Date of Hearing: July 12, 2023

ASSEMBLY COMMITTEE ON EDUCATION
Al Muratsuchi, Chair
SB 509 (Portantino) – As Amended April 20, 2023

SENATE VOTE: 40-0

SUBJECT: School employee and student training: youth mental and behavioral health: mental health education

SUMMARY: Requires, subject to an appropriation, each local education agency (LEA), state special school, and charter school ensure that all students in grades 1 to 12, inclusive, receive evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, middle school, and high school; and requires an LEA, charter school, and state special school to, on or before July 1, 2027, certify to the California Department of Education (CDE) that 75% of its classified and 75% of its certificated employees having direct contact with students at each school have received a youth behavioral health training, as specified. Specifically, **this bill**:

1) Requires each LEA, state special school, and charter school, instead of only those that offer one or more courses in health education to students in middle school or high school, to ensure that all students in grades 1 to 12, inclusive, receive evidence-based, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school, that includes the following:

    a) Reasonably designed instruction on the overarching themes and core principles of mental health;

    b) Defining signs and symptoms of mental health challenges. States that, depending on student age and developmental level, this may include defining conditions such as depression, suicidal thoughts and behaviors, schizophrenia, bipolar disorder, eating disorders, and anxiety, including post-traumatic stress disorder;

    c) Elucidating the evidence-based services and supports that effectively help individuals manage mental health challenges;

    d) Promoting mental health wellness and protective factors, which includes positive development, social and cultural connectedness and supportive relationships, resiliency, problem solving skills, coping skills, self-esteem, and a positive school and home environment in which students feel comfortable;

    e) The ability to identify warning signs of mental health problems in order to promote awareness and early intervention so that students know to take action before a situation turns into a crisis, including instruction on both of the following:

        i) How to seek and find assistance from professionals and services within the school district that includes, but is not limited to, school counselors with a student personnel

services credential, school psychologists, and school social workers, and in the community for themselves or others; and

ii) Evidence-based and culturally responsive practices that are proven to help overcome mental health challenges.

f) The connection and importance of mental health to overall health and academic success and to co-occurring conditions, such as chronic physical conditions, chemical dependence, and substance abuse;

g) Awareness and appreciation about the prevalence of mental health challenges across all populations, races, ethnicities, and socioeconomic statuses, including the impact of race, ethnicity, and culture on the experience and treatment of mental health challenges; and

h) Stigma surrounding mental health challenges and what can be done to overcome stigma, increase awareness, and promote acceptance, including, to the extent possible, classroom presentations of narratives by trained peers and other individuals who have experienced mental health challenges and how they coped with their situations, including how they sought help and acceptance.

2) Requires an LEA (defined as a school district, county office of education (COE), charter school, and state special school to, on or before July 1, 2027, certify to the CDE that 75% of its classified and 75% of its certificated employees having direct contact with students at each school have received a youth behavioral health training, as specified.

3) Requires that the youth behavioral health training be provided to classified and certificated employees during regularly scheduled work hours.

4) States that if a classified or certificated employee receives the youth behavioral health training in a manner other than through an in-service training program provided by the LEA, the employee may present a certificate of successful completion of the training to the LEA for purposes of satisfying this requirement.

5) Prohibits the youth behavioral health training from being a condition of employment or hiring for classified or certificated employees.

6) Permits an LEA to exclude a licensed mental health professional who holds a student personnel service credential from the youth behavioral health training requirement.

7) Authorizes an LEA to meet this requirement by having a school employee who holds a student personnel service credential provide the youth behavioral health training to the school employees, if the training program is identified by the CDE. Requires school employees who provide the youth behavioral health training to other school employees to complete any training requirements necessary, as established by the training program identified, to be authorized to provide training to other school employees.

EXISTING LAW:

1) Requires each LEA, charter school, and state special school that offers one or more courses in health education to students in middle school or high school to include in those courses instruction in mental health which includes all of the following:

    a) Reasonably designed instruction on the overarching themes and core principles of mental health;

    b) Defining signs and symptoms of common mental health challenges. States that, depending on student age and developmental level, this may include defining conditions such as depression, suicidal thoughts and behaviors, schizophrenia, bipolar disorder, eating disorders, and anxiety, including post-traumatic stress disorder;

    c) Elucidating the evidence-based services and supports that effectively help individuals manage mental health challenges;

    d) Promoting mental health wellness and protective factors, which includes positive development, social and cultural connectedness and supportive relationships, resiliency, problem solving skills, coping skills, self-esteem, and a positive school and home environment in which students feel comfortable;

    e) The ability to identify warning signs of common mental health problems in order to promote awareness and early intervention so that students know to take action before a situation turns into a crisis, including instruction on both of the following:

        i) How to seek and find assistance from professionals and services within the school district that includes, but is not limited to, school counselors with a student personnel services credential, school psychologists, and school social workers, and in the community for themselves or others; and

        ii) Evidence-based and culturally responsive practices that are proven to help overcome mental health challenges.

    f) The connection and importance of mental health to overall health and academic success and to co-occurring conditions, such as chronic physical conditions, chemical dependence, and substance abuse;

    g) Awareness and appreciation about the prevalence of mental health challenges across all populations, races, ethnicities, and socioeconomic statuses, including the impact of race, ethnicity, and culture on the experience and treatment of mental health challenges; and

    h) Stigma surrounding mental health challenges and what can be done to overcome stigma, increase awareness, and promote acceptance, including, to the extent possible, classroom presentations of narratives by trained peers and other individuals who have experienced mental health challenges and how they coped with their situations, including how they sought help and acceptance. (Education Code (EC) 51925)

2) Requires the adopted course of study for grades 1 to 6, inclusive, to include instruction, beginning in grade 1 and continuing through grade 6, in specified areas of study that include

health, including instruction in the principles and practices of individual, family, and community health.

3) Requires the Instructional Quality Commission (IQC), during the next revision of the publication "Health Framework for California Public Schools" (Health Curriculum Framework), to consider developing, and recommending for adoption by the State Board of Education (SBE), a distinct category on mental health instruction to educate students about all aspects of mental health.

4) Requires, for purposes of this requirement, that "mental health instruction" include, but not be limited to, all of the following:

   a) Reasonably designed and age-appropriate instruction on the overarching themes and core principles of mental health;

   b) Defining common mental health challenges such as depression, suicidal thoughts and behaviors, schizophrenia, bipolar disorder, eating disorders, and anxiety, including post-traumatic stress disorder;

   c) Elucidating the services and supports that effectively help individuals manage mental health challenges;

   d) Promoting mental health wellness, which includes positive development, social connectedness and supportive relationships, resiliency, problem solving skills, coping skills, self-esteem, and a positive school and home environment in which students feel comfortable;

   e) Ability to identify warning signs of common mental health problems in order to promote awareness and early intervention so students know to take action before a situation turns into a crisis. This should include instruction on both of the following:

      i) How to appropriately seek and find assistance from mental health professionals and services within the school district and in the community for themselves or others; and

      ii) Appropriate evidence-based research and practices that are proven to help overcome mental health challenges.

   f) The connection and importance of mental health to overall health and academic success as well as to co-occurring conditions, such as chronic physical conditions and chemical dependence and substance abuse;

   g) Awareness and appreciation about the prevalence of mental health challenges across all populations, races, ethnicities, and socioeconomic statuses, including the impact of culture on the experience and treatment of mental health challenges;

   h) Stigma surrounding mental health challenges and what can be done to overcome stigma, increase awareness, and promote acceptance. Requires that this include, to the extent possible, classroom presentations of narratives by peers and other individuals who have

experienced mental health challenges, and how they coped with their situations, including how they sought help and acceptance;

5) Requires the IQC, in the normal course of recommending curriculum frameworks to the SBE, to ensure that one or more experts in the mental health and educational fields provides input in the development of the mental health instruction in the health framework.

6) 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 students' ability to learn, fulfill existing state requirements and policies regarding students' health, and contain health care costs through preventive programs and education. (EC 49427).

7) Requires schools to notify students and parents at least twice during the school year on how to access student mental health services on campus or in the community, and authorizes schools to apply to their respective county for a grant from the county's allocation of Mental Health Services Act funds to provide these services. (EC 49428)

8) Requires the CDE to develop model referral protocols for addressing student mental health concerns, in consultation with specified agencies and stakeholders, and authorizes these protocols to be used on a voluntary basis by schools. (EC 49428.1)

9) Requires the CDE, by January 1, 2023, to recommend best practices, and identify evidence-based and evidence-informed training programs for schools to address youth behavioral health, including staff and student training, contingent upon an appropriation for this purpose. (EC 49428.15)

10) Requires COEs, in consultation with the CDE and other relevant state and local agencies, to coordinate agreements between school districts and charter schools within the county in order to develop a system through which qualified mental health professionals and other key school personnel employed by individual school districts and charter schools throughout the county could be rapidly deployed on a short- or long-term basis to an area of the county that has experienced a natural disaster or other traumatic event, in order to provide support to students and staff. (EC 49429.5)

11) Establishes the California Youth Behavioral Health Initiative (CYBHI) to be administered by the California Health and Human Services Agency (CHHSA), to transform California's behavioral health system in which all children and youth 25 years of age and younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs. (Welfare and Institutions Code (WIC) 5961)

12) Requires the Department of Health Care Services (DHCS) to award competitive grants for school-linked behavioral health partnership grants to eligible entities, including counties and city mental health departments, tribal entities, LEAs, higher education institutions, publicly funded early childhood education providers, health care service plans, community-based organizations, and behavioral health providers. (WIC 5961.2)

13) Requires the DHCS to make incentive payments to qualifying Medi-Cal managed care plans to increase access to behavioral health services in publicly funded childcare and K-12 schools. (WIC 5961.3)

14) Requires the DHCS to develop a statewide fee schedule for school-linked outpatient mental health and substance use disorder treatments provided at a schoolsite. (WIC 5961.4)

15) Requires the DHCS to develop and select evidence-based interventions and community-defined promising practices to improve outcomes for children and youth with or at high risk for behavioral health conditions. Requires the DHCS or a contracted vendor to provide competitive grants to entities deemed qualified to support implementation of evidence-based interventions/promising practices. (WIC 5961.5)

16) Establishes the Mental Health Student Services Act (MHSSA) as a 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 COE within a county. Requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to award grants to fund partnerships, subject to an appropriation being made for this purpose. (WIC 5886)

FISCAL EFFECT: According to the Senate Appropriations Committee, while the provisions of the bill would be contingent upon an appropriation, it could lead to significant Proposition 98 General Fund cost pressure to fund the mental and behavioral health training programs. Assuming a training cost of $150 each for all certificated and classified employees having direct contact with students in behavioral health, statewide costs could be in the tens of millions of dollars on a one-time basis.

COMMENTS:

Need for the bill. According to the author, "Education about mental health is one of the best ways to increase awareness, empower students to seek help, and reduce the stigma associated with mental health challenges. Schools are ideally positioned to be centers of mental health education, healing, and support. As children and youth spend more daytime hours at school than at home, the public education system is the most efficient and effective setting for providing universal mental health education to children and youth.

Historically, health education in subjects such as alcohol, tobacco and drugs, the early detection of certain cancers, and HIV have become required because they were recognized as public health crises. The mental health of our children and youth has reached a crisis point. California must make educating its youth about mental health a top priority."

Health education in California schools. According to data published by the CDE, in the 2018-19 school year, over 170,400 middle and high school students were enrolled in a Health Education course. Nearly 12,000 health courses were offered, in over 1,600 schools. Health education is sometimes provided in courses not specifically designated as health courses, such as in physical education and or an advisory period, and if this bill were to be enacted, LEAs which do not require a health course for graduation would need to provide this instruction in such a manner. As noted above, the adopted course of study for grades 1 to 6, inclusive, includes

content in health, but the amount of time dedicated to health education in those grades is not reported to the state.

A course in health is not a statewide graduation requirement, but current law authorizes school districts to establish local graduation requirements in addition to those required by state law, and some school districts have chosen to make a course in health a local graduation requirement. According to school district websites reviewed this year, 6 of the largest 10 school districts by enrollment require a course in health for graduation.

This bill is modeled after the California Healthy Youth Act (CHYA), which requires schools to teach comprehensive sexual health education and HIV prevention education in three grade spans and specifies content, instructional, and instructor training requirements. The content of the instruction required by this bill largely mirrors the content required to be considered for inclusion in the Health Curriculum Framework under current law.

Recently adopted Health Curriculum Framework includes mental health content. California has adopted both content standards and a curriculum framework for health. On May 8, 2019, the SBE adopted the current Health Education Curriculum Framework. The revised framework includes a significant amount of content and guidance on instructional strategies relating to mental health, including most if not all of the content required to be considered for inclusion under current law. After a new curriculum framework is adopted, the SBE typically adopts instructional materials for grades K-8 which align to the framework, but in 2020 the SBE cancelled the adoption of health instructional materials due to lack of publisher interest.

No information about the implementation of the current requirement to teach mental health content in secondary health courses. Current law requires each LEA, charter school, and state special school that offers one or more courses in health education to students in middle school or high school to include in those courses instruction in mental health which includes specified content. This requirement went into effect on January 1, 2022, during the 2021-22 school year. No information appears to be available on the implementation of this requirement to date. ***The Committee may wish to consider*** whether it is premature to expand this requirement when it is not clear how the recently enacted requirement is being implemented.

This bill mandates the training of school staff. This bill requires LEAs to provide training on youth behavioral health to at least 75% of certificated and classified staff with direct contact with students by January 1, 2027, contingent upon an appropriation for this purpose. The training provided must be evidence-based or evidence-informed as identified by the CDE and is to be provided during regular working hours.

There are a multitude of important staff development topics and a limited time for training within or outside of the school day. It is important that LEAs have the ability, in consultation with their employees, to identify those topics of most urgent need at a given time. Although there is a clear value in behavioral health training, ***the Committee may wish to consider whether a state requirement for training of staff potentially interferes with the ability of LEAs to identify own their priorities for staff development.***

Youth mental health crisis intensifying because of the COVID-19 pandemic. The trauma, grief, isolation, and stress experienced during the COVID-19 pandemic further strained California's children, youth, and families, resulting in decreased social connectedness, poorer

educational outcomes, increased depression and anxiety, and increased loss of young life. Recent data illustrates the poor behavioral outcomes for children and youth in California:

- Mental health is the #1 reason children ages 0-17 are hospitalized;
- Suicide is the #2 cause of death for youth ages 10-24;
- 1 in 5 children live with a mental health diagnosis; and
- 58% of adolescents with family incomes below the poverty line reported moderate to serious psychological distress. (Breaking Barriers, 2023*)*

Disparities in incidence of mental health issues. Structural inequities and racism, exacerbated by the inequitable delivery of behavioral health services, lead to worse mental and behavioral health outcomes for youth and families in underserved communities. Those in marginalized and minority populations are disproportionately affected, including those who identify as Black and Brown, Native American, Asian American and Pacific Islander; girls and women; those who are LGBTQIA+, and those with disabilities. (Breaking Barriers, 2023*)*

National data from the Centers for Disease Control and Prevention (CDC)'s Youth Risk Behavior Survey 2011-2021 illustrates these disparities:

- In 2021, 42% of high school students felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities. Female students were more likely than male students to experience persistent feelings of sadness or hopelessness. Hispanic and multiracial students were more likely than Asian, Black, and White students to experience persistent feelings of sadness or hopelessness. LGBTQ+ students and students who had any same-sex partners were more likely than their peers to experience persistent feelings of sadness or hopelessness.

- In 2021, 29% of high school students experienced poor mental health during the past 30 days. Female students were more likely than male students to experience poor mental health. Asian and Black students were less likely than Hispanic and multiracial students to experience poor mental health. Asian students were also less likely than White students to experience poor mental health. LGBTQ+ students and students who had any same-sex partners were more likely than their peers to experience poor mental health.

- In 2021, 22% of high school students seriously considered attempting suicide during the past year. Female students were more likely than male students to seriously consider attempting suicide. Asian students were less likely than students from most other racial and ethnic groups to seriously consider attempting suicide. LGBTQ+ students and students who had any same-sex partners were more likely than their peers to seriously consider attempting suicide.

- In 2021, 10% of high school students attempted suicide one or more times during the past year. Female students were more likely than male students to attempt suicide. Black students were more likely than Asian, Hispanic, and White students to attempt suicide. LGBTQ+ students and students who had any same-sex partners were more likely than their peers to attempt suicide.

Schools providing mental health services. Across the country, school systems are increasingly joining forces with community health, mental health, and social service agencies to promote student well-being and to prevent and treat mental health disorders. Utilizing the school environment—where children spend a significant part of their day—for early intervention brings public health efforts to the students, meeting children where they are and therefore providing more accessible services to those in need. It also provides immediate and continuing resources to students without requiring families to search for already limited sources of care.

Mental health services that are provided in schools may include counseling, brief interventions to address behavior problems, assessments and referrals to other systems. Providing mental health services in a school-based setting helps address barriers to learning and provides supports so that all students can achieve in school and ultimately in life. Schools are also places where prevention and early intervention activities can occur in a non-stigmatizing environment.

According to the Orange County Department of Education, "California's Multi-Tiered System of Support (MTSS) is a comprehensive framework that aligns academic, behavioral, and social-emotional learning in a fully integrated system of support for the benefit of all students. The evidence-based domains and features of the California MTSS framework provide opportunities for LEAs to strengthen school, family, and community partnerships while developing the whole child in the most inclusive, equitable learning environment thus closing the equity gaps for all students." Comprehensive school mental health programs offer three tiers of support within an MTSS approach:

- Tier 1: Universal mental health promotion activities for all students;
- Tier 2: Selective prevention services for students identified as at risk for a mental health problem; and
- Tier 3: Indicated services for students who already show signs of a mental health problem.

California lags in providing critical mental health support to students. Recent research on access to comprehensive school-based mental health services in California (Romer, 2022) includes the following key findings:

- Students in California had significant mental health and related support needs prior to the pandemic that have only further increased;
- Despite growing student mental health needs, critical school and community behavioral and mental health staffing shortages persist;
- School-based mental health referral pathways are not always aligned and coherent, and approaches to service delivery vary greatly across the state;
- Limited funding flexibility and varied understanding of how to navigate, maximize, and plan for sustainability of available funding sources constitute a key barrier to expanding access to mental health services for students; and

- A limited understanding of complex privacy laws and regulations by educational leaders and community partners can be a barrier to providing school-based mental health services.

Schools offering mental health services may provide services with credentialed school staff trained to address student mental health needs, and/or 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 students. The distribution of support personnel in schools differs significantly from one school district to another throughout the state, but it is clear from the CDE data below that, as a state, California lacks sufficient numbers of trained personnel in our schools to meet the mental health needs of over six million students. The recommended ratios are those of the relevant national organizations.

School health professional	**Number 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

A 2022 report by the California Future Health Workforce Commission notes that California has a severe workforce shortage, with too few of the right types of health workers in the right places to meet the needs of the population. Millions of Californians struggle to access the care they need, and the COVID-19 pandemic has made it clear that under-resourced communities and communities of color are hit hardest by an inadequate workforce. The aging of a generation of baby boomers will exacerbate the shortages in primary care, behavioral health care, and among workers who care for older adults.

This shortage holds true for the public education system in California as well. Schools are facing a severe workforce shortage across multiple job classifications, including the Student Personnel Service (PPS) credentialed professionals identified in the table above.

One-time investments in school mental health. In recognition of the crisis in youth mental health due in part to the COVID-19 pandemic, coupled with the state's unprecedented budget surplus in recent years, the State funded, one-time investments in counties, districts, schools, and health plans that are eligible to receive dollars to implement various student mental health projects. The table below outlines some of the more than $5 billion in one-time investments made available since 2020 for California students to address mental health staffing, service delivery, and interagency linkages.

Initiative	**Overview**	**Funding available**
Mental Health Student	Funds support services including: services provided on	$255 million

Initiative	Overview	Funding available
Services Partnership Grant Program (MHSSA)	school campuses; suicide prevention services; drop-out prevention services; and outreach to high-risk youth and young adults, including foster youth, youth who identify as LGBTQ+, and youth who have been expelled or suspended from school.	
School-Linked Partnership and Capacity Grants*	Grants to support behavioral health services to students (age 0 -25) provided by schools, behavioral health providers at or near a school site, school affiliated community-based organizations, or school-based health centers.	$550 million ($400 million for K-12 and $150 million for higher education)
Student Behavioral Health Incentive Program (SBHIP)*	Incentive payment funding for MediCal Managed Care Plans to build infrastructure, partnerships, and capacity statewide for school behavioral health services.	$389 million
Behavioral Health Coach Workforce*	Expands behavioral health workforce to serve youth through the creation of the new Wellness Coach role.	$360 million

*Component of the Children & Youth Behavioral Health Initiative (CYBHI)
Source: *One-Time Investments for School Mental Health*, Children Now, January 2023

Youth mental health trainings are currently available to LEAs. The CDE, with the support of federal funding, offers access to Youth Mental Health First Aid (YMHFA) training to district and school staff statewide. According to the CDE, "YMHFA is a research-based curriculum created upon the medical first aid model. It is designed to provide parents, family members, caregivers, teachers, school staff, neighbors, and other caring adults with skills to help a school-age child or youth who may be experiencing emotional distress, the onset of a mental illness, addiction challenge or who may be in crisis. YMHFA participants learn to recognize signs and symptoms of children and youth in emotional distress, initiate and offer help, and connect the youth to professional care through a five-step action plan. This no-cost training is currently delivered virtually through two hours of self-paced learning and five and a half hours of instructor-led training. The training can be delivered in evenings, weekends, and is also available in Spanish."

The YMHFA training is a part of the Project Cal-Well initiative, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and is designed to raise awareness of mental health and expand access to school and community-based mental health services for youth, families and school communities. The CDE has received $250,000 per year in federal funds between 2014-2019, as well as $70,000 in philanthropic funds, for a total of $1.3 million to date. This included funding for CDE to designate one staff member as YMHFA Program Coordinator; six staff members to be certified as YMHFA instructors; funding for three LEAs to administer trainings and train a minimum of 125 participants per year; pay stipends to external instructors for delivering the training; purchasing of participant manuals; and travel expenses for trainers.

Project Cal-Well was initially launched by the CDE in partnership with three Southern California LEAs from 2014-2019: Garden Grove Unified, ABC Unified and San Diego County Office of Education (COE). Building off successes and lessons learned from the first cycle, the CDE is partnering with three LEAs in Northern California for the second cycle (2019-2024): Humboldt,

Stanislaus and Sacramento COEs and will serve students and families from an additional eight school districts across five counties.

Should LEAs be required to use training programs identified by CDE? This bill requires that the mandated training used by LEAs be an evidence-based or evidence-informed youth behavioral health training program identified by the CDE as meeting specified requirements. According to the CDE, in addition to the YMHFA referenced above, there are additional evidence-based or evidence-informed programs. The CDE is currently partnering with Wellness Together to build a suite of evidence-informed asynchronous trainings for middle and high school staff, students, and families. These will be rolled out in phases, with Phase I focused on anxiety and basic mental health; and Phase II with modules on depression and emotional regulation. If additional funding is secured, Phase III is intended to include suicide prevention.

Representatives of LEAs have noted that many LEAs have well established training programs in place to train school staff and students in behavioral health issues, including suicide prevention. These programs may involve an existing contract or MOU with a provider or, in some cases, may have been developed locally by an LEA or COE to meet the unique needs of a particular student population or subgroup of students. LEAs express concern that limiting LEAs to use only CDE-approved trainings could jeopardize the success of existing programs that are effectively meeting the needs of students. There is clearly a role for CDE to provide information on appropriate trainings for those LEAs who do not have such programs in place, but ***the Committee may wish to consider*** whether requiring LEAs to use only CDE-approved trainings would lead to the unintended consequence of disrupting existing successful local programs and initiatives.

Arguments in support. The California Council of Behavioral Health Agencies writes, "SB 509 builds upon the success of SB 224 (Portantino, 2021), requiring that all students between grades 1 and 12 receive evidence based age-appropriate mental health education from a qualified instructor at least one time during elementary school, one time during middle school, and one time during high school. Education about mental health is one of the best ways to increase awareness, empower students to seek help, and reduce the stigma associated with mental health challenges.

The Centers for Disease Control (CDC) reports the percentage of children aged 3-17 who suffer from depression and anxiety has steadily risen this century. The CDC also estimates that approximately 4.5 million children in that age range have been diagnosed with a mental health or substance use disorder.

Under existing law, the California Department of Education is required to identify an evidence-based mental health training program for local educational agencies to use to train teachers and other school personnel who have direct contact with students. However, schools are not mandated to require such training for their staff. This differs from other mandated trainings for school personnel including CPR and Mandated Reporting.

Evidence-based education about mental health is one of the best ways to increase awareness, empower students to seek help, and reduce the stigma associated with mental health challenges. Schools are ideally positioned to be centers of mental health education, healing, and support. As children and youth spend more hours at school than at home, the public education system is the

most efficient and effective setting for providing universal mental health education to children and youth."

Arguments in opposition. The California Teachers Association writes, "CTA is opposed to the training mandate and suggests it be replaced with a "grant" program administered by the California Department of Education (CDE) funded by an appropriation to CDE. LEAs, in consultation with impacted collective bargaining representatives, could apply to CDE for funding to conduct youth behavioral health training based on "model" student behavioral health referral protocols developed by CDE as a result of AB 309 (Chpt. 662-2021) along with best practices and evidence-based and informed training programs addressing youth behavioral health as a result of SB 14 (Chpt. 672-2021) or local training programs developed by LEAs.

All employee youth behavioral health training, regardless of the frequency, length, and/or the specificity of the topics to be covered, must be collectively bargained at the local level.

CTA continues to express concerns around the liability of school employees and/or the school district after completing youth behavioral health training? How frequently is training to be repeated/updated? What kind of training will employees receive in a 60- to 90-minute format versus a multi-day format particularly given the instruction is to include 'recognizing the signs and symptoms of youth behavioral health disorders including common psychiatric conditions such as schizophrenia, bipolar disorder, major clinical depression, and anxiety disorders.'

SB 509 must clarify whether trained employees would be required to notify a school administrator if they 'believe' a student has behavioral health issues; as well as the consequences if a trained school employee in youth behavioral health fails to identify a student with behavioral health issues."

Recommended Committee amendments. Staff recommends that the bill be amended as follows:

1) Limit the training requirement to certificated and classified staff serving students in grades 7-12 (the grades for which the CDE-identified evidence-based program is designed); require that all 100% (instead of 75% of) certificated staff be trained and 40% of classified staff having direct contact with pupils be trained; and move the training requirement into a new section so that it is no longer subject to an appropriation.

2) Require that CDE identify evidence-based training programs on mental health for teachers of students enrolled in kindergarten to grade 6, by January 1, 2025.

3) Delete the requirement that each LEA, state special school, and charter school ensure that all students in grades 1 to 12 receive evidence-based, age-appropriate mental health education at least once in junior high school or middle school, as applicable, and at least once in high school, and instead add mental health to the health curriculum in the course of study for grades 1 to 6.

Related legislation. SB 224 (Portantino) Chapter 675, Statutes of 2022, requires LEAs, charter schools, and the state special schools that offer courses in health education to students in middle school or high school to include in those courses instruction in mental health that meets specified

requirements, and requires the CDE, by January 1, 2024, to develop a plan to increase mental health instruction in California public schools.

SB 387 (Portantino) of the 2021-22 Session would have required an LEA, on or before January 1, 2025, to certify to the CDE that 75 percent of its classified and certificated employees who have direct contact with students at each school have received specified youth behavioral health training. This bill was held in the Assembly Education Committee.

SB 14 (Portantino) Chapter 672, Statutes of 2021 adds "for the benefit of the mental or behavioral health of the student" to the list of categories of excused absences for purposes of school attendance; would require the CDE to identify an evidence-based training program for LEAs to use to train classified and certificated school employees having direct contact with students in youth mental and behavioral health and an evidence-based mental and behavioral health training program with a curriculum tailored for students in grades 10 to 12, inclusive.

AB 309 (Gabriel) of this Session requires the CDE to develop model student mental health referral protocols, in consultation with relevant stakeholders, subject to the availability of funding for this purpose.

AB 563 (Berman) of the 2021-22 Session would have required the CDE to establish an Office of School-Based Health Programs for the purpose of improving the operation of, and participation in, school-based health programs. Would have required that $500,000 in federal reimbursements be made available for transfer through an interagency agreement to CDE for the support of the Office.

AB 586 (O'Donnell) of the 2021-22 Session would have established 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. Lessons learned through the pilot project would be used as a basis to scale up robust and sustainable school-based health and mental health services throughout the state.

SB 428 (Pan) of the 2019-20 Session would have required the CDE to identify an evidence-based training program for local educational agencies to use to train classified and certificated school employees having direct contact with students in youth mental and behavioral health. SB 428 was vetoed by the Governor, who stated:

> This bill would require the CDE to identify an evidence-based training program on youth mental health for LEAs to use to train classified and certificated employees who have direct contact with students at each school site. Providing support for students facing mental health is of critical importance. Multiple public agencies beyond CDE hold a responsibility for addressing the mental health crisis impacting young people today. That is why I worked with the Legislature to appropriate $50 million in this year's budget to create the Mental Health Student Services Act. Mental health partnerships among county mental health or behavioral health departments, school districts, charter schools and county offices of education are best positioned to address the diverse mental health needs of young people.

AB 1808 (Committee on Budget) Chapter 32, Statutes of 2018, requires the CDE to identify one or more evidence-based online training programs that an LEA can use to train school staff and

students as part of the LEA's policy on student suicide prevention. Also requires the CDE to provide a grant to a COE to acquire a training program identified by the CDE and disseminate that training program to LEAs at no cost. Also appropriates, for the 2018–19 fiscal year, the sum of $1,700,000 from the General Fund to the SPI for these purposes.

AB 329 (Weber), Chapter 398, Statutes of 2015, requires LEAs to provide instruction in sexual health education, revises HIV prevention education content, expands topics covered in sexual health education, requires this instruction to be inclusive of different sexual orientations, and clarifies parental consent policy.

SB 330 (Padilla), Chapter 481, Statutes of 2013, requires, when the Health Framework was next revised, the IQC to consider developing and recommending to the SBE a distinct category on mental health instruction to educate students about all aspects of mental health.

REGISTERED SUPPORT / OPPOSITION:

Support

American Foundation for Suicide Prevention
Blue Shield of California
Board of Behavioral Sciences
California Access Coalition
California Alliance of Caregivers
California Alliance of Child and Family Services
California Association for Behavior Analysis
California Coalition for Mental Health
California Coalition for Youth
California Council of Community Behavioral Health Agencies
California State Association of Psychiatrists
California Youth Empowerment Network
Children Now
Children's Institute
Common Sense Media
Community Solutions for Children, Families and Individuals
DBSA California
Democratic Club of Claremont
East Bay Children's Law Offices
Hillsides
Los Angeles County Office of Education
Mental Health America of California
Mental Health Services Oversight and Accountability Commission
Monarch School
National Association of Social Workers, California Chapter
National Center for Youth Law
National Council for Mental Wellbeing
National Health Law Program
Nextgen California
Pallet Shelter
Pathpoint

Reach Out
Steinberg Institute
Sycamores
Tessie Cleveland Community Services Corporation
The California Association of Local Behavioral Health Boards and Commissions
The Kennedy Forum
2 individuals

Oppose

California Teachers Association
California School Boards Association

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