provisions similar to other private health insurance companies. For example, if the state has the Community Provider Plan over the Family Value Program (see Article 1 discussion of the Family Value Package above) pay $3 less for each premium, per month, per subscriber. Community Provider Plans primarily consist of traditional safety net providers such as community clinics; in many cases they are the current provider of care for those families previously receiving any health care services. The Healthy Families program theoretically became operational on July 1, 1998. As of this writing, a disproportionately small percentage of qualifying families have applied—less than 2% of those eligible. The concerns discussed above, including the cost of premiums and copayments, the complicated application and required documentation, issues for undocumented immigrants whose children are citizens, and the inherent complications in creating a new bureaucratic program—all likely contributed to this slow start. Outreach and education alone will not solve these issues. Further enhancements of the program, especially a reconsideration of the family contribution through premiums and copayments and a simplified application form, are desperately needed to fulfill Healthy Families' promises.

Impact on Children: Uninsured children are less likely to have regular health examinations, resulting in little early detection of problems. They lack a regular medical professional to monitor their development, and are three times more likely than an insured child to lack a regular source of care. Fewer immunizations, well baby checks, and genetic chronicle diseases screenings are related consequences. Most uninsured children come from families who cannot afford basic health care services even when children are ill. The Healthy Families program does not provide those services; rather it offers "working poor" families an opportunity to purchase health insurance. Without adjustments to the program—including a simplified application process, a lowering or elimination of premiums and copayments, and some assurances for immigrants that applying for their children will not harm the parents' immigration status—Healthy Families will not come close to reaching its potential. Medical insurance coverage for children is not a welfare benefit. It is a public investment in the health and safety of our children by preventing and treating illness. It heals and protects. It is not a " perk," nor is it amenable to exploitation by its beneficiaries—unsure they can depend on it to be there for them in long stretches of time or for children who may have to go without.
Health and Safety Code requirement. The emergency regulations included language dealing with standards for accreditation of training programs, certification requirements for individuals conducting abatement programs, and work practice standards for lead abatement and lead abatement evaluation. EPA requires these elements for a state to become an authorized program.

On April 10, 1998, DHS noticed two emergency rules and announced a public comment period extending until the public hearing in Sacramento on May 27, 1998. The proposed regulations vary from the federal regulations as follows: section 35065 requires the worker training course to be 24 hours (the federal rule only requires 16); section 35066 allows certified workers to take a two-day supplemental course to become a certified Supervisor or Project Monitor (the federal rule has no such supplemental course option); section 35067 requires a refresher course every ten years (the federal rules allow up to 16 years); and section 35068 permits three-year audits (the federal rules permit four-year audits). The new regulations implement the second phase of the Mental Health Managed Care, providing for the phased implementation of mental health care for Medi-Cal beneficiaries through fee-for-service or risk-based contracts with mental health plans.

Section 3180.210 applies to children's health services. Children under the age of 21 years of age are entitled to the same medical care that is provided to the population of Medi-Cal. The new regulations implement the second phase of the Mental Health Managed Care, providing for the phased implementation of mental health care for Medi-Cal beneficiaries through fee-for-service or risk-based contracts with mental health plans.

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Impact on Children: Close to three million California families, with over one-quarter of a million children, live in homes with lead paint. A large amount of lead from vehicle exhaust and paint also contaminates the soil. The state's Childhood Lead Poisoning Prevention Fund supports the state's CLPP program. The Fund assesses fees from the largest employers, requiring lead controllers to support follow-up wide-spread childhood lead screening tests, and the development of abatement policies. The regulations change codify program requirements. More significantly, the regulations meet federal standards — in a few cases exceeding them; and specific parameters that were previously absent.

Child health advocates contend that brain damage from lead occurs at levels far below visible symptoms, that some children are subject to school dosage for many hours per day of most of the year, and that the total intake of lead is the greatest danger. Lead is not a typical poison. It is cumulative in nature, with new intake adding to an inorganic load. Ingestion, which means that continuing exposure to low levels of lead can result in significant exposure over time, according to the Natural Resources Defense Council.

From 1994 to 1998, DHM took samples of paint, soil, and drinking water from a cross-section of schools and child care centers. The survey concluded that 37% of public elementary schools have deteriorating lead-containing paint significant enough to pose a hazard. More alarming, 18% have lead levels in drinking water above the federal action level of 15 parts per billion (ppb) and 6% have soil lead levels above the federal action level of 400 ppb.

A 1995 study published in Epidemiology suggests that the 80 ug/dl level (which produces visible symptoms cited by the California Department of Health Services) is not protective. A 1997 study also indicated that lead is not protective for a "triplet of the number of youngsters who need specialized educational services," since even low levels of lead in blood (10 ug/dl) can affect the behavior of young children measurably — and to below normal ranges.

Medi-Cal Specialty Mental Health Services
AB 757 (Polanco) (Chapter 633, Statutes of 1994) enacted laws for the provision of specialty mental health services to beneficiaries of Medi-Cal. On November 1, 1997, the Department of Mental Health (DMH) adopted new sections 1810.100 et seq., Title 9 of the CCR, on an emergency basis, to implement AB 757. The new regulations implemented the second phase of Mental Health Managed Care, providing for the phased implementation of managed mental health care for Medi-Cal beneficiaries through fee-for-service or risk-based contracts with mental health plans.

On November 14, 1997, DMH published notice of its intent to permanently adopt the emergency regulations. DMH accepted public comment until December 30, 1997, and held a public hearing on the same date in Sacramento. On January 9, 1998, DMH reopened the public comment period from December 30, 1997 to January 15, 1998. DMH refiled the regulations on an emergency basis on March 3, 1998 and again on June 16, 1998, to allow time for revisions based on public comment. At this writing, DMH is completing new draft regulations for notice and publication.

Impact on Children: Establisng independent medical criteria for children is vital to the provision of quality care. Children are not just small adults; they have unique medical needs, parents, and special mental health area. These initiailly proposed regulations take a step in the right direction in recognizing the high societal value of early treatment of mental illness. However, weighing such needs against physical treatment of an organic illness as an "either-or" proposition misunderstands the complex etiologies of mental illness or disability. The criteria for treatment should be based on a competent diagnosis and a professional judgment that treatment (in whatever form and coexistentially applied if appropriate) has a "reasonable chance of improving" the child's mental health.

Dental Sealants
On April 10, 1998, DHM amended sections 51003, 51307 and 51506, Title 22 of the CCR, on an emergency basis, to bring California regulations in compliance with the federal Health Care Financing Administration's regulations on the use of preventive dental services. The federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires participating states to offer eligible Medi-Cal beneficiaries dental services that meet "reasonable standards" of dental practice. The most important change as a result of this prevention (aside from water fluoridation) is the use of dental sealants. Such sealants are available to protect the teeth of children against decay and are remarkably effective. However, only 10% of the 6- to 8-year-olds surveyed in California have received this inexpensive and cost-effective preventive treatment. In contrast, Ohio already has applied sealants to over one-quarter of its children.

Existing state regulations provide for 5,037 sealants, but limit the placement of sealants without prior authorization to the first permanent molars in beneficiaries to age eight and the second permanent molars in beneficiaries to age fourteen. The amendments remove existing requirements for prior authorization of dental sealants, allowing the placement of sealants without limit on permanent first and second molars to age 21; limit the sealant benefit to once every three years; and increase the maximum reimbursement to providers.

On April 10, 1998, DHM adopted the proposed regulations changes on an emergency basis; they were effective on the same date. On April 24, 1998, DHM published notice of its intent to permanently adopt the amendments. The amendments were published in the State Register comment period until June 8, 1998. At this writing, DHM has not submitted the proposed regulatory changes to OAL.

Impact on Children: The addition of more comprehensive coverage of dental sealants is helpful to children. However, given the low costs involved, all permanent molars should be sealed before age twelve. Allowing managed care plans to provide only limited dental sealants, where the marginal cost of full treatment is inestimable, has a leveraged negative impact on child and later adult dental health. The context of this under-reach was outlined by the Dental Health Foundation's September 18, 1997, published assessment of the dental health of California's children. The first statewide assessment of the state's child oral health was conducted during the 1993-94 school year and used teams of dental examiners to survey a sample of 6,643 children in 156 schools in 10 geographic regions. The findings documented what was termed a "neglected epidemic" of oral disease, with the state's incidence of problems double that of the national average, and substantially deteriorated from 1987. The examination found high levels of untreated tooth decay and even gum disease among preschool and school-aged California children. The report described the consequences as "significant pain, interference with eating, poor self-image, overuse of..."
expansion of Medi-Cal

Children's Programs

As amended, Welfare and Institutions Code section 14148.75 (SB 903) (Lee) (Chapter 624, Statutes of 1997) allows DHS to waive the use of a resources standard for determining the eligibility of pregnant women, infants and children for certain Medi-Cal programs. A resources standard includes property and other assets as well as income in determining eligibility. Previously, the law had allowed such a waiver for pregnant women and infants, but did not allow the same disregard when determining eligibility for children.

On April 2, 1998, DHS amended section 50262.5, Title 22 of the CCR, on an emergency basis. On April 15, 1998, DHS refiled the amendment to correct a subsection number. As amended, section 50262.5 defines children as persons under 19 years of age (in accordance with federal law), effectively extending coverage for ages 14-19, and also allows for the waiving of the resources standard when determining eligibility for the program. On April 17, 1998, DHS published notice of its intent to permanently adopt the amendment, and announced a public comment period until June 1, 1998. There was no public hearing. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

Impact on Children: These regulatory changes are important provisions of medical health services, which eliminates the disregard on children for ages 14-19. Waiving the use of a resources standard allows more children to qualify for Medi-Cal benefits. However, some provisions benefit to age 19 means health coverage for older children during the critical adolescent years.

Orthodoxiatric Services

DHS and the Legal Aid Society of San Diego entered into a settlement agreement in a class action (Duram v. Belcher, San Diego County Superior Court, No. 574240) that stipulated that DHS would promulgate emergency regulations allowing the use of an expanded ICLD index (a standard for evaluating and determining the threshold need for orthodontic services and determining medical necessity). The regulations must comply with federal requirements for children in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

On January 12, 1998, DHS amended section 51003, Title 22 of the CCR, on an emergency basis to implement the settlement agreement. DHS opened a public comment period from March 23 until April 7, 1998, there was no public hearing. On April 10, 1998, DHS amended sections 51003 and 51506, Title 22 of the CCR, on an emergency basis, to further clarify language and for minor editing. Any changes to these regulations will change the process by which providers obtain authorization to perform certain procedures needed to correct handicapping malocclusion (dental abnormalities). DHS made minor non-substantive changes and again amended the sections on an emergency basis effective May 21, 1998. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

Impact on Children: These changes bring California into compliance with the federal EPSDT program. The new standards for orthodontic care are standard for determining medical necessity for handicapping malocclusion.

Prenatal Care for Immunized and Unqualified Aliens

The federal PRA prohibits states from providing state and local public benefits, including non-emergency-related services to persons who are non-qualified aliens and certain other aliens. Prior to the enactment of the PRA, federal law required states to provide services for the treatment of emergency medical conditions, including emergency labor and delivery services, to any alien otherwise eligible for Medi-Cal regardless of whether that person could document his or her immigration status. Since 1988, California has used state-only Medi-Cal funding to provide emergency pregnancy-related services to women without satisfactory immigration status as described in federal law. 42 U.S.C. § 1396a(v).

With the enactment of the PRA, federal law now prohibits states from providing certain public benefits, including non-emergency pregnancy-related services, to ineligible persons as described above, unless the state enacts a law after the PRA enactment date that affirmatively provides for such eligibility.

On November 5, 1998, DHS added section 50302.1 to Title 22 of the CCR, on an emergency basis, to specify who is eligible to receive non-emergency pregnancy-related services; amend the Manual of Criteria for Medi-Cal Authorization, effective May 22, 1998. At this writing, DHS has not submitted the proposed regulatory changes to OAL.

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Impact on Children: These changes bring California into compliance with the federal EPSDT program. The new standards for orthodontic care are standard for determining medical necessity for handicapping malocclusion.
abuser, or for medical care, mental health counseling or disability needs from the batterer or bully, or to provide care for an unwanted preg-
nancy and child from the abuser’s sexual assault or abuse of relation-
ship (insec, statutory rape, molesta-
tion).

The rule specifies some of the procedural measures to assure prenatal care cut-offs as intended. “State only funded nonemergency, pregnancy related services” for any alien may be provided only upon declaration that she is a qualified alien as defined above, using the “Supplemental Alienage and Immi-
grant Status Declaration” form of INS. Further, the alien must present documentation “issued by or accept-
able to INS as evidence of that de-
declared status, and which must be submitted to INS for verification through that agency’s Systematic Alien Verification Entitlements program (a computer record index). The verification then may require a “secondary verification” when there is an instruction from the INS index to do so, the documents presented do not include an alien registration or admission number, or the numbered document does not match other doc-
ument. If either of the above occur, the document is a fee receipt for replacement of a lost document, or the document is "suspected of being counterfeited or to have been altered." In addition, a series of em-
umerated document are excluded from verification status.

The rule provides that eligi-
bility for state-funded prenatal care must await receipt of verification of an alien’s declared status from the INS. Consistent with the statute, the rule exempts immunizations and communicable disease treatment.

The rule provides procedural due process in the form of a hearing

pursuant to Welfare and Institutions Code section 10950 for those receiv-
ing prenatal care during the month in which the rule became effective and who are denied care as a result of the rules. That due process consists of a hearing on the narrow issue of whether the aliens is a qualified alien eligible for services as described above. The rule enigmatically pro-
vides that “subject to Welfare and Institutions Code section 10950 . . . 
y any alien [declared Medi-Cal benefit] is entitled to a hearing.” No de-
tails are provided.

Impact on Children: The elimination of non-emergency prenatal health care to “unqualified aliens” (many but not all of whom are illegitimately in the United States) will result in increased complications during pregnancy which otherwise could have been detected during routine prenatal care visits. Some of these complications involve potentially fatal consequences (such as HIV transmission at birth, possibly preventable (if HIV status is known). Other complications result in lifelong disabilities preventable through routine screening. Because children born in the United States are citizens at birth, failure to provide prenatal care will impose substantial medical, mental disability, communicable disease, education, and lost productivity costs many times the prenatal care expenses involved, according to the American Academy of Pediatrics and others. There is no evidence that the denial of prenatal care has a sig-
nificant impact on illegal immigration incidence, or on pregnancy inci-
dence among those in the United States. See California Children’s Budget 1997-98 at 4-12 to 4-14. Beyond these statutory con-
sequences, the new rule narrowly defines exemptions, and imposes onerous proof requirements on law-
ful immigrants, discouraging prenatal care by those not intended to be burdens and adding drastically to infant death and disability conse-
quences.

Detection of Fluoride in Public Water

On March 28, 1997, in compliance with U.S. Environmental Protection Agency regulations under the Safe Drinking Water Act (42 U.S.C. § 300(f) et seq.), as well as Health and Safety Code sections 4026.7 and 4026.8, DHS published notice of its intent to adopt new sections 64400.47 and 64433-64434 and amend sections 64431 and 64432, Title 22 of the CCR. In these pro-
posed changes, DHS seeks to provide a definition for the term “fluorida-
tion” and establish a detection limit for fluoridate, a naturally occurring chemical.

Specifically, these regulatory changes would define the term “fluori-

dation”; add fluoride to the maximum contaminant level list to ad-

dress the natural occurrence of fluoride in natural waters and drinking water; and add fluoride to the list of inorganic chemicals monitored to set a detection limit for purposes of reporting fluo-

ride, specify exemptions and deter-
native systems which are covered by the mandate to fluoridate when funds are made available; establish optimal fluoride levels for fluoridation sys-
tems; develop monitoring and com-

munication guidelines and procedures for fluoridation; introduce the basic cri-
teria for a fluoridation system; insti-
tute recordkeeping, reporting, and notification requirements related to fluoridation systems; establish regulations for fluoridation systems operations and conditions that may be necessary or appropriate to protect the health and safety of the public; and establish water system priority funding schedule.

DHS accepted public comment until May 12, 1997; no hearing

was held. OAL approved the regula-
tory changes on March 23, 1998; they became effective on April 22, 1998.

Impact on Children: Maintaining appropriate amounts of flu-

oride in public water sources will improve the oral health of citizens.

Surface Water Quality Criteria

In June 1999, the U.S. Environmental Protection Agency adopted regulations under the Safe Drinking Water Act (42 U.S.C. § 300(f) et seq.), intended to improve the microbiological quality of sur-

face waters and groundwaters influ-

enced by surface water. DHS adopted similar regulations at that time.

On May 23, 1997, DHS published notice of its intent to amend sections 64426.5, 64650, 64651.91, 64652, 64652.5, 64653, 65564, 64655, 64656, 64660, 64661, 64663 and Title 22 of the CCR. These changes would incorporate the federal provisions that allow water systems to use surface water or groundwater under the direct influ-
cence of surface water to avoid the requirement for filtration under cer-
tain circumstances. In addition, DHS has incorporated a provision for taking an unfiltered surface water source out of service immediately if certain water quality criteria are not met.

DHS accepted public comment on the proposal until July 7, 1997; no hearing was held. DHS submitted the proposed regulations to OAL, which disapproved them on January 12, 1998, because they did not comply with the “clarify,” “nec-

essary,” and “compatibility” standards of section 10950. The regula-
tions and resubmitted the changes to OAL; they were approved on June 8, 1998 and became effective on July 8, 1998.

Impact on Children: The regulations include a public notification require-
ment whenever water quality criteria are exceeded. Such consumer notification could be es-

pecially beneficial for children, whose immune systems often are weaker than that of adults.

Special Needs

Special Education Pupils Program

The regulations are intended to assure conformity with the federal Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400 et seq, and its implementing regulations as found in the Code of Federal Regulations. On June 26,
1998, the California Department of Education (CDE), Department of Special Education Services (DDS), DMH, and DHS issued Title 22 of the CCR. These changes would incorporate the federal provisions that allow water systems to use surface water or groundwater under the direct influ-
cence of surface water to avoid the requirement for filtration under cer-
tain circumstances. In addition, DHS has incorporated a provision for taking an unfiltered surface water source out of service immediately if certain water quality criteria are not met.

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tions and resubmitted the changes to OAL; they were approved on June 8, 1998 and became effective on July 8, 1998.

Section 60020, Mental Health Definitions, includes a definition of the term “expanded IEP team” in subsection (g) which clarifies the term’s requirement to assess a pupil in all areas of suspected disability and to implement the placement of children identified as seriously emotionally disturbed in residential placements. This clarification is neces-
sary because some local education agencies (LEAs) have been out of compliance for failure to properly constitute an expanded IEP team. This definition is necessary because some local education agencies (LEAs) have been out of compliance for failure to properly constitute an expanded IEP team. This defini-
tion is necessary because some

Section 60025, Social Ser-

evc Definitions, is intended to assist education agencies, mental health programs, and social services pro-
gams to achieve a common under-
standing of terms used by DDS in authorizing payments for residential placements. Without a common defini-
tion, there is a need for different uses of the same terms and different applications.
Section 60030, Local Mental Health and Education Interagency Agreement, describes the process for coordinating services with other public agencies that are funded to serve pupils with disabilities. Subsection (c) requires the local inter-agency agreement to identify a contact person for each agency that includes a delineation of procedures governing the resolution of disputes, notification, development of mental health assessment plans, placement options, and cross-training of education and mental health staff. Highlights include subsection (c)(1), which requires stronger inter-agency agreements to improve the timeliness as required by law, and subsection (c)(3), which states that the LEA must give a complete referral package to the local mental health service; the package must include the results of the preliminary assessments, and other "relevant information" including reports compiled by other agencies.

Subsection 60040, Referral to Community Mental Health Services for Related Services, specifies the process of preparation and submission of referrals. Subsection (a)(2) specifies the requirements that an LEA must meet to refer a pupil to a community mental health service; these include written parental consent for referral, release and exchange of information, and notification of a pupil by a mental health service. Subsection (a)(5) requires a LEA to attempt and document less restrictive interventions with a pupil before referring him or her for mental health intervention. This section clarifies that a LEA must provide assessments and designated instructional services within the educational system but the interventions are clearly insufficient. Section 60045, Assessment to Determine the Need for Mental Health Services, specifies the components of the assessment process and plan. Section 60050, Individualized Education Program for Mental Health Services, changes current practice by requiring students to be consistent with the form utilized by schools in an IEP. Section 60100, Placement of a Pupil with a Disability Who is Seriously Emotionally Disturbed, includes a requirement in subsection (b)(1) that a representative of the local community mental health service be associated to participate on the IEP team. Subsection (c) places the responsibility for finding a restrictive, cost-effective residential placement alternative with the mental health case manager, although requiring that manager to consult with the IEP team's administrative designee when making the determination.

Section 60300 defines terms of use both by the California's Children's Services and the CDE. In the past, the two agencies used different terminology to describe similar functions, which could cause confusion to parents and others. Section 60320, Referral and Assessment, clarifies the application of procedures when the LEA makes a referral to CCS for an assessment based on the pupil's documented physical deficit. Subsection (a) changes the emphasis from a referral for a specific service to a referral for assessment in an area of suspected disability; this change puts California in conformity with federal regulations. Section 60272 proposes the procedure for the provision of occupational and/or physical therapy services; section 60330 identifies the LEA as the responsible party for providing space and, for the medical therapy unit and/or medical therapy unit satellites in a public school.

Section 60510 (inadvertently omitted from the emergency regulations but included in the Statement of Reasons for the permanent adoption process) prescribes the procedures for notification by an agency other than the LEA prior to the residential placement of a pupil with disabilities and before an educational placement is assured. Subsection (b)(1) mandates an educational administrator to provide information to other agencies on the availability of residential and educational services, and to affirm the authority of the IEP team in this regard. Subsection (b)(2) specifies that one of the conditions to the assumption that there is no appropriate public education program in the community before a pupil in a licensed children's institution is allowed to attend the education program at that site.

On July 24, 1998, DSS, DDS, CDE and DMH published notice of their intent to permanently adopt the emergency regulations for this proposed regulatory action. DSS accepted public comment until September 9, 1998, and held a public hearing on the same date in Sacramento. At the hearing, DSS considered the public comments prior to submitting the package to OAL.

Impact on Children: These regulations not only ensure continuity with new federal requirements under IDEA, but also to provide for uniformity among the various agencies that must work together to provide services for children. Nearly one-half million California children have some type of disability. Learning disabilities continue to be the most prevalent problem, affecting about 5% of the state's children. Under the new law, all children are guaranteed a free and appropriate education. Students may be enrolled in special education due to a variety of disabilities; in the 1995-1996 school year, about 11% (594,000) students were enrolled in special education in California public schools. Children with special needs are among our most vulnerable pupils. Clarification and early intervention and investment can turn an early expense into a successful investment.

Early Intervention Services
The Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1471 et seq., specifies the need for early intervention services for infants and toddlers before the age of three to prevent or lessen the extent of the impact of disabilities and to assure that children and families receive services and support as the child's needs develop. IDEA encourages states to establish comprehensive systems of early intervention services for infants and toddlers with disabilities or at high risk of delay. California's Part H program is called Early Start. Both DDS and CDE develop, approve, and implement regulations to comply with their respective mandates under IDEA.

On January 30, 1998, DDS readopted sections 52000, 52020, 52020a, 52040, 52060, 52082, 52084, 52086, 52100, 52102, 52104, 52106, 52106a, 52107, 52107a, 52164-75, Title 17 of the CCR, on an emergency basis; they became effective on January 31. DDS revised the regulations and reopened a public comment period until April 14, 1998. On June 1, 1998, DSS again readopted the regulatory changes on an emergency basis; they became effective the same day. On June 16, 1998, DDS submitted the proposed permanent regulations to OAL; they were approved on July 28, 1998, and became effective on August 27, 1998.

The regulations specify how state agencies must interact with one another in an integrated comprehensive service system for infants and toddlers with developmental delays, high risk or established risk conditions. Early intervention services are available for children up to three years old who exhibit certain symptoms or are otherwise determined to be at risk of developmental delay or disability. However, parents often are unaware of these services, and these regulations attempt to alleviate that problem. The regulations specify that "child find" activities shall be conducted by regional centers and local education agencies to locate eligible children. Such activities may include assigning liaison to local hospitals and hospitals with neonatal intensive care units; consulting local organizations representing special interest groups; distributing early intervention materials to specified agencies and individuals; community-wide health and developmental screening; producing and distributing public service announcements and written public outreach materials; and making public presentations. The regulations also cover program and service components, services and reintegration of children, service coordination and interruption of services, and procedural safeguards (including notices and appeals rights, process for complaints, and due process procedures).

Impact on Children: These regulations clarify the complementary roles of state agencies, regional centers and local education agencies in providing critical intervention early in the lives of children with developmental delays. The regulations provide a framework for parents and child advocates to consider in ensuring that all children receive the assistance they need.

Resource Specialist Caseload Waivers
On January 23, 1998, the State Board of Education (State Board) published notice of its intent to add section 3100, Title 5 of the CCR, to establish requirements for allowing waivers of the resource specialist caseload limits for special education programs. The proposed regulations will codify the procedures the State Board must follow in evaluating waiver requests for local education agencies and special education local plan areas. In the same notice, the State Board announced a public comment period extending until the public hearing in Sacramento on March 12, 1998.

The most frequently requested and most costly of the resource education is that of the maximum resource specialist caseload. Education Code section 56626(c) prescribes a ceiling of 28 pupils per resource specialist. The proposed regulations would limit the discretionary power of the State Board by setting the standards for consideration of waivers. The State Board could grant a waiver for good cause, but DSS would have to determine whether the waiver is beneficial to either the content and implementation of pupil's individualized education program and does not abrogate any right provided individuals with disabilities. The regulations provide for carry-forward of needs as specified federal law; or if the waiver does not provide compliance with specified federal law. The new regulations set forth conditions to establish that the program in the school district is comparable or beneficial "as defined by Education Code section 56101. The State Board may not only approve an effective period that does not exceed one school year and/or in duration in which it is approved. The number of students to be served by a resource specialist under the waiver shall not exceed 32 (no more than four students over the maximum statutory caseload of 28 students). The waivers may not result in the same resource specialist having a caseload in excess of the statutory maximum for more than two school years. The regulations include safe-
requirements for federal and state law to provide to pupils with disabilities. The regulations are divided into two principal sections – one setting standards for specialized instruction, and the other setting standards for related services.

The personnel standards, when applicable, are based on state-issued credentials and licenses, certification of registration issued by professional, nongovernmental organizations, and degrees issued by accredited postsecondary educational institutions. To be eligible for certifica-
tion as a nonpublic school or agency, an employee must be employed by a private, public, or state or nonpublic school or agency.

Impact on Children: These regulations codify the waiver procedure, adding a measure of clarity and predictability to the administration of the regulations. To the extent they do, the regulations are beneficial to children.

Personal Standards for Nonpublic Schools and Agencies
SB 899 (Polanco) (Chapter 944, Statutes of 1996) directs the State Board to adopt regulations setting personnel standards for individuals employed by nonpublic schools and agencies. On July 18, 1997, CDE adopted sections 3000-3004, and amended sections 3001 and 3005. Title 5 of the CCR, on an emergency basis. These emergency regulations specify the personnel standards for individuals employed by nonpublic, non sectarian schools and agencies for each type of service that local educational agencies are required to provide for students with disabilities.

Alternative Community Treatment Facilities for Children
The intent of SB 282 (Morgan) (Chapter 12-45, Statutes of 1993) is to establish a new community care licensing category in California ("Community Treatment Facility," as an alternative to out-of-state or acute care placement and state hospitalization for seriously emotionally disturbed children and adolescents needing a greater level of care than can be provided in a group home, but less restrictive than a state or nonpublic school or agency. This bill requires DSS to adopt regulations for these facilities.

Impact on Children: These regulations expand the alternatives for California's seriously emotionally disturbed children needing a greater level of care. The policies and procedures clarify the nature of the services and standards that should be provided for community care facilities. Expanding placement options allow decision makers to consider variables including location, the size of the facility, the type of environment for the child, and other important criteria.

Safe Schools Assessment Program
Penal Code section 628 et seq. requires all school districts and county offices of education to submit crime data to CDE each year. On April 24, 1998, the State Board published amendments to sections 700-702, Title 5 of the CCR, to improve the completeness and accuracy of the school crime data reported.

Sections 700-702 provide the definitions of the crimes to be reported, and the guidelines and procedures for submitting complete and accurate school crime data. As amended, section 700(e)(3)(B) revised the definition of trespassing to be consistent with Penal Code section 626.7. The original definition did not make a distinction between the type of persons who may be found on school property or be in the immediate vicinity of school buildings. The proposed amendment revises the definition to clarify that parents or guardians of students attending school may return their children after several days when asked if they are on the school grounds; other persons may be charged with trespassing if they return to the school grounds within thirty days. Another amendment, section 702(b), adds language to ensure that local educational agencies comply with the requirement to report all crimes; this may include police reports and suspension reports as well as expulsion reports. Other proposed changes are non-substantive.

Impact on Children: School safety is a top concern of both educators and parents.

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to implement reduced class size prior to the deadline of February 16. The proposed regulations allow school districts to reserve the higher rate of funding if a teacher hired after November 1 is replacing a previously hired teacher who has resigned from the school district or is on leave. It will allow school districts to replace a teacher after November 1 on a long-term basis (e.g., due to illness, maternity leave, resignation) without incurring the penalty of reduced funding.

On January 20, 1998, the State Board published notice of its intent to permanently adopt the regulatory changes. The State Board accepted public comment on the proposed action until March 12, 1998, and held a public hearing on the same date. The State Board adopted the amendments, which were approved by OAL on May 8, 1998 and became effective on the same date.

Impact on Children: The Class Size Reduction Program offers incentive to school districts to reduce class size, allowing children to receive more individualized attention. The regulations here provide additional specific criteria for school districts implementing the Class Size Reduction Program, enabling them to more accurately report enrollment for funding purposes.

Standardized Testing and Reporting Program (STAR) SB 376 (Alpert) (Chapter 828, Statutes of 1997) established the Standardized Testing and Reporting (STAR) program. The STAR program replaces the Pilot Testing Incentive Program as a part of the statewide pupil assessment program. Education Code, section 60643 (c) requires the State Board to adopt regulations for conducting and administering the STAR program, and for providing minimum security procedures for test publishers and school districts to ensure the security and integrity of the test questions and materials. Education Code section 60643 (c) requires CDE to develop, with the approval of the State Board, a standard agreement for use by the school districts with the publisher of the designated achievement test.

On January 19, 1998, CDE and the State Board adopted public comment on the proposed action until April 9, 1998, and held a public hearing on the same date. On May 5, 1998, CDE and the State Board adopted the regulations on an emergency basis; they were effective the same date. At this writing, CDE and the State Board have not yet submitted the regulatory changes to OAL.

Impact on Children: The proposed regulations appear to be intended to ensure that test results are based only on individual student achievement as well as overall school scores, while still protecting student privacy. The regulations demonstrate a clear intent to provide an accurate picture of students' progress, including those students with special needs and students in an alternative learning setting.

Child Protection
Child Abuse Reports and Recordkeeping
Penal Code section 11170 (a) requires DOJ to maintain an index of all reports of child abuse submitted pursuant to Penal Code section 11160. The regulations direct DOJ to continually update the index and exclude any reports determined to be

unfounded. Section 11170 (a) also specifies that DOJ may adopt rules governing recordkeeping and reporting.

On January 2, 1998, DOJ published notice of its intent to adopt sections 900-911, Title 11 of the CCR. The new sections codify the purpose of the Automated Child Abuse System index and the state's standard reporting form and aspects of the audit system. They also establish procedures for review and verification of reports including so-called "unfounded" reports and conflicting reports, and establish confirmation and notification procedures for various types of inquiries, both from public agencies as well as individuals.

DOJ accepted public comment until February 26, 1998, and held public hearings on February 24 and 25, 1998. In response to the comments received, DOJ amended the regulations to elaborate on the report procedures. DOJ adopted the amendments, which were approved by OAL on July 17, 1998 and became effective on the same date.

Impact on Children: These regulations apply a standard method in dealing with child abuse reports. If this standardization results in a more efficient method of reporting and recordkeeping, DOJ can better serve the agencies and individuals working to protect children.

Group Homes that Accept Children under Six Years of Age AB 1197 (Bates) (Chapter 1088, Statutes of 1995) requires DOJ to assess the needs of children under six years of age in group homes, and develop standards to be incorporated into the group home program state plan. On May 9, 1997, DOJ published notice of its intent to amend sections 84000-84088 (non-inclusive), repeal sections 84009, 84044, 84076, and 84080, Title 22 of the CCR, and amended sections 31-400 to 31-420 (non-inclusive) and 11-400 and 11-402 of the MPP. These regulations are intended to implement AB 1197 by setting standards for the care of children under six years of age in group homes, establishing payment rates and qualification of group home personnel, and setting forth services which should be provided to young children in group homes.

DSS' current regulations do not provide standards specific to the care of children under six years of age in group homes. The proposed regulations will establish standards to ensure that very young children are appropriately cared for in group home facilities. These regulations establish specific education and experience standards for facility personnel, additional health and safety requirements, and additional physical environment standards. In addition, because group homes for very young children are a component of the group home regulatory category, the regulations that apply to group homes for older children will also apply to group homes that care for very young children in a manner similar to or otherwise.

The proposed regulations set rates of payment for caregivers, clarify the personnel requirements and duties of caregiving staff, and address the services for the specific needs of children under six years of age in group homes.

DSS accepted public comment on its proposed regulations until June 26, 1997, and held public hearings on June 23, 24, 25, and 26, 1997. DSS then re-opened the comment period from September 3 to October 15, 1997. DSS then submitted the regulatory changes to OAL, which disapproved them on October 17, 1997, because they did not comply with the "clarity" standard of the Administrative Procedures Act. DSS then revised the Statement of Reasons and the proposed regulatory language; in December 10, 1997, notice, DSS re-opened the comment period from November 1 to December 25, 1997. DSS submitted the regulatory changes to OAL, which disapproved them on May 14, 1998; sections 84000-84088 (non-inclusive) were disapproved for numerous reasons including an incomplete record, incorrect citations, and the need for clarification sections; sections 31-002 to 31-420 (non-inclusive) were disapproved for not complying with the "clarity" and "uniformity" standards; and sections 11-400 and 11-402 were disapproved for not complying with the "clarity" standard. DSS re-opened the comment period from August 17 to September 2, 1998.

Impact on Children: Safeguards, guidelines, and specifications are important to ensure quality care for children of any age placed in group homes, but particularly so for these youngest children. At this writing, more than one year has passed without updated regulations in this important area.

Use of Manual Restraints in Group Homes
On August 29, 1997, DSS published notice of its intent to adopt sections 84001, 84022, 84061, and 84800-84808 (non-inclusive), Title 22 of the CCR. These regulations for use of manual restraints in DSS Community Care Licensing Division policy regarding the use of manual restraints in group homes when an susceptible child is threatening to endanger or injure self or others and in "runaway" situations. The proposed regulations use the term "emergency intervention" to include the use
of non-physical interventions as well as the use of manual restraints. The least restrictive form of intervention must be used first; more restrictive interventions are to be used only after the less restrictive methods have proven ineffective. For purposes of these regulations, the use of a protective separation room is considered a form of manual restraint.

DSS accepted public comment on the proposal until October 16, 1997, and held public hearings on October 14, 15, and 16, 1997. Following the public hearing, DSS modified the proposed regulations and reopened the public comment period from May 28 until June 12, 1998. At this writing, DSS has not submitted the regulations to OAL.

Impact on Children: At this time, neither general licensing requirements nor specific regulations for group homes address the use of behavior management techniques in such homes. The adoption of specific regulations that address the use of manual restraints should enable DSS to set parameters for group home staff in restraining these children, and enable it to sanction a facility which inappropriately restrains a child.

Juvenile Justice

Disciplinary Decision Making System

On April 21, 1998, Department of Youth Authority (DYA) published its notice of intent to amend sections 4633, 4636, 4641, 4642, 4643, 4644, 4645, 4647, 4648, 4649, 4650, 4652, and 4655 and to repeal section 4634, Title 15 of the CCR, to address the Disciplinary Decision Making System in the DYA population. The proposed regulatory changes adjust DYA procedures for documentation, review and action when a ward has violated a departmental or institutional rule or policy. Changes in the procedures for "action" affect the wards in a number of ways. Section 4643 acknowledges the unwillingness of wards to come forward as witnesses and testify against others; it is amended to allow a written statement as sufficient evidence. Section 4634 was repealed because DYA does not believe that a second-level of appeal is necessary for wards appealing a behavior disciplinary action. The first level of appeal authorizes the superintendent to review the appeal; the second level of appeal allowed for a review by the deputy director's office. DYA maintains that a right to a second appeal creates undue time delays and unnecessarily increases staff workload. Several other sections were amended to extend, from 12 working days to 24 calendar days, the amount of time allowed DYA before a hearing must be held in various disciplinary actions.

DYA accepted public comment on the proposed changes until May 26, 1998, and held a public hearing on May 27, 1998 in Sacramento. At this writing, DYA has not submitted the proposed regulations to OAL.

Impact on Children: While some of the amended regulations may benefit wards, many others appear to be designed to cut costs and streamline DYA operations. While wards do not have the same level of rights as other youths who are not incarcerated, careful scrutiny needs to be given to regulatory changes that involve disciplinary decision making and streamlining of the appeal process.

Youthful Offender Parole Board Review

The Youthful Offender Parole Board (Parole Board) is the authority for youth committed by the courts to the DYA. On February 20, 1998, the Parole Board published notice of its intent to amend sections 4600, 4628, 4631, 4645, 4651, 4652, 4653, 4654, 4655, 4656, 4667, 4672, 4749, 4798, 4799, 4809, 4895, 4969, and 4971, Title 15 of the CCR, primarily to address issues relating to the procedures and rules for hearings.

While several substantive changes were made as part of this regulatory package, others are more complex. Section 4666 eliminates the "special service designation" when referring a ward to parole. Under current rules, a ward who was deemed to need increased parole supervision due to a prior history of violence or commitment for a serious offense would be labeled "special service," and the Parole Board might impose special conditions for parole. The term "special service" is no longer referenced in the Board, but it is unclear in these regulations how and under what circumstances a similar designation may occur, if at all.

Section 4664 outlines the procedures for releasing wards to other jurisdictions. The proposed amendment would repeal this section because the Parole Board deems it nonregulatory.

Section 4667 outlines the procedures for out-of-state referrals. The Parole Board's proposed amendment would repeal this section because DYA has sole responsibility for such referrals.

The Parole Board accepted public comment on the proposed regulatory changes until April 30, 1998, and held a public hearing on that date in Sacramento. At this writing, the Parole Board has not submitted the proposed amendments to OAL.

Impact on Children: The Parole Board conducts almost 26,000 hearings per year. These proposed regulations would eliminate a major undertaking of the Parole Board to "clarify, make specific, and streamline its policies and procedures." It remains to be seen whether the amended rules enhance one of the Parole Board's major objectives, that of prescribing effective treatment programs for youth.

Restitution Deductions from Ward Trust Accounts

AB 1132 (Alley) (Chapter 266, Statutes of 1997) authorizes the Director of the Youth Authority (Director) to deduct from a ward's trust account up to 50% of the restitution amount owed. In addition, AB 1132 authorizes the Director to deduct an administrative fee of 10% of the amount transferred to the victim.

On February 20, 1998, DYA published notice of its intent to adopt new section 4720.1, Title 15 of the CCR, to require the Director to deduct the balance owed on a restitution order or restitution fine from the trust account deposits of a ward up to 50% of the amount, and to transfer that amount directly to the victim or the State Board of Control for deposit in the Reimbursement Fund. The amount deducted shall be credited first to the amount owing on the restitution order, and then to the amount owing on any restitution fine. The regulatory change also identifies funds or deposits that are exempt from restitution and administrative fee deductions, including Social Security benefits and Social Security disability. DYA expects that the result in multiple deductions from the same funds. Formerly, the Director could release any trust funds of a ward committed to the authority when authorized by the ward.

DYA accepted public comment on the proposed regulatory change until April 6, 1998, and held a public hearing on April 8, 1998, in Sacramento. DYA received no comments on this regulation, and there was no testimony at the public hearing. DYA submitted the proposed regulation to OAL, which approved it on May 13, 1998; it became effective immediately.

Impact on Children: This regulation could have a serious effect on youth who need public assistance during rehabilitation. This denial of assistance is made more harsh if the youth's immigrant family also is ineligible for public assistance.

The California Regulator

The Administrative Procedure Act (APA), Government Code section 11340 et seq., prescribed the process that most state agencies must undertake in order to adopt regulations (also called "rules") which are binding and have the force of law. This process is commonly called "rulemaking," and the APA guarantees an opportunity for public knowledge of and input in an agency's rulemaking considerations.

For purposes of the APA, the term "regulation" is broadly defined as "every rule, regulation, order or standard of general application... adopted by any state agency to regulate,... interpret, or make specific the law enforced or administered by it, or to govern its procedure..." Government Code section 11344(2).
The APA requires the rulemaking agency to publish a notice of its proposed regulatory change in the California Regulations Notice Register, a statewide weekly publication, at least 45 days prior to the agency's hearing or decision to adopt the change (which may be the adoption of new regulations; a change in an existing regulation; or amendment or repeal of an existing regulation). The notice must include a reference to the agency's legal authority for adopting the regulatory change, an "informative digest" containing a concise and clear summary of what the regulatory change would do, the deadline for submission of written comments on the agency's proposal, and the name and telephone number of an agency contact person who will provide the agency's initial statement of reasons for proposing the change, the exact text of the proposed change, and further information about the proposal and the procedures for its consideration. The notice may also include the date, time, and place of a public hearing to be held by the agency for receipt of oral testimony on the proposed regulatory change. Public hearings are open to the public; however, an interested member of the public can compel an agency to hold a public hearing on proposed regulatory changes by requesting it in writing no later than 15 days prior to the close of the written comment period. Government Code section 11346.8.

The rulemaking file is submitted to the Office of Administrative Law (OAL), an independent state agency authorized to review agency regulations for compliance with the procedural requirements of the APA and for six specified criteria – authority, clarity, necessity, consistency, allocation, and nomenclature. OAL must approve or disapprove the proposed regulatory changes within thirty working days of submission of the rulemaking file. If OAL approves the regulatory changes, it forwards them to the Secretary of State for filing and publication in the California Code of Regulations, the official state compilation of agency regulations. If OAL disapproves the regulatory changes, it returns them to the agency with a statement of reasons; the agency has 120 days within which to correct the deficiencies cited by OAL and resubmit the rulemaking file to OAL.

An agency may temporarily avoid the APA rulemaking process by adopting regulations on an emergency basis, but only if the agency makes a finding that the regulatory changes are "necessary for the immediate preservation of the public peace, health or safety or general welfare..." Government Code section 11344.6(b). OAL must review the emergency regulations and determine whether for an appropriate "emergency" justification and for compliance with the six criteria – within ten days of their submission to the office. Government Code section 11349.8(b). Emergency regulations are effective for only 120 days.

Interested persons may petition the agency to conduct rulemaking. Under Government Code section 11340.6 et seq, any person may file a written petition requesting the adoption, amendment, or repeal of a regulation. Within 30 days, the agency must notify the petitioner in writing indicating whether (and why) it has denied the petition, or granting the petition and scheduling a public hearing on the matter. References – Government Code section 11340 et seq; Robert Fellmeth and Ralph Olson, California Administrative and Constitutional Law: Regulation of Business, Trades and Professions (Butterworth Legal Publishers, 1991); Robert Fellmeth and Thomas Papageorge, California White Collar Crime (Butterworth Legal Publishers, 1995).

Agency Descriptions

Following are general descriptions of the California agencies whose regulatory decisions affecting children are discussed in this issue:

Department of Developmental Services

The Department of Developmental Services (DDS) has jurisdiction over the care, custody, and treatment of developmentally disabled persons. DDS is responsible for certifying that persons with developmental disabilities receive the services and support they need to lead more independent, productive and normal lives, and to make choices and decisions about their own lives. DDS executes its responsibilities through 21 community-based, nonprofit corporations known as regional centers, and through five state-operated developmental centers. DDS' enabling act is found at section 4000 et seq of the Welfare and Institutions Code. DDS regulations appear in Title 17 of the CCR. For more information on DDS regulations appearing in this issue, contact Peggy Peters, CDE Audit Response Coordinator, 916-657-4470.

Department of Health Services

The California Department of Health Services (DHS) is one of thirteen departments that constitute the state's Health and Welfare Agency. DHS is a statewide agency designed to protect and improve the health of all Californians; its responsibilities include health, and the licensing and certification of health facilities (except community care facility licensing). DHS' mission is to reduce the occurrence of preventable disease, disability, and premature death among California's children close to birth status and access to care among the state's diverse population subgroups; and improve the quality and cultural competence of its operational services, and programs. Because health conditions and habits often begin in childhood, this agency's decisions can impact children far beyond their early years. DHS' enabling act is found at section 10100 et seq, of the Health and Safety Code; DHS' regulations appear in Titles 17 and 22 of the CCR. For more information on DHS regulations in this issue, contact Allison Branscombe, Chief, DHS Office of Regulations, 916-654-0811.

Department of Mental Health

The Department of Mental Health (DMH) has jurisdiction over the laws relating to the care, custody, and treatment of mentally disordered persons. DMH may disseminate education information relating to the prevention, diagnosis and treatment of mental disorder; conduct education and training programs to improve the development of proper mental health facilities throughout the state; coordinate state activities involving other departments and outside agencies and organizations whose actions affect mentally ill persons. DMH provides services in the following four broad areas: system leadership for state and local county mental health departments; system oversight, evaluation and monitoring; administration of federal funds; operation of four state hospitals (Atascadero, Metropolitan, Napa and Patton) and an Acute Psychiatric Program at the California Medical Facility and Vacaville. DMH's enabling act is found at section 4000 et seq, of the Welfare and Institutions Code; DMH regulations appear in Title 9 of the CCR. For more information on DMH regulations appearing in this issue, contact David Nishimura, Staff Services Manager, Office of Regulations, 916-654-2631.

Department of Social Services

The California Department of Social Services (DSS) is one of the thirteen departments that constitute the state's Health and Welfare Agency. DSS administers four major program areas: welfare, social services, community care licensing, and disability evaluation. DSS' goal is to strengthen the child individual, family, and community and independence for families. Virtually every action taken by DSS has a consequence impacting California's children. DSS' enabling act is found at section 10559 et seq, of the Welfare and Institutions Code; DSS' regulations appear in Title 22 of the CCR. For more information on DSS regulations in this issue, contact Frank R. Vinall, Chief, DSS Office of Regulations Development, 916-657-1937.

Department of the Youth Authority

State law mandates the California Department of the Youth Authority (DYA) to provide a range of training and treatment services for youthful offenders committed by the courts; help local justice system agencies in their efforts to combat crime and delinquency; and monitor, oversee, and enforce the state and local criminal and delinquency prevention programs. DYA's offender population is housed in eleven institutions, four rural youth conservation camps and one institution-based camps; its facilities provide academic education and treatment for drug and alcohol abuse. Personal responsibility and
public service are major components of DYA’s program strategy. DYA’s enabling act is found at section 1710 et seq. of the Welfare and Institutions Code; DYA regulations appear in Title 15 of the CCR. For more information on DYA regulations in this issue, contact Reeshemah Davis, Youth Authority Regulations Coordinator, 916-262-1437.

**Regulatory Key**

BOC: Board of Control

CCR: California Code of Regulations

CDE: California Department of Education

DDS: Department of Developmental Services

DHS: Department of Health Services

DMH: Department of Mental Health

DSS: Department of Social Services

DYA: Department of Youth Authority

MPP: The Department of Social Services’ Manual of Policies and Procedures

MRMIB: Managed Risk Medical Insurance Board

OAL: Office of Administrative Law

Parole Board: Youth Offender Parole Board

State Board: State Board of Education

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**Other Information Sources**

The *California Children’s Budget*, published annually by the Children’s Advocacy Institute and cited herein, is another source of information on the status of children in California. It analyzes the California state budget in eight areas relevant to children’s needs: child poverty, nutrition, health, special needs, child care, education, abuse and neglect, and delinquency. The *California Children’s Budget 1998-99* can be accessed via the Web at <www.acusd.edu/childrensissues/report>.