SENATE COMMITTEE ON EDUCATION
Senator Connie Leyva, Chair
2021 - 2022 Regular

Bill No:	AB 552	**Hearing Date:**	June 1, 2022
Author:	Quirk-Silva		
Version:	January 27, 2022		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Kordell Hampton		

Subject: Integrated School-Based Behavioral Health Partnership Program.

Note: This bill has been referred to the Committees on Education and Health. A "do pass" motion should include a referral to the Committee on Health.

SUMMARY

This bill authorizes a county behavioral health agency (CBHA) and the governing board or governing body of a local educational agency (LEA) to enter into an Integrated School-Based Behavioral Health Partnership Program (Partnership Program), to provide prevention and early intervention, and access to, behavioral health and substance use disorder services for pupils at schoolsites.

BACKGROUND

Existing law:

Education Code (EC)

1) Requires the governing board of a school district to give diligent care to the health and physical development of pupils, and authorizes the district to employ properly certified persons for the work. (EC § 49400)

2) Specifies that school districts are not precluded from utilizing community-based service providers, including volunteers, individuals completing counseling-related internship programs, and state licensed individuals and agencies to assist in providing pupil personnel services, provided that such individuals and agencies are supervised in their school-based activities by an individual holding a pupil personnel services authorization. (California Code of Regulations, Title 5, Section 80049.1(c))

3) Requires the Superintendent of Public Instruction to post, and annually update, on the California Department of Education's website a list of statewide resources, including community-based organizations, that provide support to youth, and their families, who have been subjected to school-based discrimination, harassment, intimidation, or bullying. The website must also include a list of statewide resources for youth who have been affected by gangs, gun violence, and psychological trauma caused by violence at home, at school, and in the community. (EC § 234.5)

4) Requires school districts to send a notification to parents or guardians at the beginning of the first semester or quarter of the regular school term, with specified

information including parent rights and responsibilities among other things. (EC § 48980)

5) Authorizes parent or guardian having control or charge of any child enrolled in the public schools may file annually with the principal of the school in which he is enrolled a statement in writing, signed by the parent or guardian, stating that he will not consent to a physical examination of his child. Thereupon the child shall be exempt from any physical examination, but whenever there is a good reason to believe that the child is suffering from a recognized contagious or infectious disease, he shall be sent home and shall not be permitted to return until the school authorities are satisfied that any contagious or infectious disease does not exist. (EC § 49451)

Family Code (FAM)

6) Authorizes minor who is 12 years of age or older to consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the attending professional person believes the minor is mature enough to participate intelligently in the outpatient services or residential shelter services and would present a danger of serious physical or mental harm to self or to others or alleged to be a victim of incest or child abuse. (FAM § 6924(b))

7) Requires the mental health treatment or counseling of a minor tol include involvement of the minor's parent or guardian unless, in the opinion of the professional person who is treating or counseling the minor, the involvement would be inappropriate. The professional person who is treating or counseling the minor shall state in the client record whether and when the person attempted to contact the minor's parent or guardian, whether the attempt to contact was successful or unsuccessful, or the reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian. (FAM § 6924(d))

8) Clarifies the minor's parents or guardian are not liable for payment for mental health treatment or counseling services, and any residential shelter services, provided pursuant to this section unless the parent or guardian participates (FAM § 6924 (e))

Health and Safety Code (HSC)

9) Authorizes minor who is 12 years of age or older may consent to outpatient mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services. (HSC § 124260 (b))

10) Clarifies minor cannot receive convulsive treatment or psychosurgery, as defined in Welfare and Institutions Code (WIC), or psychotropic drugs without the consent of the minor's parent or guardian. (HSC § 124260 (e))

ANALYSIS

This bill authorizes a CBHA and the governing board or governing body of a LEA to enter into a Partnership Program, as established by this bill, to provide prevention and early intervention, and access to, behavioral health and substance use disorder services for pupils at schoolsites. Specifically, this bill:

General Provisions

1) Establishes the Partnership Program to provide prevention and early intervention for, and access to, behavioral health services for pupils with serious emotional disturbances or substance use disorders, or who are at risk of developing a serious behavioral health condition.

2) Authorizes a CBHA and the governing board or governing body of an LEA to develop a memorandum of understanding (MOU) outlining the requirements for the Partnership Program, as established by this bill, to conduct a needs assessment on the need for school-based mental health and substance use disorder services.

3) Requires LEAs, upon entering into an MOU with a CBHA, to provide school-based locations, including space at schools, appropriate for the delivery of behavioral health services.

4) Specifies CBHA and participating entities must collaborate with an LEA to establish hours of service at mutually agreed upon school-based locations or a process for ensuring timely interventions when needed, or both.

5) Requires the Partnership Program to identify if mental health services and/or substance use disorder services, will be delivered at the school-based location and/or telehealth.

6) Requires if a Partnership Program determines that only mental health services or only substance use disorder services shall be provided at the school-based location, the Partnership Program to develop a plan for each pupil who has been identified as needing those services that are not offered at the school-based location along with an appropriate referral.

7) Clarifies behavioral health services may be provided at locations that are not at the school-based location for purposes of accommodating the individual needs of a pupil.

8) Clarifies Medi-Cal covered behavioral health services may continue to be delivered at the school-based location beyond the delivery of brief initial interventions upon consulting with a pupil’s parent or guardian.

9) Requires an LEA, CBHA, and partnering entities to jointly develop a referral process to support school personnel in making appropriate referrals to the designated behavioral health professional.

10) Authorizes the designated behavioral health professional to provide brief initial interventions when necessary for all referred pupils, regardless of their health

coverage, to ensure timely access to behavioral health interventions at the earliest onset of a behavioral health condition.

11) Specifies the array of behavioral health services provided by the Partnership Program shall be a subset of Medi-Cal covered mental health or substance use disorder services, and shall include prevention, intervention, and, if necessary, brief initial interventions, within a multitiered system of support or other similar framework employed by the LEA.

12) Clarifies that the Partnership Program shall not be construed to modify, expand, or restrict applicable patient privacy and parental rights.

13) Clarifies that a Partnership Program does not replace current county requirements related to crisis intervention protocols and crisis intervention services.

14) Requires a CBHA and an LEA to establish a process or timely interventions that identify nonurgent, urgent, and crisis-related circumstances and guidelines for when county crisis intervention is needed instead of timely interventions related to urgent or nonurgent needs.

15) Clarifies the Partnership Program shall not create a siloed delivery system and develop processes to leverage community-based services and other resources, and a process to identify local resources related to crisis intervention protocols and services.

County Behavioral Health Agency

16) Requires a CBHA to designate and provide, through its own staff or through its network of contracted participating entities, one or more behavioral health professionals that meet the licensing and supervision to serve pupils with serious emotional disturbances or substance use disorders, or who are at risk of developing a serious behavioral health condition.

17) Clarifies that, to secure Medicaid federal matching funds for school-based services, a CBHA must require any behavioral health professional who provides mental health or substance use disorder services pursuant to a Partnership Program to contract with the health agency to provide those services and to hold an active license or credential as specified.

Reporting to the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC)

18) Requires a Partnership Program to annually report to DHCS and the *MHSOAC*, all of the following:

    a) A brief description of the Partnership Program, including the service delivery model.

    b) The financial contribution made by the county behavioral health agency and LEA participating in the Partnership Program.

c) The definition the Partnership Program uses to identify pupils "at risk of developing a serious behavioral health condition," as specified.

d) The number of school-based locations involved in the Partnership Program and the percentage of pupils who are Medi-Cal beneficiaries at each school-based location.

e) The number of pupils served in the last year including demographic data of the pupils' race, ethnicity, gender, and language.

f) The number of pupils who receive school-based services beyond the brief initial intervention as specified.

19) Requires, three years after the establishment of a Partnership Program and every three years thereafter, MHSOAC in collaboration with DHCS to report to the Legislature on the Integrated School-Based Behavioral Health Partnership Program as specified.

Pupils with Private Insurers

20) Requires an LEA and a CBHA to develop a process to collect information on the health insurance carrier for each pupil, with the permission of the pupil's parent or guardian, to allow the county behavioral health agency or the participating entity to seek reimbursement for behavioral health services provided to the pupil and informing each participating entity which pupils are privately insured.

21) Includes provisions related to how insured pupils will be served if the parent does not provide information about the insurer, appointments with and referrals to network providers, and reimbursements and payments.

Pupils with Exceptional Needs

22) Authorizes a Partnership Program to provide services to pupils with exceptional needs, including, but not limited to, services required by the pupil's individualized education program, and delineate responsibilities for any services provided to pupils with exceptional needs that are included in a pupil's individualized education program, that are consistent with state and federal law related to pupils with exceptional needs as specified.

Definitions

23) Defines, for the purposes of this bill, the following:

a) "At risk of developing a serious behavioral health condition" as defined by the applicable county behavioral health agency and LEA pursuant to the Partnership Program established.

b) "Brief initial intervention" as Medi-Cal covered behavioral health services that are a subset of essential health benefits, as defined in state and federal law.

c) "Intervention" and "intensive intervention services" as select Medi-Cal specialty mental health services and substance use disorder services that would be appropriately provided at a school-based location or through telehealth, including assessments, plan developments, therapy, substance use counseling, rehabilitation, collateral services, medication support services, therapeutic behavioral services, case management, recovery services, and intensive care coordination.

d) "Local education agency" (LEA) as a school district, county office of education, or charter school.

e) "Participating entity" as a community-based organization or other entity, including an LEA that has contracted with a county behavioral health agency to provide services and participate in the Partnership Program.

f) "Partnership Program" as an integrated school-based behavioral health Partnership Program established by a county behavioral health agency and the governing board or governing board or governing body of an LEA, which may also include other participating entities.

g) "Privately insured pupil" as a pupil with comprehensive health coverage that is not run by the state or federal government.

Findings and Declarations

24) Finds and declares that the COVID-19 pandemic has affected the mental health of children and adolescents causing an increase in depression, anxiety, and risky substance use and how Schools have been identified as a crucial place to provide behavioral health services and improve access to services for pupils.

STAFF COMMENTS

1) ***Need for the bill.*** According to the author "As California grappled with the COVID-19 pandemic, we had and continue to experience an unprecedented rise in behavioral health needs among children and youth. According to the Centers for Disease Control and Prevention, the proportion of children's mental health–related emergency department (ED) visits among all pediatric ED visits increased and remained elevated during the pandemic. Compared with 2019, the proportion of mental health–related visits for children aged 5–11 and 12–17 years increased approximately 24% and 31%, respectively throughout the pandemic. Even as students have been back to school for about a year, isolation, anxiety over the uncertainty of the immediate and long-term future, increase in suicide thoughts and attempts, and concerns with family have and will continue to take a toll with children and youth."

"AB 552 would establish the Integrated School-Based Behavioral Health Partnership Program to provide early intervention for, and access to, behavioral services for all students. This collaboration will give schools the additional support

in order to provide behavioral health and mental health as well as substance use disorder services to their students."

2) ***Increasing occurrences of pupil mental health issues.*** According to a Pew Research Center analysis of data from the 2017 National Survey on Drug Use and Health, in 2017, 3.2 million teens aged 12-17 said they had at least one depressive episode within the past 12 months. This is up by 1.2 million from the same survey conducted by the National Survey on Drug Use and Health in 2007. One-in-five (2.4 million) teenage girls reported experiencing one depressive episode in 2017, compared to 845,000 teenage boys. According to data from the Centers for Disease Control and Prevention, 13 percent of students in grades 9-12 in California in 2017 reported experiencing at least one depressive episode within the last 12 months. 32 percent felt sad or hopeless almost every day for 2 or more weeks in a row so they stopped doing some usual activities within the past year, compared to 31 percent for the United States. 17 percent of pupils in grades 9-12 reported considering suicide attempts, while 9 percent reported they attempted suicide at least once within the past 12 months.

   This trend is confirmed by data from the Office of Statewide Health Planning and Development. In 2019, emergency rooms throughout California treated 84,584 young patients' ages 13 to 21 who had a primary diagnosis involving mental health. That is up from 59,705 in 2012, a 42 percent increase.

3) ***SB 75 (Committee on Budget and Fiscal Review; Chapter 51, 2019).*** As a result of increasing mental health occurrences, the legislature passed SB 75. This bill required the Department of Education, the Department of Health Care Services, and the Department of Developmental Services to jointly convene one or more workgroups to provide input to the following:

   - Improving transition of three-year-old children with disabilities from regional centers to local educational agencies, to help ensure continuity of services for young children and families.

   - Improving coordination and expansion of access to available federal funds through the LEA Medi-Cal Billing Option Program, the School-based Administrative Activities Program, and medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment benefits.

   The report on improving coordination and expansion of access to Medi-Cal systems summarizes the context, process, and resulting recommendations of the workgroup. The workgroup identified five overarching recommendations to improve the coordination and expansion of access to available federal reimbursement for LEAs through Medi-Cal Billing Option Program and the School-Based Medi-Cal Administrative Activities Program. Specifically, it includes program requirements (e.g., changes to interagency coordination practices) and support services (e.g., training and technical assistance) needed to improve the coordination and expansion of LEA access to Medicaid funds for student health services.

4) ***Funding for School-Based Mental Health Services in California.***

LEA Billing Option Program (BOP). This program was established in 1993 and is administered by the DHCS, in collaboration with the CDE. The LEA BOP reimburses LEAs (school districts, county offices of education, charter schools, community colleges, and university campuses) for health-related services provided by qualified health service practitioners to Medi-Cal enrolled students. Recent changes to Medicaid, including the "free care rule" and the opportunity for schools to be reimbursed for services provided to all Medi-Cal eligible students, rather than only those with disabilities, provide a significant opportunity to draw down additional federal funds for school-based health and mental health services.

School-Based Medi-Cal Administrative Activities (SMAA). The SMAA program provides federal reimbursements to LEAs for the federal share of certain costs for administering the Medi-Cal program. Those activities include outreach and referral, facilitating the Medi-Cal application, arranging non-emergency/non-medical transportation, program planning and policy development, and Medi-Cal administrative activities claims coordination. The Centers for Medicare & Medicaid Services administers the SMAA program at the federal level, and DHCS administers the SMAA program in California.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT is the health benefit in Medicaid for children and youth under age 21. Under federal Medicaid law, EPSDT services include screening, vision, dental, hearing, and other Medicaid health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

5) ***Family Educational Rights and Privacy Act (FERPA).*** FERPA protects the privacy of students' personal records held by educational agencies or institutions that receive federal funds under programs administered by the U.S. Secretary of Education. Almost all public schools and public school districts receive some form of federal education funding and must comply with FERPA. Organizations and individuals that contract with or consult for an educational agency also may be subject to FERPA if certain conditions are met. FERPA controls disclosure of recorded information maintained in a pupil's education record. FERPA generally limits access to all student records, and for example, only school staff with a legitimate educational interest in the information should be able to access it. FERPA also requires schools to include in their annual notices to parents a statement indicating whether the school has a policy of disclosing information from the education file to school officials, and, if so, which parties are considered school officials and what the school considers to be a legitimate educational interest.

6) ***Committee amendments.*** *The amendments will be accepted when the bill is in the Senate Health Committee.*
   - *"The local educational agency shall notify parents and guardians, pursuant to Section 48980, of the prevention and early intervention for, and access to, behavioral health services offered for pupils pursuant to this article. The notification shall, consistent with Section 124260 of the Health and Safety Code, include a form on which a parent or guardian may indicate that they do not consent to their child receiving those services and to, consistent with Section 124260 of the Health and Safety Code, opt out their child, if the child*

is under 12 years of age, from receiving prevention and early intervention for, and access to, behavioral health services offered pursuant to this article by submitting the completed form to the local educational agency."

7) ***Argument in support.*** According to the Los Angeles Trust for Children's Health "AB 552 would authorize county behavioral health agencies and their community-based organization partners to serve all children including privately insured students, if necessary. For students in need of behavioral health treatment that are privately insured, this bill would set forth procedures for county school-based providers to first attempt to connect the student with their insurance-based provider. If the insurance-based provider is unable to serve the student in need within state mandated timeframes, the county will provide initial services to privately insured students to mitigate the worsening of a behavioral health condition. The COVID-19 pandemic has created a significant barrier for the provision of behavioral health services on school campuses."

"The result is an unprecedented rise in behavioral health needs among children and youth. As students have returned to schools, the need for school-based services is more important than ever. For these reasons, The L.A. Trust respectfully urges you and all members of the Senate Education Committee to support AB 552."

8) ***Related Legislation. SB 75 (Committee on Budget and Fiscal Review)*** Chapter 51, Statutes of 2019, establishes the Mental Health Student Services Act as a mental health partnership competitive grant program for establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county, as provided. Also requires the CDE to jointly convene with the DHCS, a workgroup that include representatives from local educational agencies, appropriate county agencies, and legislative staff to develop recommendations on improving coordination and expansion of access to available federal funds through the LEA BOP, SMAA, and medically necessary federal EPSDT benefits.

AB 748 (Carrillo) of this Session On or before the start of the 2023–24 school year, this bill requires each schoolsite in a school district, county office of education (COE), or charter school serving pupils in any of grades 6 to 12 to create a poster that identifies approaches and shares resources regarding pupil mental health. This bill also requires the California Department of Education (CDE) to develop a model poster.

AB 2315 (Quirk Silva) Chapter 759, Statutes of 2018, requires the CDE, in consultation with the DHCS and appropriate stakeholders with experience in telehealth, to develop guidelines on or before July 1, 2020, for the use of telehealth technology to provide mental health and behavioral health services to pupils on public school campuses, including charter schools.

AB 2022 (Chu) Chapter 484, Statutes of 2018, requires each school of a school district or county office of education, and each charter school, to notify students and parents or guardians of pupils, at least twice per school year, about how to

initiate access to available student mental health services on campus or in the community.

SUPPORT

County Behavioral Health Directors of California (Co-Sponsor)
America Academy of Pediatrics, California – Chapter 2
American Academy of Pediatrics, California Chapter 2
Association of Regional Center Agencies
CA Association of Alcohol and Drug Executives, INC
CA Council of Community Behavioral Health Agencies
California Alliance of Child and Family Services
California Charter Schools Association
California State Association of Psychiatrists (CASP)
County of San Diego
County Welfare Directors Association of California (CWDA)
Los Angeles Trust For Children's Health
Seneca Family of Agencies
Sycamores
United Parents
United Parents
Women's Foundation of California, Dr. Beatriz Maria Solis Policy institute (SPI)

OPPOSITION

None on file.

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