Date of Hearing: April 28, 2021

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 883 (O'Donnell) – As Amended April 8, 2021

[Note: This bill is double referred to the Assembly Health Committee and was heard by that Committee as it relates to issues under its jurisdiction.]

SUBJECT: Mental Health Services Act: local educational agencies

SUMMARY: Requires a county that has had Mental Health Services Act (MHSA) funds reverted to work with local educational agencies (LEAs) and key stakeholders within that county to create a plan for the use of the reverted funds by the LEAs to provide school-based or school connected mental health services, including early intervention services to youth. Specifically, **this bill**:

1) Adds school mental health services to the types of activities for which MHSA funds may be retained by a county for up to 10 years without being subject to the reversion policy.

2) Amends the MHSA by requiring that funds subject to reversion, except as specified, be reallocated to the county from which the funds reverted.

3) Requires a county that has had funds reverted to work with the LEAs, community-based mental health agencies, and other stakeholders within that county to create a plan for the use of the reverted funds by the LEAs to provide school-based or school-connected services, including early intervention services to youth.

4) Requires that once the plan for reverted funds is developed, the county allocate the reverted funds to the LEAs for use as directed by the plan.

5) Requires, if the county has not created a plan within three years of the date of reversion, that the funds be deposited into the Reversion Account of the Mental Health Services Fund (MHSF) for distribution to other counties in future years.

6) Authorizes LEAs to provide mental health services to youth directly or through partnerships with county or community-based local agencies.

7) Prohibits the use of reverted funds to pay for educationally-related mental health services, as specified.

8) Provides that if there are reversion funds available after the funds are distributed in accordance with the plan, the funds be deposited in the State MHSF for distribution to other counties in future years.

9) Makes findings and declares that this bill is consistent with, and furthers the intent of, the MHSA.

EXISTING LAW:

1) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

2) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of MHSA, made up of 16 members appointed by the Governor and the Legislature, as specified.

3) Requires each county mental health department to prepare and submit a three-year plan to the Department of Health Care Services (DHCS) that must be updated each year and approved by DHCS after review and comment by the MHSOAC. Requires the three-year plans to include a list of all programs for which MHSA funding is being requested and identify how the funds will be spent and which populations will be served.

4) Requires that MHSA funds and interest accrued from those funds, other than those appropriately placed in a reserves fund, that have been allocated to a county and that have not been spent for their authorized purpose within three years, revert to the MHSA Reversion Fund and be available to other counties for future years.

5) Allows funds from counties with a population of less than 200,000 that have not spent their funds for their authorized purpose within five years to revert to the MHSA Reversion Fund.

6) Provides that funds allocated for capital facilities, technological needs, or education and training may be kept for a period of 10 years before reverting to the Reversion Fund.

7) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be amended by a majority vote.

8) Expresses the intent of the Legislature that the governing board of each school district and each county superintendent of schools maintain fundamental school health services at a level that is adequate to accomplish all of the following: preserve pupils' ability to learn, fulfill existing state requirements and policies regarding pupils' health, and contain health care costs through preventive programs and education.

9) Authorizes school districts to utilize 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, if such individuals and agencies are supervised in their school-based activities by an individual holding a pupil personnel services authorization.

FISCAL EFFECT: Unknown

COMMENTS:

Need for the bill. According to the author, "We know that too many of our students are suffering from trauma, depression, anxiety, and other mental health issues and are not receiving the necessary support and treatment. This was true prior to the COVID-19 pandemic, but these needs have become significantly more acute due to the multiple impacts of the pandemic on our students and families. If counties have unused MHSA funds, we must ensure these are directed to the urgent needs for mental health services in our schools."

Background on MHSA. Proposition 63, the MHSA, was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million and creates the 16 member MHSOAC charged with overseeing the implementation of MHSA. The MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology, and training needs for the community mental health system.

The MHSA requires each county mental health department to prepare and submit a three-year plan to the DHCS that must be updated each year and approved by the DHCS after review and comment by the MHSOAC. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. There are five components to the MHSA:

1) Community Services and Supports: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment.

2) Prevention and Early Intervention: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling.

3) Innovation: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community.

4) Capital Facilities and Technological Needs: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services.

5) Workforce Education and Training: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

Counties must submit their plans for approval to the MHSOAC before they may spend certain categories of funding, including Prevention and Early Intervention and Innovation funds.

Stakeholder processes guide expenditures of MHSA funds. The MHSA requires counties to use a structured Community Program Planning (CPP) process, in partnership with stakeholders, to develop a three-year plan guiding the utilization of MHSA funds allocated to that county. The MHSA CPP process must include the following participants and processes:

a) Clients and family members;

b) Broad-based constituents including adults and seniors with serious mental illnesses (SMI), families of children, adults, and seniors with SMI, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests;

c) Underserved populations: Participation from representatives of unserved and/or underserved populations and family members of unserved/underserved populations; and,

d) Diversity: Stakeholders that reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity, and have the opportunity to participate in the CPP process.

The MHSA CPP processes must include training; outreach to clients with serious mental illnesses and serious emotional disturbances, and their family members, to ensure the opportunity to participate; and a local review process prior to submitting the Three-Year Program and Expenditure Plans or Annual Updates that includes a 30-day public comment period.

Recent changes in MHSA reversion policies. Under the MHSA funds are distributed to counties based on a formula for local assistance, and must be spent for their authorized purpose within three years or revert to the state to be deposited into the MHSA Reversion Fund and be available for other counties in future years.

In 2017-18, concerns began to rise regarding the accumulation of unspent MHSA funds resulting in inappropriate reserve levels in many counties. AB 114 (Committee on Budget), Chapter 38, Statutes of 2017 modified the MHSA reversion policy to state that unspent funds subject to reversion as of July 1, 2017, were deemed to have reverted and been reallocated to the county of origin. The effect was that no "real" reversion took place in 2017 but rather that monies that should have been reverted were deemed reverted and counties were allowed three additional years to spend down their revenues. AB 114 also required that counties must have a plan for how these reallocated funds would be spent and stipulated that reallocated funds must be spent by July 1, 2020, or they would revert to the State.

AB 114 also provided that if a county receives approval from the MHSOAC of a plan for innovative programs, the funds identified in the plan would not revert until three years after the date of the approval, but that funds allocated to a county with a population of less than 200,000 would not revert for five years, or five years after the date of the approval.

In 2017, the California State Auditor (CSA) released a report entitled, "The State Could Better Ensure the Effective Use of Mental Health Services Act Funding," at the request of the Joint Legislative Audit Committee. The CSA evaluated the effectiveness of both the DHCS and MHSOAC in providing oversight of MHSA funding. The Audit Report found that DHCS did not

enforce annual revenue and expenditure reporting, nor had it performed fiscal or program audits to ensure local mental health agencies complied with fiscal and program requirements. The Audit Report concluded that despite having significant responsibility for the MHSA program since 2012, the DHCS had not developed a process to recover unspent MHSA funds from local mental health agencies after the statutory periods for spending the funds had elapsed.

Since the passage of AB 114 and the attention brought to bear on county MHSA expenditures, counties have improved in both reporting their expenditures and in actually spending down the amount of monies that were subject to reversion in July of 2020.

Linkages between mental health and educational outcomes. There is an increasing recognition of the intrinsic connection between student health and academic outcomes. While the associations between physical health problems and school attendance, behavior, and academic achievement have been noted for decades, increasing attention is now being paid to the relationship between adverse childhood experiences (ACEs), student mental health, and academic outcomes. Research has demonstrated a strong association between ACEs and poor performance in school, including a higher risk of learning and behavior problems. Other research into the effects of chronic stress on children (often caused by ACEs), has identified a profound effect on the developing brain, which in turn affects school performance and behavior. This research has led to an increased focus on the provision of health services at schools, and is promoting closer connections between health and education agencies.

California lags in providing critical health and mental health support to pupils. Schools are well positioned to provide mental health services with credentialed school staff trained or they may rely on partnerships with community systems, such as county behavioral health agencies, community mental health providers or centers, hospitals, and universities. Credentialed school counselors, psychologists, social workers, and nurses provide critical health and mental health services to pupils. The distribution of support personnel in schools differs significantly from one school district to another throughout the state, but it is clear from the data below that, as a state, California falls far short of meeting the recommended ratios of students to professionals and overall lacks sufficient numbers of trained personnel in our schools to meet the mental health needs of over six million pupils.

School health professional	# of professionals in California schools in 2018/19	2018/19 ratio of students/professional	Recommended ratios by relevant professional associations
School counselors	10,416	576:1	250:1
School psychologists	6,329	948:1	500-700:1
School social workers	865	6,936:1	250:1
School nurses	2,720	2,205:1	750:1

Source: CDE Dataquest.

The COVID-19 pandemic has increased need for school-based health and mental health services. The American Academy of Pediatrics noted in recent guidance that "emotional and behavioral health challenges were of growing concern before the COVID-19 pandemic, and the public health emergency has only exacerbated these challenges." Prior to the pandemic, the incidence of youth mental health crises was increasing at an alarming rate. Suicide rates among youth ages 10-24 increased over 57% between 2007 and 2018, and as of 2018 suicide was the second leading cause of death for youth ages 15-19, according to the CDC. Youth visits to pediatric emergency departments for suicide and suicidal ideation also doubled during this time period (Burstein, 2019).

The pandemic has dealt a particularly hard blow to students' mental health and well-being - increasing social isolation, disrupting routines, and eliminating social traditions and rites of passage, while also reducing students' access to schools, which serve as the de facto mental health system for children and adolescents. For students from families also facing economic and other challenges, the crisis is deeper still. The available evidence documents intensifying mental health impacts among students during the pandemic:

- FAIR Health analyzed data from its database of over 32 billion private healthcare insurance claim records, tracking month-by-month changes from January to November 2020 compared to the same months in 2019 and found:

    - Overall Mental Health: In March and April 2020, mental health claim lines for individuals aged 13-18, as a percentage of all medical claim lines, approximately doubled over the same months in the previous year;

    - Intentional Self-Harm: Claims for intentional self-harm as a percentage of all medical claim lines in the 13-18 age group comparing April 2020 to April 2019, doubled (100%);

    - Overdoses: For the age group 13-18, claim lines for overdoses increased by 119% in April 2020 over the same months the year before; and

    - Anxiety and Depressive Disorders: For the age group 13-18, in April 2020, claim lines for generalized anxiety disorder increased 93.6% as a percentage of all medical claim lines over April 2019, while major depressive disorder claim lines increased 84% percent and adjustment disorder claim lines 90% percent. Claims for obsessive compulsive disorder also increased for children aged 6-12.

- According to the CDC, the proportion of children's mental health-related emergency room visits among all pediatric emergency room visits increased and remained elevated through between April and October of 2020. 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; and

- A student survey conducted by the ACLU of California at the start of the pandemic found rising rates of adolescent students reporting needing mental health services (22% to 32%), and a decline in reported wellness (from 65% to less than 40%). 23% of students rated their mental wellness at a level requiring immediate intervention.

Arguments in support. The Los Angeles Unified School District (LAUSD), sponsor of this bill, states "This bill would ensure counties work with LEAs to develop plans to access MHSA funds. This bill is part of the long-term solution to provide sustainable resources to support school-based mental health services to students, particularly as they return to campus during these trying times that will affect an entire generation. Schools are critical partners in addressing student mental health needs, but often lack the resources to provide the critically needed services and cannot continue to bear the cost of children's mental health. This bill requires that counties work with LEAs to develop plans to utilize unspent, reverted MHSA funds."

Concerns have been raised by the County Behavioral Health Directors Association (CBHDA), who have a Support if Amended position, including the following: "AB 883 outlines a meritorious purpose for using the relatively small amount of reversion funds and although the bill outlines a role for the MHSA community program planning process that role is significantly reduced. Typically, local stakeholder engagement is a partnership with county behavioral health and constituents and stakeholders to ensure meaningful stakeholder involvement. Typically, stakeholders are not told that they must support a specific funding allocation or plan but are instead allowed to identify their own priorities. CBHDA seeks an amendment to AB 883 to allow for meaningful stakeholder involvement in deciding how reverted funds should be used. Stakeholders should be told specifically that funds can be used for a plan developed by county behavioral health agencies and local educational agencies to deliver early intervention services, but this should not be the only option for local stakeholders to consider."

Related legislation. AB 586 (O'Donnell) of this Session establishes the School Health Demonstration Project to expand comprehensive health and mental health services to students by providing intensive assistance and support to selected LEAs to build the capacity for long-term sustainability through leveraging multiple funding streams and partnering with county Mental Health Plans, Managed Care Organizations, and community-based providers.

AB 552 (Quirk-Silva) of this Session authorizes LEAs and county behavioral health agencies to enter into partnerships to provide school-based behavioral health and substance abuse disorder services on school sites and authorizes the billing of private insurance providers for these services under specified conditions.

AB 563 (Berman) of this Session requires the CDE to establish an Office of School-Based Health Programs for improving the operation of, and participation in, school-based health programs, including the Medi-Cal Administrative Activities claiming process and the LEA Medi-Cal billing option program. Requires that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for support of the Office.

AB 58 (Salas) of this Session requires LEAs to provide suicide awareness and prevention training annually to teachers.

AB 309 (Gabriel) of this Session requires the CDE to develop model pupil mental health referral protocols, in consultation with relevant stakeholders.

AB 1080 (Cunningham) of this Session authorizes school districts to partner with local or community mental health providers or clinics to administer its educational counseling program.

AB 1081 (Cunningham) of this Session requires the SPI, beginning with the 2021-22 fiscal year, to annually adjust the local control funding formula grade span adjustment by a specified amount

for those LEAs documenting a partnership with a local mental health agency to promote integrated services, federal reimbursements, positive school climate, and pupil success, including but not limited to peer-led strengths-based, and wellness-oriented services.

AB 1117 (Wicks) of this Session establishes the Healthy Start: Toxic Stress & Trauma Resiliency for Children Program within the CDE, in partnership with the Health and Human Services Agency, to oversee a grant program to fund innovative local collaboratives between schools, communities, county and city agencies, nonprofit service providers, and early childhood serving programs and agencies.

SB 14 (Portantino) of this Session adds "for the benefit of the behavioral health of the pupil" to the list of categories of excused absences for purposes of school attendance, requires the CDE to identify an evidence-based training program for LEAs to use to train classified and certificated school employees having direct contact with pupils in youth behavioral health, and requires an evidence-based behavioral health training program with a curriculum tailored for pupils in grades 10 to 12.

SB 229 (Dahle) of this Session requires the DHCS, in consultation with the CDE, to provide up to $500 million in grants annually to LEAs and private schools, to provide mental health services for pupils affected by school closures and distance learning requirements resulting from the COVID-19 pandemic.

SB 508 (Stern) of this Session requires specified health care service plans, health insurers, and Medi-Cal managed care plan to enter into memoranda of understanding (MOUs) with all LEAs where 15% or more of the pupils of that LEA are insured by the plan or insurer; authorizes the LEA to bill for mental health and substance use disorder services provided if the plan or insurer fails to enter into a MOU with the LEA; approves telehealth as an approved modality for provision of specified services by an LEA; and authorizes a school district to require parents to provide information on a pupil's health care coverage.

SB 773 (Roth) of this Session require the DHCS to make incentive payments to qualifying Medi-Cal managed care plans to increase access to school-based preventive, early intervention, and behavioral health services for pupils.

AB 8 (Chu) of the 2019-20 Session would have required schools to have one mental health professional for every 400 pupils accessible on campus during school hours, and for schools of less than 400 pupils, to employ at least one mental health professional for one or more schools or enter into an agreement with a county agency or community-based organization to provide mental health services to pupils. AB 8 was held in the Senate Health Committee.

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 the purpose of 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. Requires the CDE to jointly convene with DHCS a workgroup that include representatives from LEAs, appropriate county agencies, and legislative staff to develop recommendations on improving coordination and expansion of access to available federal funds through the LEA Medi-Cal Billing Option Program, the School-based Medi-Cal Administrative Activities Program, and medically necessary federal EPSDT benefits.

REGISTERED SUPPORT / OPPOSITION:

Support

Alliance for A Better Community
California Association of School Counselors
California Association of School Psychologists
California Teachers Association
Innercity Struggle
Los Angeles Unified School District
San Diego Unified School District
2 individuals

Opposition

None on file

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