Date of Hearing: April 12, 2023

ASSEMBLY COMMITTEE ON EDUCATION
Al Muratsuchi, Chair
AB 912 (Jones-Sawyer) – As Amended April 3, 2023

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

SUBJECT: Strategic Anti-Violence Funding Efforts Act

SUMMARY: Redirects cost savings from Department of Corrections and Rehabilitation prison closures by investing in early violence intervention programs, school-based physical and mental health services, and youth recreational activities. Specifically, **this bill**:

1) States that these provisions may be cited as the Strategic Anti-Violence Funding Efforts (SAFE) Act.

2) Updates references in the Health and Safety Code from "Public School Health Center Program" to "School-Based Health Center Program."

3) Defines a "school-based health center" as a student-focused health center or clinic that meets off of the following conditions:

   a) Is located at or near a school or schools;

   b) Is organized through school, community, and health provider relationships; and

   c) Provides age-appropriate, clinical health care services onsite by qualified health professionals.

4) Authorizes a school-based health center to provide primary medical care, behavioral health services, or dental care services onsite or through mobile health or telehealth.

5) Requires school-based health centers to provide specified data to the State Department of Public Health (CDPH) only to the extent that they receive state funding under the program.

6) Requires school-based health centers receiving grant funds under this program to meet, or have a plan to meet, certain requirements, including providing primary medical care, and authorizes the provision of other health care services, including behavioral health, dental care, health education, and related services in response to community needs; and requires school-based health centers to strive to provide a comprehensive and integrated set of health care services provided or supervised by a licensed or credentialed professional.

7) Adds substance use disorder services to the list of services that a school-based health center may provide, including education, prevention, screening, early interventions, counseling, and referral to treatment services.

8) Requires school-based health centers receiving funding under this program to:

a) Strive to address the population health of the entire school campus by focusing on prevention services, including group and classroom education, schoolwide prevention programs, and community outreach strategies within the school's Multi-Tiered System of Support (MTSS) or other similar framework employed by the local educational agency (LEA);

b) Strive to provide integrated and individualized support for students and families and to act as a partner with the student or family to ensure that health, social, or behavioral challenges are addressed; and

c) Strive to integrate the school-based health center in the school or LEA's community school model, if applicable.

9) Requires the CDPH, on or before January 1, 2025, to make available planning grants of $50,000 to $100,000 for up to 24 months, to be used for costs associated with assessing the need for a school-based health center in a particular community or area and developing partnerships for its operation.

10) Requires the CDPH, on or before January 1, 2025, to make available school-based health center facilities and startup grants of $300,000 to $850,000 for a three-year period, to establish a school-based health center. Funds may be used to cover a portion or all of the costs associated with designing, retrofitting, renovating, constructing, or buying a facility or mobile health unit for a school-based health center. Requires preference be given to proposals that include cost sharing among LEAs, health providers, and community organizations, or that identify match funds for facility construction and renovation costs. Also requires that preference be given to proposals that include plans to provide integrated primary medical care and behavioral health services.

11) Requires CDPH, on or before January 1, 2025, to make available expansion grants of $150,000 to $300,000 for up to a three-year period for the purpose of renovating and improving an existing school-based health center; enhancing and expanding programming at a fully operational school-based health center, including adding physical health, oral health, or behavioral health services; or supporting operations at a fully operational school-based health center. Requires preference be given to proposals that increase access to comprehensive health care services at the school-based health center by adding staff or services or expanding the facility. Requires that the applicant has the ability to bill county mental health plans, in addition to managed care plans, or other public insurance programs. Also requires the applicant to develop a plan to sustain expanded services after the grant period.

12) Requires the CDPH, on or before January 1, 2025, to make available sustainability grants of $150,000 to $300,000 per year ongoing, for the purpose of operating a school health center. Requires applicants to seek reimbursement and have procedures in place for billing public and private insurance that covers students at the school-health center.

13) Requires the CDPH to collaborate with the Office of School-Based Health Programs in the California Department of Education (CDE) in developing a request for proposals (RFP)

process and in determining which proposals receive grant funding. Requires preference for grant funding be given to school-based health centers serving any of the following:

a) Areas designated as federally medically underserved areas or with medically underserved populations or areas with a shortage of health professionals;

b) Areas experiencing health disparities in child and adolescent access to primary care, behavioral health, preventative health, or oral health services; or

c) Schools in which more than 55% of the enrolled students are unduplicated pupils.

14) Creates the Department of Justice (DOJ) Violence Reduction Grant Program (VGRP) which requires the DOJ to oversee a grant program to support, expand, and replicate evidence-based, deterrence-focused, collaborative programs that conduct outreach to individuals involved in gangs and offer supportive services as a preemptive measure to curb gang violence, and states that the grants must be made on a competitive basis with preference to jurisdictions disproportionately impacted by violence and gangs, and community-based organizations (CBOs) that serve such jurisdictions.

15) Requires the Department of Parks and Recreation (DPR) to award grants to local governments and with preference to CBOs to support existing and create new parks and recreation opportunities, as well as summer programs for youth. States that the DPR, when developing the program, must establish criteria and accountability measures as needed, and must ensure priority is given to underserved populations and CBOs. Mandates that the DPR give priority to outdoor recreational and health-based intervention programs that operate during peak times of violence.

16) Reestablishes the Youth Reinvestment Grant Program (YRGP) and designates the Office of Youth and Community Restoration (OYCR) to administer it. Creates the Youth Reinvestment Fund and allocates monies into it, and requires that OYCR allocate YRGP funds to implement a mixed-delivery system of trauma informed health and development diversion programs for Native American youth. Outlines eligibility criteria to receive YRGP funding, as specified. Defines, among other terms, "youth" as a person subject to the jurisdiction of the juvenile court.

17) Establishes the Cognitive Behavioral Intervention for Trauma Program and requires the Health and Human Services Agency (HHSA) to evaluate applications and award grants on a five-year cycle to schools, including charter schools, located in the counties of Alameda, Fresno, Merced, Tulare, Kern, and Los Angeles, to implement the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program, and to an organization to study specified student outcomes for the improvement in the health and well-being of the youth and school and community stability.

18) Requires that the specified counties have the first right of refusal for seeking grant funding for this program, and authorizes the HHSA to open eligibility to other counties if any of these counties elect not to seek funding for this program.

19) Requires that HHSA award grants to schools that meet the following criteria:

    a) The school uses the monies for implementing the CBITS program, which may include trauma-focused cognitive behavioral therapy;

    b) The school is located in a region significantly impacted by gun violence as indicated by violent crime data, and whose students typically are unable to access traditional services, including, but not limited to, students who are low income or homeless, display symptoms of post-traumatic stress disorder or severe trauma related symptoms, members of immigrant and refugee groups, students with disabilities, and students who interact with child protective services, or who have had contact with the juvenile justice system;

    c) The school present substantial plans for the collection and distribution of information to the appointed research organization and for fidelity monitoring; and,

    d) Any other criteria specified by HHSA.

20) Requires recipients of grants to give priority to schools, community-based organizations, and nonprofit organizations in contracting for services under the CBITS program.

21) Requires the HHSA to open eligibility for CBITS grants every five years and to give priority to the top six counties with the highest rate of violent crime and homicide, as reported by the DOJ's annual crime data report. Requires the HHSA, if any of the six counties elect not to seek grant funds for this program, to open eligibility to other counties.

22) Requires the HHSA, when considering research grant applications, to give preference to organizations with demonstrated track records of studying youth, and CBOs and nonprofits, working with schools to create trauma-sensitive environments, and other specified criteria.

23) Requires the HHSA to submit a report to the Legislature by December 1, 2028 detailing outcomes, including academic performance, truancy rates, disciplinary actions, and rates of criminal offenses, among other things.

24) Appropriates $235,000 in funding from the General Fund for the purpose of delivering diversion and alternative-sanction programs, academic- and vocational-education services, mentoring, behavioral health services, and mental health services, as follows:

    a) $50 million to the HHSA to administer the CBITS pilot program;

    b) $50 million to the OYCG for the purpose of awarding grants pursuant to the Youth Reinvestment Grant Program;

    c) $50 million to the DPR to award grants for the purpose of supporting existing and creating new parks and recreation opportunities, as well as supporting existing and creating new summer programs for youth, including, but not limited to, extended park hours and expanded programming for nighttime sports, educational activities, and visual and performing arts opportunities, in order to create and enhance recreation- and health-based interventions for youth during peak times of violence;

d) $50 million to the CDPH to provide operational grants to school-based health centers in order to provide physical and mental health services to youth on school sites; and

e) $35 million to the DOF for the purposes of providing funds to support evidence-based, focus-deterrence collaborative programs that conduct direct outreach to targeted gangs in order to preemptively reduce and eliminate violence and gang involvement.

EXISTING LAW:

1) Requires the CDPH to establish the Public School Health Center Support Program (Program), in collaboration with the CDE, to perform specified functions relating to the establishment, retention, or expansion of SBHCs in California. (Health and Safety Code (HSC) 124174.2)

2) Establishes a grant program administered by the CDPH to provide technical assistance and funding to SBHCs, to the extent funds are appropriated for implementation of the Program. Provides for planning grants of $25,000 to $50,000; facilities and startup grants of $20,000 to $250,000; and sustainability and technical assistance grants of $25,000 to $125,000 per year, as specified. (HSC 124174.6)

3) Requires a SBHC receiving grant funds to meet, or have a plan to meet the following:

   a) Strive to provide a comprehensive set of services including medical, oral health, mental health, health education, and related services in response to community needs;

   b) Provide primary and other health care services, provided or supervised by a licensed professional, which may include all of the following:

      i) Physical examinations, immunizations, and other preventive medical services;

      ii) Diagnosis and treatment of minor injuries and acute medical conditions;

      iii) Management of chronic medical conditions;

      iv) Basic laboratory tests;

      v) Referrals to and follow-up for specialty care;

      vi) Reproductive health services;

      vii) Nutrition services;

      viii) Mental health services, as specified; and

      ix) Oral health services that may include preventive services, basic restorative services, and referral to specialty services. (HSC 124174.6)

4) Requires grant funding preference to be given to the following schools:

a) Those located in areas designated as federally medically underserved areas or in areas with medically underserved populations;

b) Those with a high percentage of low-income and uninsured children and youth;

c) Those with large numbers of limited English-proficient students;

d) Those in areas with a shortage of health professionals; and,

e) Those that are low-performing with Academic Performance Index rankings in the deciles of three and below. (HSC 124174.6)

5) Defines an SBHC, for purposes of the Program, as a center or program located at or near a LEA that provides age-appropriate health care services at the program site or through referrals, and may conduct routine physical, mental health, and oral health assessments, and provide referrals for any services not offered onsite. A school health center may serve two or more nonadjacent schools or LEAs. (HSC 124174)

6) Establishes the Office of School-Based Health at the CDE for the purpose of assisting LEAs regarding the current health-related programs under the purview of the CDE, and requires the scope of the Office to include collaborating with the DHCS and other departments in the provision of school-based health services, and assisting LEAs with information on, and participation in specified school-based health programs. (Education Code (EC) 49419)

7) Requires the governing board of any school district to give diligent care to the health and physical development of pupils, and authorizes it to employ properly certified persons to conduct this work. (EC 49400)

FISCAL EFFECT: Unknown

COMMENTS:

This bill establishes and funds a number of programs designed to reduce crime and support youth. This analysis will focus on the two programs linked most closely to educational institutions and students, namely the proposed investments in school-based health centers and the CBITS program. For discussion of the other proposed investments, see the analysis by the Assembly Public Safety Committee.

Need for the bill. According to the author, "By advancing sensible legislation and budget items to improve public safety and advance justice and equity, the State Legislature has decreased the number of incarcerated people in California. It is imperative that the resulting savings be reinvested into effective strategies proven to further reduce crime and violence. AB 912, the SAFE Act, will capture the savings from the closure of two prisons in the 2023-24 state budget and reinvest those funds in programs with proven success.

By keeping the funding within our crime prevention budget rather than sending it back to the General Fund, we send a message that our efforts to reduce crime are continuous and we provide much needed resources for some outstanding programs. As such, the SAFE Act, specifically, will provide ongoing funding for the Youth Reinvestment Grant Program; reduce gang violence

and gang involvement through programs modeled after successful ones, such as Oakland Ceasefire; expand the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program; increase access to physical and mental health services for K-12 students through school-based health centers; and, support parks and recreation opportunities, including summer youth leagues and extended programming."

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).

Wide range of health needs of children and adolescents. In addition to behavioral health issues, there are a multitude of health conditions impacting children and youth that may impact their school attendance and academic performance. Data from the Population Research Bureau (PRB) identifies the impacts and incidences of childhood conditions:

- More than 1.25 million California children and youth, have, or are at increased risk for, a chronic health condition and require care and related services of a type or amount beyond that required by children generally. Their ongoing health problems—physical, behavioral, or developmental—can affect their ability to function and participate in important educational and social activities, and, in some cases, can shorten their lives. The vast majority of children with special health care needs nationally (86%) do not receive care that meets federal standards for a well-functioning system. Further, racial/ethnic and socioeconomic inequities in access to care and other supports can lead to poorer outcomes for vulnerable children and their families.

- Asthma is one of the most common chronic diseases among children in the U.S. and is the top reason for missed school days, accounting for more than 5.2 million absences annually. Asthma affects around 6 million children nationwide. Approximately 14.3% of children in California aged 1-17 years have been diagnosed with asthma, which can be life-threatening when it is not managed properly. The Centers for Disease Control (CDC) estimates that approximately 40% of children with asthma do not have their disease under control. Children who face difficulty accessing quality health care are less likely to have well-controlled asthma.

- Oral health affects overall health and is essential for healthy development. Tooth decay is the most common chronic disease and the greatest unmet health need among children in

> California and the U.S. Untreated dental problems such as cavities and gum disease can affect a child's health and quality of life by causing pain, loss of teeth, impaired growth, sleep and speech issues, self-confidence problems, poor school performance, and increased school absences, among other issues. Nationwide, children miss more than 51 million hours of school each year due to dental problems. In California, the disparity in oral health between low- and higher-income children is among the worst in the nation.

Many children are not receiving adequate medical services. A 2018 report by the California State Auditor on the oversight of the delivery of preventative services to children enrolled in the Medi-Cal program found that millions of children do not receive the preventative services to which they are entitled. The report notes that California ranks 40th for all states in providing preventative health services to children.

What is a school-based health center (SBHC)? According to the California School-Based Health Alliance:

> SBHCs offer a range of health services, with the most common being primary medical services. Many SBHCs play an important role in managing students' chronic illnesses such as asthma and diabetes, and in responding to acute injuries or illness on campus. Some SBHCs in secondary schools offer reproductive health services, such as abstinence counseling, pregnancy prevention, and STD/HIV testing and treatment. Other services provided by SBHCs include dental care, mental health counseling, and youth development programs.
>
> SBHCs are uniquely situated to bring health care professionals and educators together to address the multifaceted needs of children, youth and families. Some SBHCs serve only students, while others also serve family members or the broader community surrounding the school. SBHCs provide a safe place for students and family members to talk about challenging issues (depression, behavior problems, academic performance, substance abuse, sexuality or relationships, etc.). The unique value of SBHCs is that they can connect medical services and mental health services to classroom health education, group interventions, and other campus projects, clubs or activities.

SBHCs respond to the needs of the schools and communities they serve. Local school boards give final approval to the services provided by the SBHC. According to the California School-Based Health Alliance, common services provided by SBHCs in California, and the percentage of SBHCs offering them, include:

- Medical services 85%;
- Mental health services 70%;
- Reproductive health 60%;
- Dental prevention 65%;
- Dental treatment 35%; and
- Youth engagement programs 51%.

SBHCs in California are operated by different entities, including the following:

- 52% by federally qualified health centers;
- 27% by school districts; and
- 22% by other agencies, including hospitals or local health departments.

How many SBHCs are there in California? According to the California School-Based Health Alliance, while there are over 10,000 schools in California, there are only 293 SBHCs, distributed as follows:

- 39% in high schools;
- 21% in elementary schools;
- 10% in middle schools; and
- 25% are "school linked" or mobile medical vans.

The existing SBHCs serve an estimated 286,000 students. These SBHCs are spread throughout the state, with high concentrations in Los Angeles and the San Francisco Bay Area. They tend to be located in schools with higher concentrations of low-income Latino and African American students. Most of California's SBHCs are physically located on campus within a main building or in a portable. In some areas, health services are provided by mobile medical or dental vans, and in other areas, "school-linked" health centers are off campus and have formal operating agreements with schools.

Disproportionate access to SBHCs. Currently, 70% of students attending schools with an SBHC are socioeconomically disadvantaged. The SBHCs reduce health disparities for these students by increasing access to comprehensive health care, and may also improve educational equity by reducing missed school days due to illness, often disproportionately experienced by low-income students and students of color.

As noted above, the current SBHCs in California are largely concentrated in large urban areas. The California School-Based Health Alliance recently released the *Student Health Index,* focusing on the need to support more SBHCs across the state to reach students facing the greatest health and education disparities.

The Student Health Index is made up of 12 indicators that characterize population characteristics and health care access and combines the component scores into a need score, based upon data from a variety of sources including the American Community Survey, the U.S. Census Bureau, the CDE, the CDC, and institutions of higher education.

Over 8,000 schools serving pupils in kindergarten through 12th grade and having over 100 pupils were included in the initial analysis. Further analysis focused on schools with large enough populations to warrant construction of a SBHC, so additional schools were excluded including small rural schools, and urban high schools with enrollments under 1,000 students. The final list includes 4,752 urban schools and 69 rural schools.

The indicators used in the student health index include the following:

- Health: diabetes rates, asthma admissions, teen birth rates, health professional shortage areas;

- Socio-economic: poverty among children and youth, lack of insurance coverage, healthy places index; and

- Schools: % of students qualifying for free and reduced lunch, % English learners, % homeless, chronic absenteeism, suspension rate.

Currently the counties with the greatest number of SBHCs are Los Angeles (38), Alameda (15), and Santa Clara (10). 23 counties have no SBHCs. Based upon the analysis conducted, the study concludes that San Bernardino, Fresno, San Joaquin, Kern, Riverside, and Los Angeles Counties all have over 100 schools and more than 25% of those schools have the highest relative need level. The majority of the top ten districts with highest need are located inland, in the central valley and southern counties east of Los Angeles and San Diego.

These factors will be important considerations in determining the feasibility of constructing or expanding SBHCs in high need locations. In some cases, telehealth options or mobile health clinics may be better suited to meet a school and community's needs.

SBHCs are funded through a variety of funding streams. The existing SBHCs in California are financed through:

- Reimbursement for services through Medi-Cal and contracts for mental health services;

- School district contributions and in-kind support, such as space, nurses, utilities, and custodial services;

- Sponsoring agency contributions or subsidies; and

- Federal government and private grants.

Despite having had statutory authorization to establish SBHCs in California since 2006, California has not provided any state funds to establish or expand SBHCs. This bill proposes to appropriate $50 million from the General Fund to provide grants to establish and expand school-based health centers.

Children and youth facing significant trauma. According to the California Surgeon General:

> An overwhelming scientific consensus demonstrates that cumulative adversity, particularly during critical and sensitive developmental periods, is a root cause to some of the most harmful, persistent and expensive health challenges facing our nation. The term Adverse Childhood Experiences (ACEs) refers to ten categories of stressful or traumatic events. These include physical, emotional or sexual abuse, physical or emotional neglect or "household dysfunction" including parental incarceration, mental illness, substance dependence, parental separation or divorce, or intimate partner violence. A robust body of literature demonstrates that ACEs are highly prevalent, strongly associated with poor childhood and adult health,

mental health, behavioral and social outcomes and demonstrate a pattern of high rates of intergenerational transmission.

In California, more than 36% of children had at least one ACE, 15% had two or more ACEs, and nearly 4% had four ACEs or more. Statewide and nationally, African American/black children were more likely than their Hispanic/Latino and white peers to have two or more ACEs. The range of children with two or more ACEs varies significantly across the state, from 12% in Marin, San Mateo, and Santa Clara counties, to 25% in Lake and Mendocino counties, and 29% in Humboldt County. (Let's Get Healthy California, 2023)

California has taken major steps to address adversity and its associated health- and development-disrupting stress, setting an ambitious goal to cut ACEs and toxic stress in half in one generation. The state has passed legislation to support early identification and intervention for ACEs and toxic stress, and made substantial investments in screening, research, and other cross-sector efforts. Still, ACEs remain common among California children, with children of color and those in poverty disproportionately impacted by adversity and trauma.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) This bill proposes to provide $50 million to the HHSA to administer the CBITS pilot program in California schools.

The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) program is designed for use with groups of students who have experienced significant traumatic experiences and are suffering from related emotional or behavioral problems, particularly symptoms of post-traumatic stress disorder. Delivered by school-based clinicians and taking into account cultural context, it uses a variety of cognitive behavioral techniques in an early intervention approach, including psychoeducation about trauma and its consequences, relaxation training, learning to monitor stress or anxiety levels, recognizing maladaptive thinking, challenging unhelpful thoughts, social problem-solving, creating a trauma narrative and processing the traumatic event, and facing trauma-related anxieties rather than avoiding them. CBITS focuses primarily on three goals: decreasing current symptoms related to trauma exposure, building skills for handling stress and anxiety, and building peer and caregiver support. (Jaycox, 2018)

CBITS was developed by a team of clinician-researchers from several institutions to help children traumatized by violence. The team included professionals from the RAND Corporation, the University of California, Los Angeles (UCLA), and the Los Angeles Unified School District (LAUSD) and has expanded over time to include colleagues at the University of Southern California and many community partners. RAND, UCLA, and LAUSD began to collaborate in 1998 to conduct studies to determine the magnitude of violence exposure and post-traumatic stress symptoms among LAUSD schoolchildren and to develop effective interventions. Building on the earlier work, the team designed and conducted a randomized controlled study in the 2000–2001 academic year. Students in the study attended one of two Los Angeles public middle schools in largely Latino neighborhoods. Students in the study were randomly assigned to two groups. One group started the program promptly; the other was waitlisted for later in the school year.

The CBITS consists of ten group sessions designed for inner-city schools with a multicultural population. Activities include training children in relaxation; dealing with negative thoughts; solving real-life problems; approaching anxiety-provoking situations; and coping with the violent event through talking, drawing pictures, and writing. The program is also designed to build both

peer and parental support. In addition to the group sessions, the program included at least one individual session for each child, four group parenting meetings, and an educational presentation for teachers. The LAUSD school clinicians who delivered the program received two days of training and weekly supervision from the other members of the research team.

At three months, the early-intervention students showed substantial improvement. 86% of the early-intervention group reported less-severe post-traumatic stress symptoms than would have been expected without intervention. In addition, parents of students in the early-intervention group reported that their children were functioning significantly better. At six months, both groups had completed the program. The group that received CBITS after the waiting period also showed substantial improvement in symptoms, and the group that had received CBITS earlier maintained their gains.

Extensive research since 2000 has supported the team's initial study results. CBITS is now recognized as a recommended practice by several national agencies that assess the quality of mental health interventions, including the Centers for Disease Control and Prevention's Prevention Research Center, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Registry of Evidence-Based Programs and Practices, and the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention.

Although it is clear that the CBITS is an evidence-based program, the ***Committee may wish to consider*** whether funding should be allocated to one specific program to meet the needs of children and youth suffering from trauma, or if the funding should be made available for schools to choose the evidence-based practice most suited to meet the needs of their particular students and families.

Arguments in support. According to Children NOW, "This comprehensive measure reinvests cost savings from prison closures into programs that reduce violence, provide diversion opportunities, and deliver critical community supports, including mental health, education and vocational services. On December 6, 2022, the California Department of Corrections and Rehabilitation announced the closure and exiting of contract for two additional prison facilities. With the closure of these facilities, the Legislative Analyst's Office estimates a cost savings of $235.3 million annually. Rather than returning to the General Fund, it is imperative these savings are kept within the Legislature's crime prevention budget and reinvested into effective strategies proven to further reduce crime and violence.

Studies have shown health-based approaches have been successful in curbing violence through applied, skill-based prevention programs. Addressing youth mental health and adverse childhood experiences (ACEs) is crucial in mitigating long-term effects, such as substance abuse, mental illness, chronic health problems, and criminality. Existing programs have been successful in providing crucial resources and early intervention to youth."

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

1) Make technical and clarifying changes to the sections related to school-based health centers.

2) Delete references to the Cognitive Behavioral Intervention for Trauma Program, and require the HHSA to establish a program to provide grants to local educational agencies to

implement evidence-based interventions to pupils impacted by trauma, to improve the health and well-being of children and youth.

3) Requires that the HHSA prioritize, but not limit grant funding, to specified counties most impacted by gun violence, as specified.

4) Require the HHSA to develop a list of evidence-based interventions that local educational agencies receiving funding pursuant to this section may implement.

Related legislation. AB 1940 (Salas) of the 2021-22 Session would have renamed the existing Public School Health Center Support Program, established within the CDPH, as the School-Based Health Center Support Program (SBHCS Program). Would have also updated the functions of the SBHCS Program to include serving as a liaison between organizations on health equity, oral health and behavioral health. The bill also revised existing grant programs for purposes of the SBHCS Program. This bill was vetoed by the Governor with the following message:

> I appreciate the author's effort to modernize the existing Public School Health Center Support Program and their intent to increase access to physical and behavioral health services for students. SBHCs are vital tools to address the significant disparities in both health and educational outcomes for our state's children and youth. However, I have concerns this bill could create significant one-time Proposition 98 General Fund cost pressures in the tens of millions of dollars to fund the SBHC Support Program, and ongoing General Fund costs in the millions of dollars for CDPH to administer the program that were not included in the budget.
>
> With our state facing lower-than-expected revenues over the first few months of this fiscal year, it is important to remain disciplined when it comes to spending. We must prioritize existing obligations and priorities, including education, health care, public safety and safety-net programs.

AB 309 (Gabriel) Chapter 662, Statutes of 2021, 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.

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

SB 224 (Portantino) Chapter 675, Statutes of 2021, requires schools that offer one or more courses in health education to students in middle school or high school to include in those courses instruction in mental health.

AB 552 (Quirk-Silva) of the 2021-22 Session would have authorized LEAs and county behavioral health agencies to enter into an Integrated School-Based Behavioral Health Partnership Program to provide school-based behavioral health and substance abuse disorder

services on school sites, and authorizes the billing of private insurance providers for these services under specified conditions. This bill was vetoed by the Governor with the following message:

> While I share the author's goal of addressing the mental health needs of children and youth, the partnership programs proposed under this bill would duplicate requirements for school-based behavioral health services being developed pursuant to the Children and Youth's Behavioral Health Initiative (CYBHI), which take effect in 2024. Implementation of the CYBHI's statewide all-payer fee schedule will provide a solution to the issue that this bill attempts to address. Additionally, I am concerned that this bill could create significant one-time and ongoing costs in the millions of dollars for the departments that would play a role in implementing these programs.

AB 2691 (Jones-Sawyer) of the 2017-28 Session would have established the Trauma-Informed Schools Initiative within the CDE, contingent upon the availability of funding, and required CDE to provide information regarding the trauma-informed care approach to school districts and charter schools; to develop a guide for schools on how to become trauma-informed schools; to offer training on the trauma-informed care approach to schools; and to develop and post online a website about the Trauma-Informed Schools Initiative. This bill was vetoed by Governor Brown with the following message:

> It's a no brainer that our schools should be sensitive to the unique and diverse characteristics of all students. With that goal in mind, I have signed dozens of bills that have sought to ensure that all our students are free from discrimination, bullying, or any other form of disrespect. While this bill is intended to do good, I am alarmed by the amount of jargon it creates and the inevitable labeling it will encourage. The issues here are best handled by local schools -- and in plain English.

AB 766 (Ridley-Thomas) of the 2015-16 Session would have required the CDPH to give grant funding preference to schools with a high percentage of students enrolled in Medi-Cal, under the Public School Health Center Support Program. This bill was held in the Senate Appropriations Committee.

AB 1025 (Thurmond) of the 2015-2016 Session would have required the CDE to establish a three-year pilot program in school districts to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multi-tiered framework. AB 1025 was held in the Senate Appropriations Committee.

SB 1055 (Liu) of the 2013-14 Session would have renamed the Public School Health Center Support Program the School-Based Health and Education Partnership Program; made changes to the requirements and funding levels; and created a new type of grant to fund interventions related to obesity, asthma, alcohol and substance abuse, and mental health. This bill was held on the Senate Floor.

REGISTERED SUPPORT / OPPOSITION:

Support

California Alliance for Youth and Community Justice
California Public Defenders Association

Californians for Safety and Justice
Children Now
Community Agency for Resources, Advocacy and Services
Community Works
Defy Ventures
Drug Policy Alliance
Faith in The Valley
Freedom 4 Youth
Freedom Within Project
Friends Committee on Legislation of California
Indivisible CA Statestrong
Insight Prison Project, a Division of Five Keys Schools and Programs
John Burton Advocates for Youth
Kalw Public Media
LA Defensa
March for Our Lives Action Fund
Milpa
National Center for Youth Law
Pacific Juvenile Defender Center
Prosecutors Alliance California
Reevolution
Sacred Purpose
Santa Cruz Barrios Unidos
Sigma Beta Xi
Smart Justice California
Sow a Seed Community Foundation
Success Stories Program
The Transformative In-prison Workgroup
Theatreworkers Project
Women's Foundation of California, Dr. Beatriz Maria Solis Policy Institute
Young Women's Freedom Center
Youth Forward

Opposition

None on file

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