Date of Hearing: January 12, 2022

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 58 (Salas) – As Amended, January 3, 2022

SUBJECT: Pupil health: suicide prevention policies and training: school-based health programs: pilot program

SUMMARY: Requires that local educational agencies (LEAs) update their suicide prevention training materials, and provide suicide awareness and prevention training to teachers annually beginning with the 2024-25 school year, and requires the California Department of Education (CDE) to develop and issue resources and guidance on conducting suicide prevention training remotely, by June 1, 2024. Specifically, **this bill**:

1) Requires LEAs to provide suicide awareness and prevention training to teachers of pupils in all grades served by the LEA at the beginning of each school year, commencing with the 2024-25 school year.

2) Requires LEAs to revise their suicide prevention training materials by June 1, 2024 to incorporate best practices identified by the CDE in their model policy.

3) Requires the CDE to complete the development of, and issue to LEAs, resources and guidance on how to conduct suicide awareness and prevention training remotely by June 1, 2024.

4) Requires the governing board or body of an LEA serving pupils in grades K to 12 to review and update its policy on pupil suicide prevention to incorporate best practices identified by the CDE in the CDE's model policy by June 1, 2024.

5) Defines LEA for these purposes as a county office of education (COE), school district, state special school, or a charter school.

EXISTING LAW:

1) Requires the governing boards of school districts, COEs, the state special schools, and charter schools which serve students in grades 7 to 12 to adopt, before the beginning of the 2017–18 school year, a policy on student suicide prevention for students in those grades. (EC 215)

2) Requires the governing boards of school districts, COEs, the state special schools, and charter schools which serve students in kindergarten and grades 1 to 6 to adopt, before the beginning of the 2020-21 school year, a policy on student suicide prevention for students in those grades. (EC 215)

3) Requires that these policies address, at a minimum, procedures relating to suicide prevention, intervention, and postvention.

4) Requires the policies to be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts.

5) Requires that the policies specifically address the needs of high-risk groups, including youth bereaved by suicide, youth with disabilities, mental illness, or substance use disorders, youth experiencing homelessness or in out-of-home settings, students in foster care, and lesbian, gay, bisexual, transgender, or questioning youth.

6) Requires that the policy address any training to be provided to teachers on suicide awareness and prevention.

7) Requires that materials approved by an LEA for training include how to identify appropriate mental health services, both at the schoolsite and also within the larger community, and when and how to refer youth and their families to those services.

8) States that materials approved for training may also include programs that can be completed through self-review of suitable suicide prevention materials.

9) Requires the policy to be written to ensure that school employees act only within the authorization or scope of their credential or license.

10) Requires the CDE develop, and issue to LEAs, resources and guidance on how to conduct suicide awareness and prevention training remotely.

11) Require an LEA serving pupils in kindergarten and grades 1 to 12 to review its policy on pupil suicide prevention at least every five years and to update the policy if necessary.

FISCAL EFFECT: The Office of Legislative Counsel has keyed this bill as a possible state-mandated local program.

COMMENTS:

Need for the bill. According to the author, “Approximately one out of every 15 high school students report attempting suicide each year and suicide is the second leading cause of death among youth age 10-24. In recent years, there has been an increase in youth suicides and suicide attempts. In September 2020, the State Auditor released a report titled Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm which found that “schools can more effectively assist students if they have appropriate suicide prevention policies in place, in they train their faculty and staff to recognize and respond to youth who are at risk of suicide or self-harm” and “the deficiencies we found in these areas during our review suggest LEAs could do more to address youth suicide and self-harm.” This bill will implement recommendations from the State Auditor’s report to help improve prevention of youth suicide and self-harm.”

Youth suicide. 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.

In 2014, there were 3,575 hospitalizations for non-fatal self-inflicted injuries among children and youth ages 5-20 in California. In 2015, 495 California children and youth ages 5-24 were known to have committed suicide: 23 of these were between the ages of 5-14.

According to figures from the U.S. Centers for Disease Control (CDC), from 1999 through 2015 more than 1,300 children ages 5 to 12 took their own lives in the United States. There was a 54% increase in suicides of 11 and 12-year-olds from 2013 to 2015. From 1999 to 2015, the CDE reports there were deaths due to suicide among very young children, including two among five-year-olds, four six-year-olds, and eight for seven-year-olds. Overall, the rate of suicide among children from 5 to 12 years of age is low compared to other age groups at 0.31 suicides per 100,000 children over the past 17 years, compared to 7.04 per 100,000 for youth between 13-18.

A study published in Pediatrics in 2016 (Sheftall et al) noted that suicide in elementary school-aged children is not well studied despite a recent increase in the suicide rate among U.S. black children. The study analyzed national data and found that children who died by suicide were more commonly male, black, died by hanging/strangulation/suffocation, and died at home. The researchers suggested there is a need for developmentally-specific suicide prevention strategies during the elementary school-aged and early adolescent years.

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. Suicide rates among youth ages 10-24 increased over 57% between 2007 and 2018, and as of 2018 suicide was the second leading cause of death for youth ages 15-19, according to the Centers for Disease Control and Prevention (CDC). Youth visits to pediatric emergency departments for suicide and suicidal ideation also doubled during this time period (Burstein, 2019).

Since the pandemic began, rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders, have increased. During 2020, the proportion of mental health-related emergency visits among adolescents aged 12-17 years increased 31% compared with during 2019. 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).

What schools can do. Research points to several practices shown to reduce suicide risk, including creating a safe and supportive school climate with a focus on social-emotional learning; promoting school-based programs which foster connections to caring adults; and training school personnel to recognize warning signs and make appropriate referrals for suicide

and self-injury. A 2021 Advisory on "Protecting Youth Mental Health" by the U.S. Surgeon General identifies actions that educators, school staff, and school districts can do to support and protect the mental well-being of students, including:

- Create positive, safe, and affirming school environments;
- Expand social and emotional learning programs and other evidence-based approaches that promote healthy development;
- Learn how to recognize signs of changes in mental and physical health among students, including trauma and behavior changes. Take appropriate action when needed;
- Provide a continuum of supports to meet student mental health needs, including evidence-based prevention practices and trauma-informed mental health care;
- Expand the school-based mental health workforce;
- Support the mental health of all school personnel;
- Promote enrolling and retaining eligible children in Medicaid or other health plan so that children have health coverage that includes behavioral health services; and
- Protect and prioritize students with higher needs and those at risk of higher risk of mental health challenges.

One study on the role of teachers in school-based suicide prevention noted "the important role that teachers play in identifying, referring, and supporting students in crisis or at risk for suicide. We also discovered that teachers are actively interested in further training in suicide risk factors, practical tools for responding to students in need, classroom management, and how to connect students to resources. Suggestions were made for direct training of teachers by the school district, in-service meetings regarding crisis policies and procedures, and regular refresher trainings. Our findings also underscore the value of having on-campus mental health resources and the importance of a collaborative relationship between mental health providers, administrators, and teachers" (Nadeem, 2011).

California school district policies on suicide prevention. A recent audit report, *Youth Suicide Prevention: Local Educational Agencies Lack the Resources and Policies Necessary to Effectively Address Rising Rates of Youth Suicide and Self-Harm* (California State Auditor, 2020) found that "schools can more effectively assist students if they have appropriate suicide prevention policies in place, in they train their faculty and staff to recognize and respond to youth who are at risk of suicide or self-harm" and "the deficiencies we found in these areas during our review suggest LEAs could do more to address youth suicide and self-harm." Among the findings of the audit, it notes that the LEAs that were reviewed had not adopted adequate youth suicide prevention policies and training, that school-based health centers could provide students with better access to mental health professionals, and that LEAs should seek local and federal funding to help increase the number of mental health professionals on school campuses.

In addition, with regard to training, the Audit found that, "Although state law does not mandate training on suicide prevention, it does require that if LEAs conduct such training, the training materials must include information on how to identify appropriate mental health services—both at the school site and within the larger community—and when and how to refer youth and their families to those services. Although all six LEAs we reviewed provided suicide prevention training during the 2019–20 academic year, each failed to include one or more of the elements in state law or Education's model policy. These deficiencies may leave teachers and staff unprepared to identify and assist students at risk of self-harm and suicide."

Arguments in support. The American Academy of Pediatrics, California states "American youth have high rates of suicides and suicide attempts. The American Academy of Pediatrics (AAP) Committee on Adolescence reports that suicide is the second leading cause of death for adolescents 15 to 19 years old, affecting young people from all races and socioeconomic groups. According to a survey conducted by the AAP in 2019, 80% of pediatricians had had a patient who attempted or died by suicide, 48% within the past year. Schools are well-positioned to offer help to students in terms of access, but currently lack the model prevention policies and training for faculty and staff to recognize and respond to youth who are at risk of suicide or self-harm to do so. Teachers and other school staff provide an additional layer of support for our youth and need access to up-to-date, best-practice-based training on suicide prevention and awareness. AAP-CA strongly supports AB 58."

Arguments in opposition. Public Risk Innovation, Solutions, and Management notes "Public agencies, and schools in particular, are often targets of litigation. Our state's laws open the door for litigation through the enactment of seemingly straightforward laws such as the ones at issue in this letter. Unfortunately, there is a very real danger that Plaintiffs' attorneys will argue that such enactments create a mandatory duty on the schools that are subject to these bills. While we do not believe that it is the intent of the legislature to create a mandatory duty for schools through these bills, without language in the bills specifically stating that no mandatory duty is intended, schools will likely be named as defendants in litigation if they mistakenly fail to do one of the new things that they will be required to do under the bills set forth above. Specifically, a plaintiff's attorney would cite to California Government Code Section 815.6 which provides that a public entity is liable for any injury of the kind proximately caused by the entity's failure to discharge the mandatory duty. The attorney would then argue that his/her client was injured because the school district failed to do something. For example looking at AB 58, if a school failed to provide suicide prevention training at the school and one of the students at the school subsequently committed suicide, the attorney would argue that the district is liable because it failed to provide the training."

Related legislation. 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.

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 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

American Academy of Pediatrics, California
California Association for Health, Physical Education, Recreation & Dance
California Chapter of the American College of Emergency Physicians
California Consortium of Addiction Programs and Professionals
California State Association of Psychiatrists
Children Now
National Association of Pediatric Nurse Practitioners - San Francisco Bay Area Chapter

Opposition

Public Risk Innovation, Solutions, and Management (PRISM)

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