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California Board of Behavioral Sciences
Workforce Development Committee

Re: School-Based Practice by BBS Licensees in California Public Schools

Dear Members of the Workforce Development Committee:

Thank you for the opportunity to submit these materials for the Committee's consideration.

I am an independently licensed Professional Clinical Counselor in California currently employed directly by a school district as a mental-health counselor. I spent the previous decade in various community and acute mental-health settings, much of that time as a licensed professional counselor in Georgia, before entering the California public-school system in 2024 as part of a newly established mental-health program. Since joining, I have found school-based clinical practice to be a unique professional environment in which BBS licensure intersects with Pupil Personnel Services credentialing, special-education law, school behavioral-health systems, institutional employment requirements, and, increasingly, healthcare reimbursement.

Having never worked in a school district, I naturally encountered circumstances that raised questions requiring further clarification. As I began looking for answers to specific questions that arose in my work, I found that the issues were not always limited to the circumstances that prompted them. My review of publicly available BBS, CTC, CDE, and DHCS guidance increasingly pointed to broader questions about how independently licensed clinicians fit within California's educational systems when their work crosses multiple professional and regulatory frameworks. Although my own experiences and observations prompted these inquiries, I want to make the point directly that I am not seeking advice or relief regarding any personal employment matter.

Beyond my own circumstances, these questions seem particularly timely as California continues to invest in school-based behavioral-health services and expand reimbursement opportunities for LEAs. I strongly support efforts to make mental-health care more readily available to children through schools. I also believe, however, that the professional infrastructure supporting the licensed workforce may require further development alongside the service-delivery and financing framework surrounding that care.

I am therefore submitting the enclosed issue brief, School-Based Practice by BBS Licensees in California Public Schools: Considerations for Workforce Development, Public Protection, and Interagency Coordination, along with a one-page set of Questions for BBS Consideration. I respectfully ask the Committee to consider whether these issues warrant further examination and would benefit from BBS guidance, additional study, or collaboration with CTC, CDE, DHCS, professional associations, LEAs, and school-based BBS licensees.

Thank you for considering whether greater clarity in this area could support both clinicians entering school-based practice and the students and families they serve.

Sincerely,

Ashley McIntosh, LPCC
California Licensed Professional Clinical Counselor

Questions for BBS Consideration

School-Based Practice by BBS Licensees in California Public Schools

As California expands school-based behavioral-health services and reimbursement, BBS professionals increasingly practice within systems also governed by educational credentialing, special-education law, school behavioral-health policy, and institutional employment requirements. The following questions are offered for BBS consideration and, where appropriate, interagency discussion.

1. Where is the boundary between independent BBS practice, PPS "assistance," and a PPS assignment?

What distinguishes permissible assistance under Title 5, California Code of Regulations, section 80049.1(c) from a position whose duties substantially align with a PPS authorization and require the appropriate credential? To what extent may the assistance provision serve as an ongoing staffing model for PPS-overlapping work under different workload, employment, or professional safeguards?

2. What should PPS supervision of independently licensed BBS clinicians actually entail?

Should California clarify the purpose, expected activities, frequency, documentation, and appropriate PPS specialization involved when BBS licensees assist in providing pupil personnel services?

3. Should LEAs operating clinical mental-health programs have minimum organizational clinical standards?

Should programs maintain core procedures for implementing consent and confidentiality requirements, assessment, treatment planning, documentation, risk management, caregiver involvement, referral, termination, quality assurance, and role clarity, in addition to structured support for graduate trainees or BBS associates serving at school sites without another clinician routinely present?

4. How should school-based BBS professionals navigate the contact-to-treatment and behavioral-response boundaries?

Would school-specific guidance help distinguish general support, stabilization, behavioral/crisis response, clinical screening, psychotherapy, and educational or IEP-related mental-health services, including when a treating clinician should remain distinct from disciplinary, enforcement, or behavioral-control functions?

5. What setting-specific preparation should support school-based clinical practice and supervision?

Should employers establish structured onboarding and verify preparation for specialized or high-stakes functions before clinicians assume independent responsibility, and should professionals supervising clinicians or overseeing school-based clinical programs receive additional setting-specific preparation?

6. What professional supervision, consultation, and safeguards should support BBS professionals working within educational institutions?

For associates and independently licensed clinicians, how should individual clinical, legal, and ethical accountability be supported when employer directives or institutional interests conflict with licensing obligations, including through independent consultation, escalation pathways, and appropriate professional or licensing-defense resources?

7. Is an interagency framework warranted for California's growing school-based licensed mental-health workforce?

Would collaboration among BBS, CTC, CDE, DHCS, LEAs, professional associations, and school-based practitioners help clarify the professional framework governing clinicians who work across clinical, educational, special-education, behavioral-health, and reimbursement systems?

Central Question

As California increases its investment in school-based behavioral-health care, what minimum regulatory clarity, organizational infrastructure, and professional safeguards are necessary to ensure that BBS professionals can practice competently, ethically, and with appropriate clinical independence within public educational systems?

School-Based Practice by BBS Licensees in California Public Schools

Considerations for Workforce Development, Public Protection, and Interagency Coordination

Scope of Review

This paper is based primarily on publicly available materials from the California Board of Behavioral Sciences (BBS), Commission on Teacher Credentialing (CTC), California Department of Education (CDE), California Department of Health Care Services (DHCS), and relevant California statutes and regulations. References to apparent regulatory or guidance gaps reflect a review of these publicly available authorities and are presented as questions for agency consideration rather than legal conclusions.

Key Point

California has established substantial regulatory systems for licensed mental-health practice and pupil personnel services while rapidly increasing the availability of behavioral-health services within schools. The questions raised in this paper concern the intersections among those systems for BBS-regulated professionals employed within public educational agencies.

Purpose

Licensed and associate mental-health professionals regulated by BBS increasingly work directly within local educational agencies (LEAs), alongside professionals regulated through CTC and within systems governed by state and federal education law.

The growing presence of BBS professionals in schools presents an important opportunity to make mental-health care more readily available to children, adolescents, and their families. It also creates a professional environment that differs substantially from traditional outpatient practice.

A BBS professional employed by an LEA may perform functions involving clinical mental-health treatment, pupil personnel services, special education, behavioral intervention, crisis response, schoolwide prevention, and healthcare reimbursement. These systems are governed by overlapping but distinct professional and regulatory frameworks; yet the professional path through them is not always clearly mapped for the clinician practicing at their intersection.

The significance of these questions is growing alongside California's expansion of school-linked behavioral-health services and financing. As of August 2026, DHCS reported approximately 700 LEAs and public institutions of higher education participating in the Children and Youth Behavioral Health Initiative Fee Schedule Program, representing approximately 3.6 million students across participating school sites.[1] As California develops the service-delivery, referral, and financing systems surrounding school behavioral-health care, there is a corresponding need to examine the professional infrastructure supporting the licensed and associate workforce providing that care.

The purpose of this paper is not to question the appropriateness of employing BBS professionals in public schools, nor to suggest that BBS alone should regulate educational mental-health programs. Rather, it is to identify areas in which clearer guidance, minimum professional infrastructure, or interagency collaboration may help protect students and families while supporting clinicians in meeting their professional obligations.

Five areas appear particularly worthy of consideration.

[1] California Department of Health Care Services, Children and Youth Behavioral Health Initiative Fee Schedule Program, program data reported August 3, 2026.

1. Clarify the Regulatory Relationship Between BBS Licensure and Pupil Personnel Services

California permits independently licensed mental-health professionals to provide services within public educational settings. California separately regulates Pupil Personnel Services (PPS) through CTC.

Current CTC guidance states that if the actual duties of a position substantially align with duties authorized by a PPS credential, the appropriate PPS credential authorization is required. CTC emphasizes that the required authorization is determined by the duties of the position rather than its title.[2]

CTC also recognizes that state-licensed individuals may assist in providing pupil personnel services when supervised in their school-based activities by an individual holding a PPS authorization. Current CTC public materials are not entirely uniform in describing this requirement: the PPS FAQ refers to supervision by an individual holding the "appropriate" PPS authorization, while CTC's Contracting Mental Health Services page describes supervision by a holder of a PPS authorization more generally.[3]

These provisions establish a role for state-licensed professionals in PPS-related work. However, the CTC materials reviewed for this paper leave several practical questions about how that arrangement is supposed to work.

- What distinguishes assisting with PPS services from occupying a position whose actual duties substantially align with a PPS authorization?
- Can a state-licensed clinician function as the primary provider of a PPS-overlapping service while remaining within the assistance provision?
- What activities constitute supervision of an independently licensed professional's school-based activities?
- Is any minimum frequency, documentation, case review, or professional involvement required?
- When a BBS licensee's position spans functions associated with multiple PPS specializations, how should the appropriate PPS authorization for supervision be determined?
- To what extent may the assistance provision be used as an ongoing staffing model for positions whose functions substantially overlap those ordinarily performed under a PPS authorization?

The distinction may also have workforce implications beyond credentialing alone. If a state-licensed professional may be employed on an ongoing basis to perform duties substantially overlapping those of a PPS-credentialed professional under the assistance provision, questions arise about when the provision functions as permissible professional assistance and when it effectively becomes an alternative staffing pathway for PPS-overlapping work. This may be particularly significant when employees performing substantially similar student-facing functions are subject to different employment classifications, workload expectations, compensation structures, or other working-condition safeguards. Some of these differences, particularly those involving workload and professional support, may also affect the conditions under which services are provided to students.

These questions matter in part because BBS licensure carries professional obligations that remain with the individual licensee. When the role of a BBS professional within the educational system is not clearly defined, the clinician may lack established role expectations, professional support, and safeguards while remaining individually accountable for clinical, legal, and ethical decisions made within that environment.

Greater clarity regarding the relationship among independent BBS practice, PPS assistance, and PPS assignments would benefit LEAs, licensees, and the students and families they serve. Because these questions

[2]California Commission on Teacher Credentialing, Pupil Personnel Services Credential FAQ (current assignment guidance).

[3]California Commission on Teacher Credentialing, Pupil Personnel Services Credential FAQ; Contracting Mental Health Services.

arise at the intersection of two regulatory systems, they may be particularly appropriate for joint BBS-CTC consideration.

2. Consider Minimum Clinical Governance Standards for LEA-Operated Mental-Health Programs

Independent licensure appropriately allows a clinician to practice without the clinical supervision required of an associate. Independent clinical judgment and organizational clinical infrastructure, however, are separate concepts. Reasonable professional variation should be preserved, with clinicians appropriately differing in theoretical orientation, assessment style, intervention method, and clinical formulation. Establishing a common clinical floor would not require standardizing psychotherapy itself. Rather, such a framework would provide an organizational safeguard ensuring that fundamental clinical processes are addressed regardless of variation in individual practitioners' approaches or practices.

A comparable statewide BBS framework setting minimum organizational clinical processes for LEA-operated mental-health programs is less apparent in the publicly available authorities. An organized mental-health program serving minors could reasonably maintain core procedures addressing:

- referral and clinical screening;
- procedures for obtaining and documenting informed consent;
- initial assessment and required assessment domains;
- caregiver collateral when clinically and legally appropriate;
- treatment planning;
- progress documentation;
- risk assessment and follow-up;
- procedures for confidentiality and lawful information sharing;
- referral and care coordination;
- reassessment when indicated;
- termination and discharge; and
- quality assurance.

Without a defined organizational clinical framework, students receiving services within the same LEA may experience materially different intake, assessment, treatment-planning, risk-management, and termination processes based primarily on the individual practices developed by the clinician to whom they are assigned.

A common framework can also help nonclinical school staff understand the role and responsibilities of BBS professionals. When organizational procedures for referral, obtaining consent, student contact, applying confidentiality requirements, behavioral response, and communication are left largely to individual clinicians, differences in practice may be interpreted as differences in willingness or job performance rather than legitimate differences in professional judgment. Clear organizational expectations can help distinguish the responsibilities of the clinical role from matters appropriately left to individual clinical judgment.

These considerations may be particularly significant for associate-level clinicians whose first post-graduate clinical employment occurs within an educational setting. Where an associate is assigned independently to a school site rather than practicing within a clinic-style environment, the employing program's assessment procedures, documentation standards, consultation structure, orientation to educational law, crisis protocols, and quality of clinical supervision may constitute much of the professional infrastructure through which the clinician learns to translate graduate training into practice.

Related organizational considerations may arise when LEAs serve as clinical training sites for graduate students completing supervised practicum or fieldwork toward a BBS-regulated profession. BBS requirements already provide for supervision and coordination between graduate programs and clinical training sites. Those requirements, however, do not appear to establish whether a graduate trainee should ordinarily be permitted

to serve as the only clinical provider routinely present at an individual school site. Particularly where trainees are providing services to minors within an institutional setting, consideration may be warranted regarding whether BBS should establish minimum expectations for site-level clinical support rather than leaving the adequacy of that structure entirely to individual graduate programs and placement sites. Such guidance could recognize circumstances in which alternative supervision arrangements are appropriate while establishing a general expectation that trainees should not be placed in roles requiring them to function independently as the sole on-site clinical resource.

California has increasingly recognized organizational responsibility for the behavioral-health systems surrounding treatment. CDE's Model Referral Protocols address structured referral pathways, clearly assigned responsibilities, family participation and consent, secure referral tracking, staff role clarification, trauma-informed care, scope-of-practice limitations, data-sharing practices, and continuous evaluation. These developments raise a related clinical-governance question: if California increasingly specifies how school systems should identify behavioral-health concerns and connect students with appropriate services, what minimum organizational standards should support the licensed clinical program once the student reaches a treating professional, particularly when the LEA itself operates that program?

The policy question is not whether BBS should prescribe psychotherapy practice to school districts. It is whether organizations that deliberately operate clinical mental-health programs serving minors should bear identifiable responsibility for creating conditions in which BBS professionals can consistently practice competently, ethically, and lawfully.

3. Develop School-Specific Guidance for Applying Existing Consent and Confidentiality Requirements Across the Boundaries Between Support, Behavioral Response, and Treatment

School-based practice creates professional encounters that differ from traditional outpatient practice, where the clinician's role as a treatment provider is generally established before services begin. In schools, a licensed or associate clinician may be asked to meet with a student following a fight, peer conflict, classroom behavioral incident, emotional episode, disciplinary event, disclosure, or concern raised by a teacher or administrator. A student who has no established treatment relationship with the clinician may also independently seek assistance.

Schools have long responded to many of these same student needs through teachers, administrators, counselors, behavioral staff, and other educational personnel. The increasing presence of BBS professionals within schools, however, introduces a different professional framework when clinicians are asked to perform these functions specifically because of their mental-health training and expertise. An activity that may appropriately constitute educational support when performed by school personnel does not necessarily remain solely educational when an LEA assigns the same student or function to a licensed or registered clinician for a mental-health purpose. Conversely, the use of informal terms such as a “check-in,” “processing,” or “behavior support” does not resolve whether the actual service provided falls within a clinical role.

This distinction may become particularly difficult where educational and clinical functions overlap. Similar activities, such as responding to an emotionally distressed student or providing small-group social-emotional support, may occur within an educational prevention or intervention framework or through a BBS-regulated clinician acting in a professional mental-health capacity. The role of the professional, reason for the referral or contact, purpose of the intervention, and nature of the service provided may therefore affect which consent, confidentiality, documentation, and other professional requirements apply. A more clearly defined boundary could help LEAs and clinicians determine when an activity remains an educational pupil-support function and when assigning that function to a BBS professional brings it within a clinical framework.

As discussed above in Section 2, CDE's Model Referral Protocols establish a framework for identifying behavioral-health concerns and connecting students with appropriate services. The protocols also distinguish between identifying and referring students for behavioral-health needs and providing diagnosis or treatment, which requires an appropriately licensed professional employed to provide those services.[4] Applying that distinction becomes less straightforward once a licensed treating professional is embedded within the school itself.

Existing BBS materials do not appear to address how clinical obligations apply to these recurring school-specific encounters outside an established treatment relationship. A school-specific framework could distinguish among:

- incidental or general school-based support;
- immediate stabilization or safety response;
- school behavioral or crisis response;
- clinical screening or risk assessment;
- ongoing psychotherapy or clinical counseling; and
- educational or IEP-related mental-health services.

Families may also benefit from knowing in advance when a licensed mental-health professional is regularly stationed on their child's campus and how that role differs from other school-based support positions. Where students may encounter the clinician before formal treatment is established, LEAs could provide clear information about the clinician's role, the kinds of contacts that may occur outside an ongoing treatment relationship, when parent or guardian consent will be obtained for continuing clinical services, and how families may request or decline those services when a choice is available.

The role of a treating mental-health clinician in responding to student behavior presents a related need for clarification. A distinction may be warranted between an established clinician therapeutically supporting a student with whom a treatment relationship already exists and a clinician being incorporated into the school's behavioral response to a student outside an established treatment relationship.

A clinician's initial contact with a student during a coercive, disciplinary, or highly escalated behavioral event may affect the student's subsequent understanding of the clinician's role and the development of therapeutic trust. The clinician's visible role in such events may also shape how other students understand the clinician's function, potentially affecting whether the mental-health professional is perceived as a source of voluntary support or as part of the school's behavioral-control system. Guidance could therefore address circumstances in which the treating clinician should remain distinct from personnel responsible for discipline, behavioral control, physical intervention, or enforcement of school expectations, while recognizing that an established clinician may sometimes provide valuable support when clinically appropriate or requested by the student.

Where clinician participation in crisis response *is* appropriate, clearly defined roles, coordinated protocols, and trauma-responsive training across the responding team may be important. The conduct of other personnel participating in the response can affect the student's experience of the clinician's involvement even when the clinician's own conduct is therapeutically appropriate.

These questions may be conceptualized as both a **contact-to-treatment boundary** and a related **behavioral-response boundary**.

A school-specific framework could also address when clinical documentation is warranted, which existing confidentiality and information-sharing requirements apply to different types of encounters, and what steps

[4]California Department of Education, Senate Bill 153: Model Referral Protocols for Addressing Pupil Behavioral Health Concerns (2025) (differentiated referral processes and scope limitations regarding diagnosis and treatment).

should follow when a non-treatment contact reveals a need for ongoing clinical care.[5] Additional clarification may be particularly useful regarding how BBS professionals should exercise clinical judgment when sharing sensitive treatment information within educational teams, including how FERPA's legitimate-educational-interest standard interfaces with the clinician's professional confidentiality obligations and whether lawful access to an education record necessarily establishes a clinical need for all information contained within it. As California expands the licensed mental-health workforce employed directly within educational agencies, consideration may also be warranted regarding whether existing federal and state privacy frameworks provide sufficient protection and clarity for sensitive clinical information generated through school-based treatment, or whether additional regulatory, statutory, or interagency measures should be explored.

Clearer school-specific guidance would not replace existing federal and California consent, confidentiality, or emergency-response requirements. It would assist clinicians in applying them consistently within an institutional environment in which students often encounter mental-health professionals through pathways other than the traditional outpatient intake process.

4. Establish Expectations for Setting-Specific Preparation and Competency

Licensure represents substantial graduate education, supervised experience, examination, and preparation for independent clinical practice. It does not necessarily establish competence in every specialized educational function an employer may incorporate into a school-based mental-health position.

Examples may include:

- ERMHS assessment;
- IDEA and IEP procedures;
- analysis of educational impact;
- school-specific records, FERPA, state confidentiality requirements, and information sharing;
- participation in MTSS/PBIS systems;
- behavioral crisis response;
- de-escalation of aggressive or severely dysregulated students; and
- specialized school crisis procedures.

California already recognizes that general professional qualification and competency requirements for particularly high-stakes functions can coexist. BBS requires specified education or applied experience in suicide-risk assessment and intervention in addition to the broader education and experience required for licensure.[6]

CDE's current referral guidance likewise calls for compliance with FERPA and applicable privacy requirements, protocols for safe data sharing, and training staff in responsible data use. For BBS professionals, setting-specific preparation may need to go beyond generic privacy training to address the relationship among educational records, clinical documentation, information shared within educational teams, parent access, and records generated through school-based treatment or healthcare billing. Clinicians should understand the confidentiality and information-sharing framework governing their school-based practice before assuming responsibility for clinical services and records within that system.[7]

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[5] Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g; 34 C.F.R. Part 99. FERPA governs access to and disclosure of education records maintained by covered educational agencies and institutions, including circumstances in which records may be disclosed without prior consent to school officials with legitimate educational interests

[6] California Business and Professions Code § 4999.66.

[7] California Department of Education, *Senate Bill 153: Model Referral Protocols for Addressing Pupil Behavioral Health Concerns* (2025), Part 4: Implementation – Data Practices (FERPA/HIPAA compliance, safe data-sharing protocols, and staff training in responsible data use).

BBS has also previously addressed the intersection of its workforce with ERMHS. Effective January 1, 2020, qualified Licensed Educational Psychologists may supervise specified BBS associates for up to 1,200 hours of experience providing ERMHS within the LEP's scope of practice, subject to BBS supervision requirements. The development of that framework reflects recognition that school-based mental-health practice can implicate specialized educational as well as clinical knowledge.[8]

A similar competency principle may warrant consideration for independently licensed clinicians: specialized assigned duties should be accompanied by the setting-specific preparation necessary to perform those duties competently. This does not necessarily require creation of another credential or school-based license certification. A more practical approach would be for employing programs to identify the specialized functions assigned to BBS professionals and determine what training, demonstrated competency, consultation, or certification is needed before clinicians perform those functions independently.

Setting-specific preparation may also need to address how familiar clinical responsibilities are operationalized within the employing educational agency. General professional competence in areas such as mandated reporting or suicide-risk assessment does not necessarily prepare a clinician to navigate an LEA’s particular procedures for documentation, internal notification, records management, follow-up, consultation, or coordination with other school personnel. Similarly, clinicians assigned to ERMHS work may require orientation to local assessment procedures, report expectations, special-education processes, and documentation systems before assuming independent responsibility for those functions.

Structured onboarding, access to written procedures, opportunities for consultation or observation when appropriate, and periodic review of high-stakes or infrequently performed responsibilities could therefore form part of the organizational infrastructure supporting competent practice. Such preparation would not replace the clinician’s responsibility to maintain professional competence; rather, it would ensure that clinicians understand how their professional responsibilities are to be carried out within the particular educational system in which they practice.

ERMHS assessment, specifically, illustrates the issue. California special-education law establishes general requirements for assessment, including use of qualified personnel, multiple measures and sources, assessment in relevant areas of suspected disability, and written reporting requirements. Certain psychological assessments are reserved to appropriately credentialed school psychologists. What is less clear is whether a statewide standard establishes the assessment methodology expected of BBS clinicians conducting ERMHS assessments.

CDE's Diagnostic Center currently offers training for school psychologists and ERMHS assessors on comprehensive psychosocial assessment, selection of social-emotional tests, qualitative data, rating scales, and systematic organization of findings. This supports the view that ERMHS assessment is a specialized function requiring more than general psychotherapy competence.[9] Accordingly, clarification may be useful regarding what establishes minimum competence, methodology, assessment domains, professional scope, and quality standards when a BBS professional is assigned to conduct an ERMHS assessment, and how those responsibilities interface with psychological or psychoeducational assessment reserved to other professionals.

Behavioral crisis response illustrates a related but distinct competency issue. As discussed in Section 3, there is a threshold question regarding when a treating clinician should participate in a school's behavioral response. Where such participation is appropriately included in the clinician's assigned duties, independent responsibility for responding to severely dysregulated or aggressive students should be preceded by

[8]California Board of Behavioral Sciences, January 2020 Newsletter, “LEPs May Now Supervise Associates for up to 1,200 Hours of Educationally Related Mental Health Services.”

[9]California Department of Education, Diagnostic Center, Northern California, Psychosocial Assessment: Emotional Disability Eligibility / ERMHS training materials.

appropriate preparation in crisis prevention, verbal de-escalation, applicable emergency procedures, and the clinician's defined role within the response team.

Competency considerations may also extend to professionals responsible for developing or overseeing school-based clinical programs and supervising clinicians within them. A professional may satisfy applicable licensure or supervision requirements while having developed much of their experience within educational rather than traditional clinical-service systems. Where an LEA operates an ongoing mental-health treatment program, additional preparation in clinical supervision and program leadership within educational settings could help ensure that those responsible for its oversight are prepared for the clinical-governance responsibilities associated with operating a treatment program.

Similar considerations may apply when a BBS associate working in an educational setting receives clinical supervision from a supervisor who is not employed within that setting. A supervisor may be well qualified to provide clinical supervision generally while having limited familiarity with the educational, legal, and institutional frameworks affecting the associate's school-based practice. Consideration may therefore be warranted regarding whether supervisors of associates practicing in schools should have sufficient setting-specific knowledge to provide meaningful supervision regarding the legal, ethical, and institutional circumstances affecting that practice.

Individual clinicians remain responsible for practicing competently. An employer that creates and assigns a specialized professional responsibility, however, may also reasonably bear responsibility for ensuring that the organizational conditions necessary to perform that assignment competently are present.

5. Address Clinical Independence, Professional Supervision, Consultation, and Individual License Risk Within Institutional Employment

School-employed clinicians practice with responsibilities running in two directions: to the institutions that employ them and to the professional standards that govern their licenses. As employees, they are subject to organizational policies, administrative supervision, work assignments, schedules, documentation systems, and program priorities. As BBS licensees or registrants, they are also individually responsible for complying with the laws and professional standards governing their practice, both to protect the clients they serve and to meet the obligations attached to their licenses.

These responsibilities ordinarily coexist. Educational settings can nevertheless produce questions at the intersection of employer expectations and professional judgment. Examples may involve:

- whether a particular student contact constitutes clinical treatment;
- which consent requirements apply to a particular student contact;
- which confidentiality and information-sharing requirements govern a particular disclosure;
- whether an assigned activity falls within the clinician's competence;
- whether the clinician is functioning therapeutically, behaviorally, administratively, or disciplinarily;
- how the clinician's professional involvement is represented to a family or educational team; or
- whether a clinical recommendation or legal/ethical obligation conflicts with an institutional preference.

When professional roles and governing expectations are not clearly defined, these questions may create more than operational uncertainty. Because professional accountability remains with the individual BBS licensee or registrant, a clinician may be expected to make decisions carrying clinical, legal, or ethical consequences without the setting-specific procedures, consultation structures, or professional safeguards that would help support those decisions.

Role ambiguity may also arise when BBS professionals are assigned general educational, supervisory, or behavioral responsibilities unrelated to clinical treatment. For example, a school-based clinician may be asked to supervise a classroom or large group of students in place of instructional personnel, manage student behavior outside a therapeutic context, or assume other campus responsibilities for which clinical licensure

itself establishes no particular preparation. Such assignments raise a broader workforce question regarding how LEAs should distinguish appropriate institutional duties from functions that rely upon credentials, training, professional roles, or supervision standards that may fall outside the clinician's qualifications or that BBS licensure itself does not address.

Even with clearer organizational procedures and setting-specific preparation, school-based practice will inevitably present circumstances requiring professional judgment beyond what a standardized framework can address. Independent licensees do not require the clinical supervision required for associates, but both groups may need access to competent professional consultation on school-specific legal, ethical, assessment, scope, and clinical questions. For associates, particular consideration may be warranted when the BBS-required clinical supervisor is employed by the same educational agency. Although institutional and professional interests will ordinarily align, associates should have a clear avenue for guidance when an employer directive or institutional practice appears to conflict with their individual legal or ethical obligations.

Similar concerns may arise for independently licensed clinicians when institutional expectations and professional obligations appear to diverge. Because BBS accountability attaches to the individual professional, school-based clinicians may benefit from clear escalation and consultation pathways and access to appropriate professional support or representation when a licensing complaint arises from assigned duties. Employer-provided civil liability protection should not necessarily be presumed to address individual licensing-board exposure.

The principle is not that licensed or registered employees should be exempt from ordinary administrative authority. Rather, administrative authority, clinical supervision, professional consultation, and individual accountability should be structured so that BBS professionals can meet the obligations for which they are personally responsible.

Recommendations for BBS Consideration

1. Engage CTC regarding joint clarification of the role of BBS professionals who perform PPS-overlapping duties, including the distinction between independent licensed practice, assistance under Title 5 section 80049.1(c), and assignments requiring PPS authorization.

2. Examine whether minimum clinical-governance standards are appropriate for institutional mental-health programs employing BBS professionals to serve minors, including organizational standards for implementing consent and confidentiality requirements, assessment, treatment planning, documentation, risk management, termination, quality assurance, role clarity, and support for graduate trainees or BBS associates serving at school sites without another clinician routinely present.

3. Develop school-specific practice guidance regarding the contact-to-treatment and behavioral-response boundaries, including family awareness of the clinician's role; application of existing minor-consent and confidentiality requirements, including the relationship between FERPA-authorized educational access and a clinician's professional judgment regarding disclosure of sensitive clinical information; circumstances in which screening, stabilization, de-escalation, or other brief student contacts may occur before treatment consent is established; appropriate documentation of the basis for such contacts; crisis response; and circumstances in which treating clinicians should remain distinct from disciplinary or behavioral-control functions.

4. Encourage competency-based organizational practices for school-based clinical work, including structured onboarding and setting-specific preparation for ERMHS assessment, IEP-related work, crisis/de-escalation responsibilities, mandated reporting, suicide-risk procedures, and school-specific privacy, records, FERPA, and information-sharing requirements.

5. Clarify expectations for school-based clinical supervision of associates, including whether supervisors would benefit from setting-specific preparation or continuing education, and identify appropriate consultation

and escalation pathways for associates and independently licensed clinicians when institutional expectations and individual professional obligations appear to diverge.

6. Collaborate with CTC, CDE, DHCS, professional associations, LEAs, and school-based BBS professionals to examine the broader regulatory and workforce implications of California's expanding school-based behavioral-health system, including whether existing privacy frameworks adequately address sensitive clinical information generated by BBS professionals practicing within educational agencies and whether additional guidance, regulatory clarification, statutory protections, or interagency action may be warranted.

Conclusion

California does not lack regulation of school mental health. BBS licensure and registration law, CTC credentialing requirements, special-education law, CDE behavioral-health policy, and DHCS reimbursement programs each provide substantial regulatory structure.

The challenge is that these systems serve different regulatory purposes and do not always provide a unified answer for the BBS professional employed directly within a public educational agency. As California expands school-based behavioral-health access and reimbursement, this is an opportune time to examine the bridges between these systems.

Clearer guidance and appropriate organizational safeguards could benefit all parties. Students and families could receive more consistent and transparent services; LEAs could gain greater clarity regarding appropriate utilization and supervision of clinical staff; associates could enter school-based practice within stronger professional structures; and independently licensed clinicians could be better positioned to fulfill the obligations for which they remain individually accountable.

The goal is not to restrict school-based mental-health care, but to ensure that the professional infrastructure supporting it develops alongside its expansion.

References and Authorities

The following statutes, regulations, and agency materials informed the accompanying issue brief. Agency guidance and historical policy materials are identified separately from statutory and regulatory authority.

California Statutes and Regulations

Cal. Code Regs., tit. 5, § 80049.1. Pupil Personnel Services credential authorizations; subdivision (c) addresses state-licensed individuals and agencies assisting in pupil personnel services under PPS supervision.

Cal. Educ. Code §§ 56320, 56322, 56324 & 56327. Special-education assessment procedures, competency of assessment personnel, psychological assessment, and assessment-report requirements.

Cal. Educ. Code §§ 49428.1-49428.2. Behavioral-health referral protocols/model policy, staff training, scope-of-practice alignment, and related requirements.

Cal. Fam. Code § 6924. Minor consent to outpatient mental-health treatment or counseling and parent/guardian involvement.

Cal. Bus. & Prof. Code §§ 4999.20 et seq. Statutory framework governing Professional Clinical Counselors and Associate Professional Clinical Counselors.

Cal. Bus. & Prof. Code § 4999.66. Suicide-risk assessment and intervention education or applied-experience requirements.

Cal. Bus. & Prof. Code § 4999.90. Grounds for LPCC disciplinary action and unprofessional conduct.

Cal. Gov. Code §§ 825 & 995. Public-employee indemnification and defense in qualifying civil actions and proceedings.

Federal Law and Guidance

Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g; 34 C.F.R. Part 99. Federal requirements governing access to and disclosure of personally identifiable information from student education records, including disclosure to school officials with legitimate educational interests and applicable exceptions to prior consent.

U.S. Department of Education, Student Privacy Policy Office. FERPA Guidance and Frequently Asked Questions. Current federal guidance concerning education records, school officials, legitimate educational interests, consent requirements, and exceptions permitting disclosure without consent.

Commission on Teacher Credentialing

California Commission on Teacher Credentialing. Pupil Personnel Services Credential FAQ. Current assignment guidance addressing PPS-aligned duties, appropriate credential authorization, licensed professionals assisting with PPS services, and PPS supervision.

California Commission on Teacher Credentialing. Contracting Mental Health Services. Guidance concerning LEA use of state-licensed mental-health professionals and Title 5, section 80049.1(c).

California Commission on Teacher Credentialing. Services Authorized by PPS Credentials. Descriptions of functions authorized under PPS specializations.

California Board of Behavioral Sciences

California Board of Behavioral Sciences. Statutes and Regulations Relating to the Practices of Professional Clinical Counseling, Marriage and Family Therapy, Educational Psychology, and Clinical Social Work. Current compilation of statutes and regulations governing BBS licensees and registrants.

California Board of Behavioral Sciences. January 2020 Newsletter: "LEPs May Now Supervise Associates for up to 1,200 Hours of Educationally Related Mental Health Services." Historical and current implementation context concerning associate ERMHS experience under qualified LEP supervision.

California Board of Behavioral Sciences. 2019-2020 Policy/Board Materials concerning AB 1651 and ERMHS supervision. Historical policy context regarding the intersection of clinical supervision, associate development, and specialized educational mental-health practice.

California Department of Education

California Department of Education. Senate Bill 153: Model Referral Protocols for Addressing Pupil Behavioral Health Concerns. 2025. Voluntary statewide guidance concerning behavioral-health referral systems, differentiated referrals, trauma-informed care, family involvement and consent, staff roles, FERPA/HIPAA data practices, scope-of-practice limitations, and evaluation.

California Department of Education. Model Policy on Referral Protocols for Addressing Pupil Behavioral Health Concerns. 2025. Model framework addressing referral procedures, authorized staff roles, credential/license alignment, privacy, family involvement, training, and follow-up.

California Department of Education, Diagnostic Center, Northern California. Psychosocial Assessment: Emotional Disability Eligibility / ERMHS training materials. Training for school psychologists and ERMHS assessors addressing social-emotional test selection, qualitative data, comprehensive psychosocial assessment, and systematic analysis.

California Department of Health Care Services

California Department of Health Care Services. Children and Youth Behavioral Health Initiative Fee Schedule Program. Current program information and participation, claims, reimbursement, and school-linked behavioral-health expansion data.

California Department of Health Care Services. State Plan Amendment 26-0008 - Local Educational Agency Medi-Cal Billing Option Program. 2026. Proposed State Plan Amendment concerning updates to the LEA Medi-Cal Billing Option Program, including proposed qualified-practitioner changes relevant to LPCCs and APCCs.

Note on Use of Authorities

These authorities are not offered as evidence that any individual LEA is operating unlawfully or that any single state agency has exclusive jurisdiction over school-based mental-health practice. They provide the legal and regulatory context for the interagency and workforce questions raised in the accompanying issue brief.