Date of Hearing: June 12, 2024

ASSEMBLY COMMITTEE ON EDUCATION
Al Muratsuchi, Chair
SB 1318 (Wahab) – As Amended May 16, 2024

SENATE VOTE: 32-7

SUBJECT: Pupil health: suicide prevention policies: pupil suicide crisis

SUMMARY: Requires the California Department of Education (CDE), by July 1, 2026, to update the model suicide prevention policy to address crisis intervention protocols and requires local educational agencies (LEAs) to update their suicide prevention policies to include crisis intervention protocols. Specifically, **this bill**:

1) Requires the CDE, by July 1, 2026, to update the model suicide prevention policy to address crisis intervention protocols that LEAs must follow in the event of a student suicide crisis, including all of the following:

    a) The process by which staff and external agencies are deployed to address a pupil suicide crisis, including a prioritization of the use of school mental health professionals;

    b) If a school mental health professional is not available, the protocol would suggest that a school employee who has completed youth behavioral health training may be deployed to provide interim care and a warm handoff to a mental health professional;

    c) If a trained school employee is not available, the protocol must identify one or more community-based organizations, mobile crisis units, 988 services, or other qualified mental health professionals to be contacted;

    d) Law enforcement be involved and notified only when a student's life is in imminent danger and their needs cannot be addressed by a mental health professional;

    e) The assessment process that a law enforcement officer should follow to determine whether the student involved in the suicide crisis would be endangered by parental notification; and

    f) The student be informed if their parent or guardian is notified.

2) Requires the governing board or body of an LEA, on or after July 1, 2026, during the next regularly scheduled review of their suicide prevention policy to update the policy to include crisis intervention protocols in alignment with the model policy developed by the CDE.

3) Requires an LEA governing board or body, at each meeting where they are reviewing their policy on suicide prevention, to discuss whether funding should be identified to hire a school mental health professional if they do not employ or contract with a mental health professional.

4) Defines the following terms for the purpose of this section:

a) "Local educational agency" as a county office of education (COE), school district, state special school, or charter school.

b) "Mental health professional" means an individual licensed or registered, or an intern or associate working towards licensure, by the Board of Behavioral Sciences or the Board of Psychology in the Department of Consumer Affairs.

c) "School mental health professional" means a school employee with a clear or preliminary pupil personnel services (PPS) credential with a specialization in school counseling, school social work, or school psychology, a credentialed school nurse, or a licensed, registered, or associate marriage and family therapist, professional clinical counselor, clinical social worker, educational psychologist, or psychologist under the supervision of a school employee with a PPS or administrative services credential.

d) "Pupil suicide crisis" means any of the following: a student who is exhibiting suicidal thoughts or behaviors, a student who has completed a suicide risk assessment and is determined to be at risk of suicide, or a student who is attempting to physically harm themselves or others.

EXISTING LAW:

1) Requires the governing board of an LEA that serves pupils in grades 7 to 12 to adopt, before the 2017-18 school year, procedures relating to suicide prevention, intervention, and postvention in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts. (Education Code (EC) 215)

2) Requires the governing board of an LEA that serve pupils in kindergarten to grade 6 to adopt, before the 2020-21 school year, a policy on pupil suicide prevention in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts. (EC 215)

3) Requires the CDE to develop and maintain a model suicide prevention policy to serve as a guide for LEAs. (EC 215)

4) Requires the CDE to identify one or more evidence-based online training programs that a LEA can use to train school staff and pupils as part of the LEAs policy on pupil suicide prevention. (EC 216)

5) 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)

6) 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)

7) Requires, beginning July 1, 2019, a public school, including a charter school, or private school that serves students in grades 7 to 12, and a public or private institution of higher education, that issues student identification cards to have printed on either side of the cards

the telephone number for the National Suicide Prevention Lifeline, 1-800-273-8255. (EC 215.5)

8) Authorizes, beginning July 1, 2019, a public school or private school that serves students in any of grades 7-12 that issues student identification cards to have printed on either side of the cards:

   a) The Crisis Text Line, which can be accessed by texting HOME to 741741; and

   b) A local suicide prevention hotline telephone number. (EC 215.5)

9) Authorizes a school district to establish a security department or a school police department. (EC 38000)

10) Requires a school police officer to successfully complete a basic course of training prescribed by the Commission on Peace Officer Standards and Training (POST) before exercising the powers of a peace officer; requires POST to prepare a specialized course of instruction for the training of school peace officers to meet the unique safety needs of a school environment; and requires any school police officer to successfully complete the specialized course of training within two years of first employment. (Penal (PEN) 832.3)

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) 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, this bill could result in a reimbursable state mandate for school districts to develop mental health crisis intervention protocols, as specified. Costs will vary by LEA but statewide Proposition 98 General Fund costs could be in the hundreds of thousands of dollars on a one-time basis to develop the protocols. This bill could also result in additional, unknown local cost pressures for LEAs to provide training related to youth behavioral health for teachers.

COMMENTS:

Need for the bill. According to the author, "The rising suicide rate among California's children is unprecedented, and it is time to take action. In the first year of the pandemic, intentional self-harm among children aged 13-18 increased by 91%, and without making substantial changes to our youth suicide prevention policies, this statistic will not improve. SB 1318 is a strong step to provide children with the professional mental health support they need in times of crisis. The bill clarifies that the involvement of law enforcement officers, including resource officers, should be

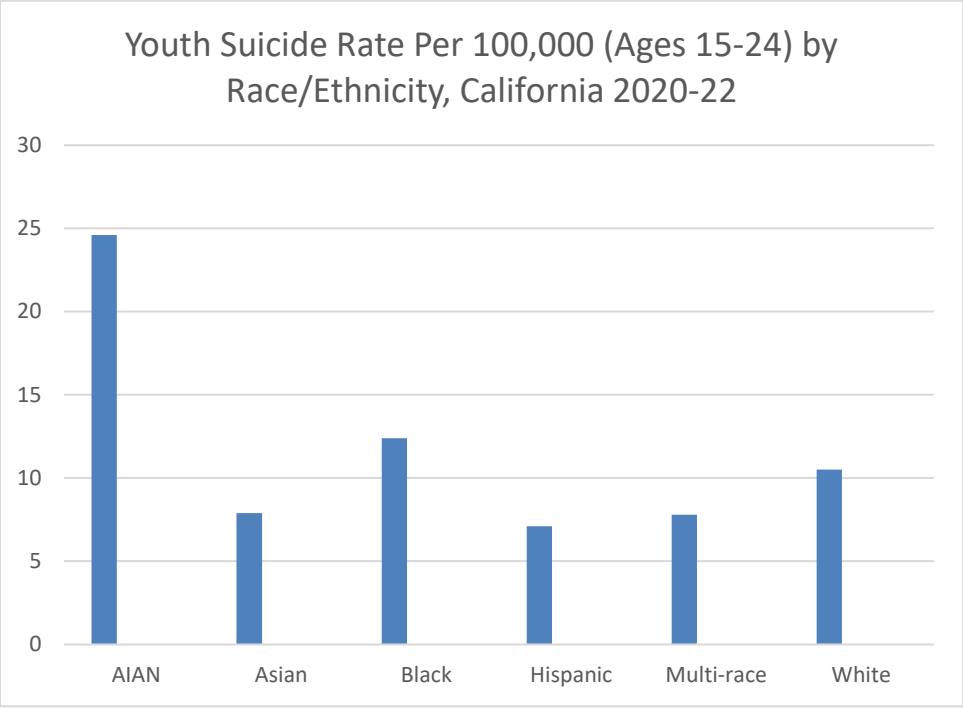
the final step to protect a child's life, and that connection with mental health professionals should be the first. SB 1318 is a lifeline for our most vulnerable youth."

Youth mental health crisis intensifying as a result of the COVID-19 pandemic. The American Academy of Pediatrics noted in recent guidance that "emotional and behavioral health challenges were of growing concern before the COVID-19 pandemic, and the public health emergency has only exacerbated these challenges." Prior to the pandemic, the incidence of youth mental health crises was increasing at an alarming rate.

Since the pandemic began, rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders, have increased. Mental health issues are the number one reason that California children are hospitalized. In 2022, 19% of child hospitalizations were due to mental diseases and disorders, up from 9% in 2002. (California Department of Health Care Access and Information)

Youth suicide risk. According to the Lucile Packard Foundation for Children's Health, "Youth suicide and self-inflicted injury are serious social and public health concerns. Approximately 157,000 youth ages 10-24 are treated for self-inflicted injuries in emergency rooms every year. Self-inflicted injuries are not necessarily the result of suicide attempts; in fact, self-harm without the intent to die is more prevalent than self-harm with such intent.

Some groups are at a higher risk for suicide than others. Males are more likely than females to commit suicide, but females are more likely to report attempting suicide. Among racial/ethnic groups with data, American Indian/Alaska Native youth have the highest suicide rates. Research also shows that lesbian, gay, and bisexual youth are more likely to engage in suicidal behavior than their heterosexual peers. Several other factors put teens at risk for suicide, including a family history of suicide, past suicide attempts, mental illness, substance abuse, stressful life events, low levels of communication with parents, access to lethal means, exposure to suicidal behavior of others, and incarceration.



National and statewide data show suicide to be the third leading cause of death among young people aged 15-24. In California, in 2022 the youth suicide rate was 6.2 per 100,000 for those aged 15-19 years. This varies substantially by geographic region, by race/ethnicity, and gender. *Source: CDPH, 2020-22*

In early 2021, emergency department visits in the U.S. for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same period in 2019 (Yard, 2021). In California, 15,030 females and 5,119 males aged 10-25 years old visited emergency rooms in 2021 for self-harm. The gender breakdown reverses for deaths as 469 males and 156 females died due to suicides. (Griffin, 2022)

The California Healthy Kids Survey is a research-based assessment of all the major domains of school climate as it affects students, staff, and parents. It measures a multitude of factors including but not limited to, engagement; school safety; mental, behavioral, and physical health, including substance abuse, depression/suicide risk, and other health risks. Results from the 2020-22 survey include the following:

- One-fifth of 5th graders report being sad most or all of the time;
- About one-third of 7th and 11th graders report incapacitating sadness and 15% report contemplating suicide;
- Between 49%–60% of 7th and 11th graders who have been bullied report incapacitating sadness and 30% report contemplating suicide;
- Eleventh graders reported the highest levels of sadness and suicide risk, with 37% reporting incapacitating sadness and 16% reporting that they had contemplated suicide;
- Females in secondary schools had a far greater risk of incapacitating sadness and suicide ideation than males. Among 7th graders, 36% of females report chronic sadness, and 19% report contemplating suicide. This compares to 21% and 10%, respectively, among males; and
- Almost half (46%) of 11th grade females reported chronic sadness and 20% reported contemplating suicide, compared to 27% and 12% of males, respectively.

Schools are required to have suicide prevention policies. Current law requires public schools serving students in kindergarten through 12th grade to adopt a suicide prevention policy and to review the policy and update it, if necessary, at least every five years. The policy is to be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts and at a minimum address procedures relating to prevention, intervention, and postvention.

The adopted policy must also specifically address the needs of high-risk groups, including but not limited to: youth bereaved by suicide; youth with disabilities, mental illness, or substance use disorders; youth experiencing homelessness or in out-of-home settings such as foster care; and lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) youth. The policy must address any training provided to teachers on suicide awareness and prevention and ensure school employees act within the authorization and scope of their credential or license. The training should not be interpreted to mean it is authorizing or encouraging a school employee to diagnose or treat mental illness unless the employee is specifically licensed and employed to do so.

The model suicide prevention policy provided by the CDE includes an action plan for suicide attempts in-school or during school sponsored events, including the following steps to be implemented:

- Remain calm, remember the student is overwhelmed, confused, and emotionally distressed;
- Move all other students out of the immediate area;
- Immediately contact the administrator or suicide prevention liaison;
- Call 911 and give them as much information about any suicide note, medications taken, and access to weapons, if applicable;
- Parents/guardians/caregivers/families should be contacted as soon as possible;
- Do not send the student away or leave them alone, even if they need to go to the restroom;
- Listen and prompt the student to talk;
- Review options and resources of people who can help;
- Be comfortable with moments of silence as you and the student will need time to process the situation;
- Provide comfort to the student;
- Promise privacy and help, and be respectful, but do not promise confidentiality; and
- Students should only be released to parents/guardians/caregivers/families or to a person who is qualified and trained to provide help.

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 California lacks sufficient numbers of trained personnel in our schools to meet the mental health needs of over six million students.

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 Pupil Personnel Service (PPS) credentialed professionals.

Pupil Personal Service (PPS) Credential. This bill would require the protocols to specify that school employees who hold a PPS credential be prioritized for interactions with youth experiencing a suicide crisis before engaging community-based organizations and law enforcement, in that order, as specified.

PPS credential holders may work with individual students, groups of students, or families to provide the services authorized by their credentials to address the needs of all students by providing a comprehensive PPS program. PPS credential covers services for individuals who serve as counselors, school psychologists, school social workers, school nurses, and school child welfare and attendance regulators.

Statewide investments in youth 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.

Many of these programs are a part of the CYBHI. As noted on the Department of Health Care Services (DHCS) website, the CYBHI is a $4.6 billion investment in youth behavioral health designed to focus on promoting social and emotional well-being, preventing behavioral health

challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health (mental health and substance abuse) needs for children and youth ages 0-25 years. The CYBHI initiatives offering school-linked services include:

- Statewide multi-payer school linked fee schedule;
- School-linked partnerships and capacity grants;
- Mindfulness, resilience, and well-being supports;
- Youth peer-to-peer support program;
- School behavioral health incentive program (SBHIP); and
- CalHOPE student support.

In addition to these, in January 2024, the DHCS, in partnership with Kooth and Brightline, launched two behavioral health virtual services platforms for children, youth, and families. Launching as a part of the state's CalHOPE program, with funding from the CYBHI, the web- and app-based platforms will offer all California residents, regardless of insurance coverage, free one-on-one support with a live coach, a library of multimedia resources, wellness exercises, and peer communities moderated by trained behavioral health professionals to ensure the appropriateness of content and the safety of all users. These new CalHOPE platforms will complement existing services offered by health plans, counties, and schools by providing additional care options and resources for parents and caregivers, children, youth and young adults in California.

Initiative	**Overview**	**Funding available**
Mental Health Student Services Partnership Grant Program (MHSSA)	Funds support services provided on 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.	$255 million
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

Initiative	Overview	Funding available
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 behavioral health training and support. SB 14 (Portantino, Chapter 672, Statutes of 2021) required the CDE to recommend, by January 1, 2023, best practices and identify evidence-based and evidence-informed training programs for schools to address youth behavioral health, including, but not necessarily limited to, staff and pupil training. The CDE has identified Youth Mental Health First Aid (YMHFA), a research-based curriculum created upon the medical first aid model, to meet this requirement. 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. The ideal audience for this training includes teachers, administrators, nurses, counselors, and any other credentialed staff, classified staff (school secretaries, registrars, yard supervisors, campus monitors, bus drivers, lunch staff, janitors, aides, after school staff, etc.), parents, youth employers, and other community partners that have contact with students.

The CDE has also convened a Statewide Suicide Postvention Response Team (SSPRT) to support districts in navigating the journey after a youth or staff suicide. The primary goal of the SSPRT is to offer support and guide a district affected by a suicide. The CDE website notes that the SSPRT will serve as a support with whom districts can discuss the postvention process. The team will help affected LEAs receive accurate and timely information, resources to fill in identified gaps; assistance with messaging to staff, parents, students, and the media; and help them find ways to support staff, parents, families, and students. The SSPRT is also designed to help LEAs build their capacity and connect them to their local resources, including their COE, county behavioral health department, and community mental health and suicide prevention and postvention resources

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

1) Remove reference to a trained employee providing "interim care".

2) Remove requirement that LEAs must follow the model policy and require LEAs to incorporate best practices identified in the department's model policy.

3) Encourage rather than require that governing boards and bodies consider funding for hiring mental health professionals if the LEA does not employ or contract with such professionals.

Arguments in support. The Santa Clara County Office of Education, a co-sponsor writes, "Under the current student suicide prevention model policy, school staff are required to call 911

when a student is experiencing a mental health crisis. This policy applies regardless of whether the school has behavioral health professionals on campus who could address the crisis. It also does not limit application of the policy to situations where the student presents a physical threat to himself or others. While there may be instances when it is necessary to involve law enforcement, doing so significantly increases the likelihood of student injury, incarceration, or involuntary commitment, and should therefore be the exception, not the default.

SB 1318 would require the CDE to revise their model youth suicide prevention policy to clarify that schools should prioritize the use of behavioral health professionals when responding to a student experiencing a mental health crisis. The bill would also encourage schools to provide more on-campus mental health services by requiring the district governing board to consider the merits of hiring behavioral health professionals every five years."

Related legislation. SB 1063 (Grove) of the 2023-24 Session would require public and private schools serving students in grades 7 to 12 to print on the student identification (ID) card the uniform resource locator (URL) for the local county mental health agency or a quick response (QR) code that links to the website.

AB 2072 (Gabriel), Chapter 909, Statutes of 2022, requires, by November 1, 2024, 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 to develop a system for rapidly deploying qualified mental health professionals and other key school personnel employed by individual school districts and charter schools throughout the county to areas of the county that experienced a natural disaster or other traumatic event.

AB 58 (Salas), Chapter 428, Statutes of 2022, requires an LEA, on or before January 1, 2025, to review and update its policy on pupil suicide prevention, and encourages LEAs to provide suicide awareness and prevention training to teachers, beginning with the 2024-25 school year. Requires the CDE to develop and issue resources and guidance to LEAs on how to conduct suicide awareness and prevention training remotely, by June 1, 2024.

AB 309 (Gabriel), Chapter 662, Statutes of 2021 requires the CDE to develop model pupil mental health referral protocols, in consultation with relevant stakeholders, subject to the availability of funding for this purpose.

SB 224 (Portantino), Chapter 675, Statutes of 2021, requires LEAs and charter 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 14 (Portantino), Chapter 675, Statutes of 2021, requires a student's absence related to pupil mental or behavioral health to count as an excused absence for school attendance reporting and, subject to appropriation, 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.

AB 1767 (Ramos), Chapter 694, Statutes of 2019, requires LEAs serving students in grades K-6 to adopt and periodically update a policy on student suicide prevention that is appropriate for that age group.

SB 972 (Portantino), Chapter 460, Statutes of 2018, requires schools that serve students in any of grades 7-12, and institutions of higher education, that issue student identification cards to have printed on either side of the identification card the number for a suicide hotline.

AB 2639 (Berman), Chapter 437, Statutes of 2018, requires the CDE to identify and make available an online training program in suicide prevention that an LEA can use to train school staff and pupils, consistent with the LEA's policy on suicide prevention.

AB 2022 (Chu), Chapter 484, Statutes of 2018, requires each school of a school district or COE, and each charter school, to notify students and parents or guardians of students, at least twice per school year, about how to initiate access to available student mental health services on campus or in the community.

AB 2246 (O'Donnell), Chapter 642, Statutes of 2016, requires LEAs to adopt policies for the prevention of student suicides, and requires the CDE to develop and maintain a model suicide prevention policy.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of School Counselors
California Association of School Psychologists
California County Superintendents
California Federation of Teachers
California School Nurses Organization
California State Association of Psychiatrists
California State PTA
California Teachers Association
Cleanearth4kids.org
Generation Up
Mental Health Services Oversight and Accountability Commission
National Association of Pediatric Nurse Practitioners
Santa Clara County Office of Education
Santa Clara County School Boards Association
Steinberg Institute

Opposition

None on file

Analysis Prepared by: Debbie Look / ED. / (916) 319-2087