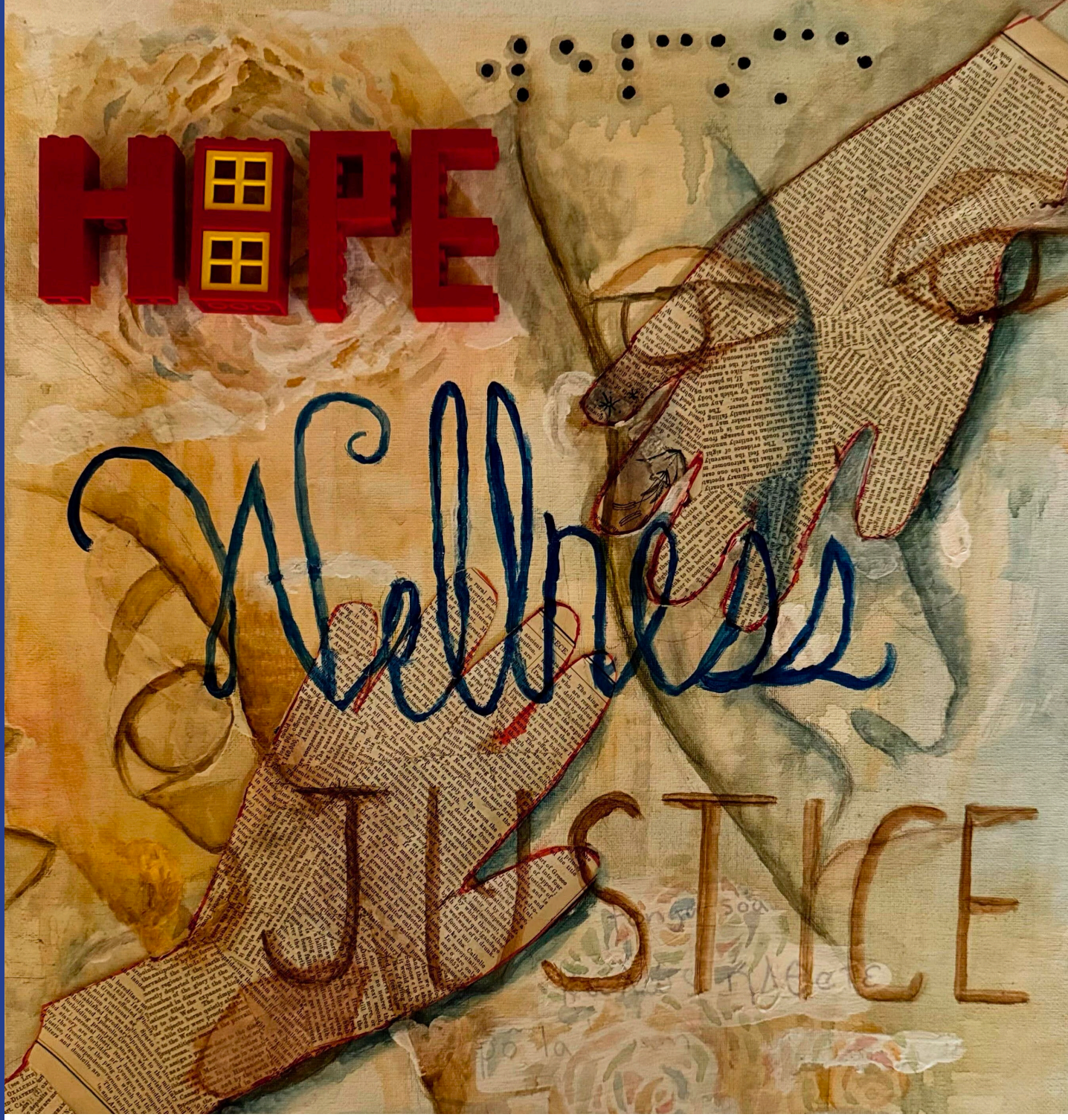
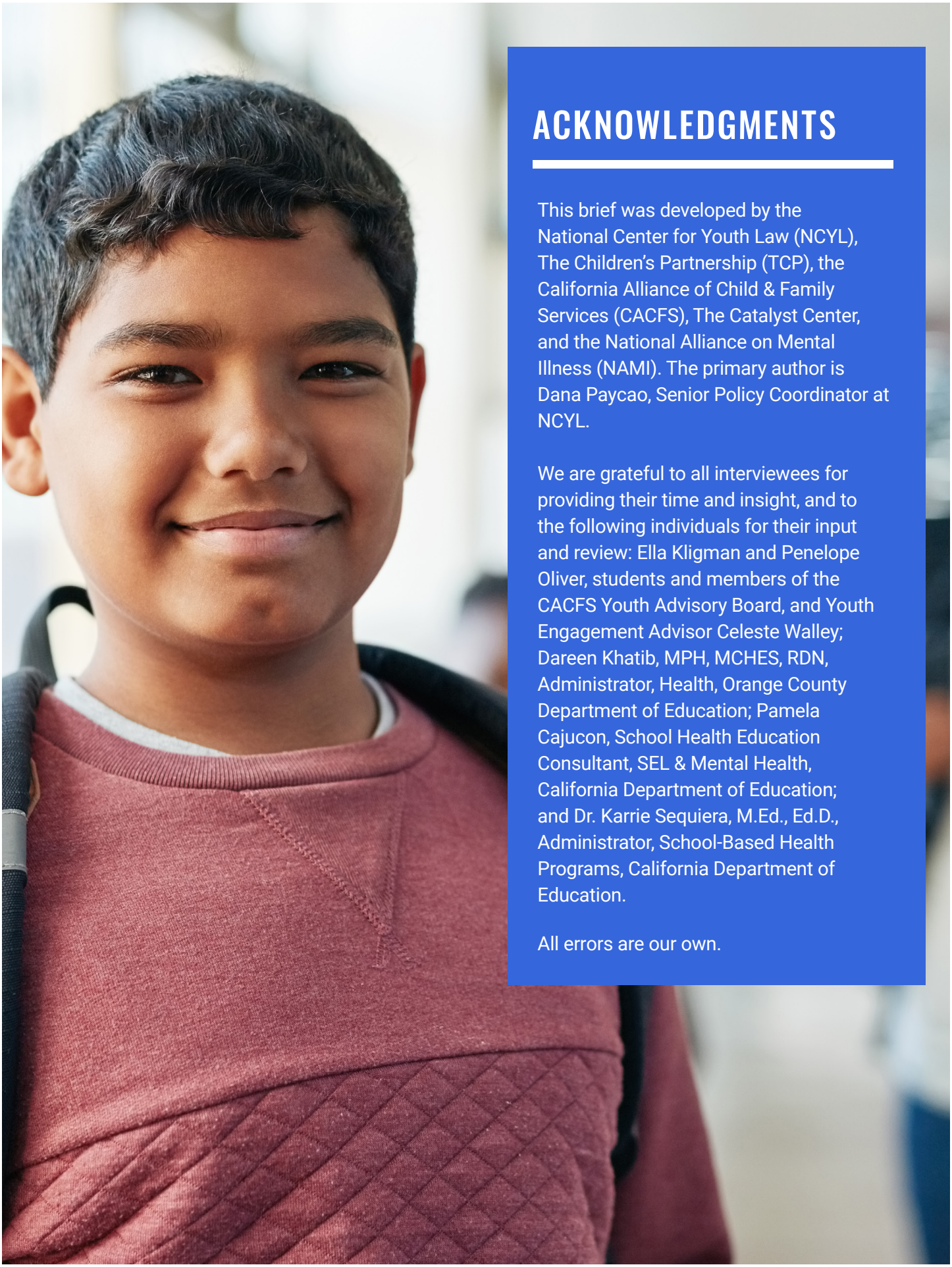


PROVIDING MENTAL HEALTH EDUCATION TO STUDENTS IS CRITICAL – AND ACHIEVABLE

HOW SOME SCHOOL COMMUNITIES ARE MAKING IT HAPPEN, AND HOW WE CAN ENSURE EVERY CA STUDENT HAS THE SKILLS THEY NEED TO THRIVE

National Center for Youth Law
The Children's Partnership
Catalyst Center
NAMI California
National Alliance on Mental Illness
California Alliance
Empowering lives. Enriching futures.



ACKNOWLEDGMENTS

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We are grateful to all interviewees for providing their time and insight, and to the following individuals for their input and review: Ella Kligman and Penelope Oliver, students and members of the CACFS Youth Advisory Board, and Youth Engagement Advisor Celeste Walley; Dareen Khatib, MPH, MCHES, RDN, Administrator, Health, Orange County Department of Education; Pamela Cajucon, School Health Education Consultant, SEL & Mental Health, California Department of Education; and Dr. Karrie Sequiera, M.Ed., Ed.D., Administrator, School-Based Health Programs, California Department of Education.

All errors are our own.

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Cover art was created for this publication by student and artist, Chaitanya Verma.

"Created on blank canvas, this piece illustrates the undefined potential we hold. Two hands, extending from polarity, alludes to a compartmentalized world, where storytelling and authentic connection remedy the dissonance, tracing the outlines of our identities, both intellectually and on paper, like a child learning to draw. Filled with the excess of a previous work, they hold a future beyond their original purpose. The dots hovering just above, are 'welcome' in braille.

In watercolor, two gender-neutral faces represent anonymous entities up to interpretation. This anonymity mirrors the uncounted faces we encounter in life, each with their own story, unlabeled and unique, meant to spark curiosity beyond stereotypes.

'Hope,' spelled with prominent red Legos, symbolizes the unwavering hope we build, brick by brick. Red is unapologetic, just like humanity when we dare to dream of better days.

'Wellness,' depicted in blue, embodies fluidity, the free-form nature of water, symbolizing its vitality in health and desire in reality.

'Justice,' blends into the background, signifying that justice prevails when we the people harness the fire within, standing for what we deserve and believe in.

And I believe in you."

EXECUTIVE SUMMARY

In 2021, amidst a growing youth mental health crisis, California leaders enacted Senate Bill 224 (SB 224 - Asm. Portantino). The law required that middle and high schools that offer health courses include mental health instruction in those courses, and directed the state to develop plans to expand this instruction to schools across the state. While only a subset of California schools are currently subject to the SB 224 mandate, this was an important first step in equipping the next generation with the knowledge and skills needed to achieve positive mental health and well-being. It provided an opportunity and framework for school communities to identify local needs, to select or develop mental health curricula right for their school communities, to begin implementation, and to gather feedback.

In this brief, we share insights gathered from the field - what's working, where there's room to grow, and what needs to happen next to build upon SB 224.

We strongly recommend that California leaders and policymakers:

> Expand access to mental health education in schools, so all California students - *not just a subset* - can benefit.
> Dedicate funding for mental health education and for educator support.
> Create and facilitate a statewide virtual community and database of mental health curriculum materials and implementation information.
> Increase and leverage the power of school-health partnerships.
> Continue to uplift the importance of mental health education and success stories.
> Make space for, and listen to, students.

BACKGROUND

Worldwide, mental health challenges are among the leading causes of illness and disability among young people.[1] Half of all mental health disorders start by age 14, but overwhelmingly, youth's needs are undetected and untreated.[2] In 2020, California ranked 48th in the nation for providing needed mental health care to children.[3] Over the last few years, the state has made important investments like the Child and Youth Behavioral Health Initiative (CYBHI) to address growing needs.[4] However, more could, and must, be done to confront the ongoing persistent mental and behavioral health crisis for our young people. An important, yet often overlooked, step in preventing mental health crises is ensuring that youth have a baseline knowledge and understanding of mental health and well-being, so they can develop positive coping strategies and, when needs arise, know how to seek help for themselves and others.

In 2021, a coalition of mental healthcare providers, advocates, and educators sought to equip California students with the knowledge and skills to understand mental health and empower them to seek needed mental health support through the passage of SB 224.[5] As originally introduced, SB 224 sought to ensure that all students in grades 1-12 would receive mental health education at least once during elementary school, once during middle school, and once during high school. The legislature recognized the value of mental health education, finding: "Mental health education is one of the best ways to increase awareness and the seeking of help, while reducing the stigma associated with mental health challenges. The public education system is the most efficient and effective setting for providing this education to all youth."[6] Ultimately, SB 224 passed and was signed into law, but with a narrowed scope: it required California middle and high schools that offer health classes to include in those classes mental health instruction covering key themes and principles related to mental health.[7] SB 224 also required the development of a plan to expand mental health education beyond middle and high schools that already provide health education, to all California public schools.[8]

This expansion is critical.

Health literacy, including **mental health literacy**, is recognized as a social determinant of health. Low levels of health literacy can be a risk factor while high levels of health literacy can function as a protective factor.[9]

Risk and protective factors are characteristics at the biological, psychological, family, community, or societal level that affect the likelihood of negative or positive outcomes. While risk factors are associated with a higher likelihood of negative outcomes, protective factors can mediate that impact.[10]

When individuals have limited health literacy, they are at higher risk for poor health care and health outcomes, making the issue of mental health literacy an important health equity issue.[11] As health literacy is often more limited in historically underserved populations, such as low income and uninsured communities, it is also an important tool in addressing health disparities.[12] Like for all health needs, mental health literacy is critical to building knowledge and skills to increase overall awareness, tackle stigma, and encourage help-seeking behavior. As our coalition and the California Department of Education (CDE) explore pathways for expansion SB 224, we can look to the work being done in and out of California in mental health education for models and best practices.

California, in many ways, leads the nation on mental health care reform. In 2021, the state launched the CYBHI, a landmark $4.7 billion dollar investment in youth mental health and well-being. However, in the space of mental health curriculum, California continues to lag when compared to other states. This is an opportunity for California to examine the work being conducted in other states as potential models for mental health education implementation. For example, Maryland's model of mental health education is embedded within their mandated and comprehensive health education standards from Pre-K to 12th grade.[13] This model builds a foundation of understanding broad concepts such as emotions and relationships for the youngest students that is reinforced with curriculum on stress, suicide prevention, and help seeking behaviors for older students.[14]

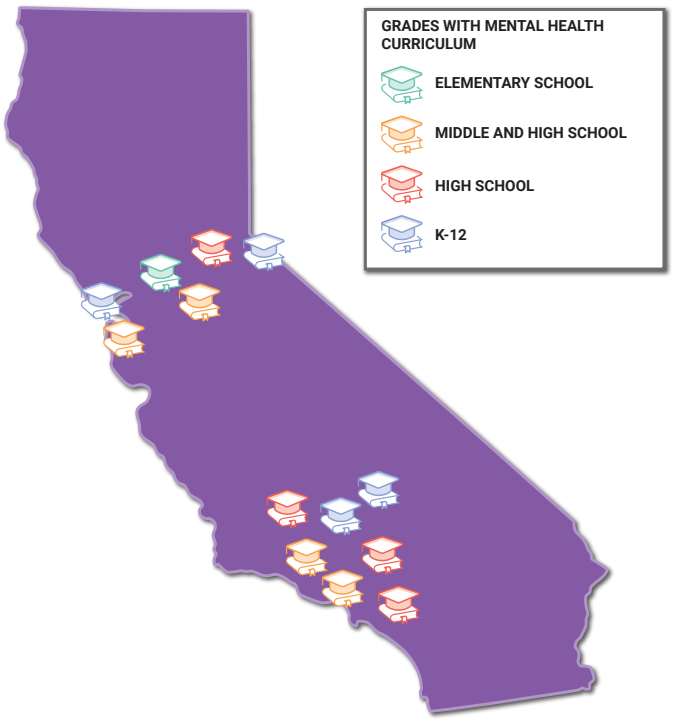
Within California, schools are implementing many different models of mental health education that reflect the specific needs of diverse school communities. As of the publication of this brief, there was no publicly available data indicating the number of schools or districts that have implemented, or the number of students that have received, mental health education in schools, or how schools across the state are implementing this instruction. Instead, we turned to the field to learn more.

Through interviews with students, educators, and other school staff, we found that schools are approaching mental health education in equally varied ways. Importantly, there is a significant need for comprehensive mental health education and demand to expand mental health curriculum beyond the scope of SB 224.

FINDINGS

All of the individuals we spoke to recognized the need for, and the value of, mental health education for overall student well-being while elevating the need for more support to ensure efficacy. For educators, success was measured in different ways, such as improved student behaviors, increased access and use of needed mental health supports, and increased student and community engagement with curriculum. It is also important to note that the schools were often at different stages of implementation. At some schools, these classes are still in their infancy, having just been developed within the last couple of years, while some programs have been around for decades. Despite the wide variability in the resources each school and district had, all the educators and school staff we interviewed reflected a dedication to teaching mental health curriculum. In this issue brief we explore how different schools are implementing mental health education as well as highlight some best practices, areas for growth, and needed next steps to ensure that California students receive mental health education.

MAP OF SCHOOLS INTERVIEWED



METHODOLOGY

In total, we interviewed 16 individuals, four high school students and 12 school staff, including educators, administrators, and mental health providers. Each interview was conducted separately and ranged from 30-60 minutes. These California-based individuals represented nine different counties spanning urban and rural communities. The interviewees were from public and private schools, covering kindergarten to high school grade levels.

IMPLEMENTATION: LESSONS LEARNED & RECOMMENDATIONS FROM THE FIELD

CURRICULUM

The individuals we spoke to serve a variety of school communities with diverse student bodies. Consequently, the mental health curricula implemented to serve these communities were also diverse and aimed to meet the needs of their unique communities. Each individual was also attempting to implement mental health education within the confines of the resources available at their own school and district. This range of implementation factors was reflected in all the aspects of their approach to the mental health instruction, from the format of the classes to the choice of instructors.

Schools and districts need flexibility in implementation. There are several ways that schools deliver mental health curriculum. The strategies schools use to approach mental health education delivery reflects the importance of adaptability and flexibility. For schools with a health education or wellness class, mental health curriculum is integrated into the overall health curriculum. At schools without health classes, the mental health curriculum is integrated into other classes, provided as a standalone elective course, or as part of advisory periods. A few schools offer mental health curriculum in both a health class and in an advisory or elective course. Due to the different delivery forms, the amount of lesson time allotted to mental health is highly variable, with some schools allotting one to two weeks across the year to their mental health curriculum and others dedicating one to two hours weekly.

Curriculum delivery approaches must be age-appropriate. Delivery of the curriculum also differed greatly depending on grade levels. For schools providing mental health curriculum at the elementary level, students were taught by one teacher throughout the day as part of their regular classes. One school serving elementary students integrated social-emotional learning (SEL) instruction in the morning, with 30 minutes allotted at the beginning of classes. This approach allowed the classroom teacher for the class to learn from the curriculum too, as they observed the SEL instructor, and provided opportunities to integrate the practical strategies taught into the classroom, such as communication and interaction strategies. For this school, this approach prepared students for the day ahead, helping them transition from the "house space" to the "school space."

There was more variability of curriculum delivery at the middle and high school grade levels. Some schools offer mental health curriculum through wellness or health classes, or in an advisory or elective class, and others offer mental health education in both formats. Providing a mental health curriculum as part of a required class ensured that all students received the curricula. Some schools offered mental health curriculum at only specific grade levels, while others chose to integrate mental health education at every grade level. One school utilizing the latter approach selected themes for grades 6 to 12. This allowed students to build an initial foundation of mental health knowledge, but also ensured that foundation was further developed in age-appropriate ways. Unsurprisingly, schools that offer mental health curriculum in multiple grade levels dedicate the highest number of hours to mental health lessons.

Topics must be age-appropriate and tied to practical strategies. Educators also highlighted the importance of tailoring the curriculum topics to be age-appropriate, focusing on foundational coping and self-regulation in earlier grades and then exploring heavier mental health topics and strategies with older students. For the elementary school level, mental health curriculum was primarily focused on SEL. For younger students, focusing on broader themes and practical strategies, as opposed to specific topics, seemed most effective to educators. Some early mental health themes educators highlighted as important for younger students include emotional regulation, communicating feelings, and developing kindness and empathy. These themes were intended to build a foundation of understanding of social and emotional needs that were then reinforced with education on specific topics like bullying, mindfulness, and coping skills. At one school, not only were these topics reinforced in lessons, but they were also put into practice by school staff who then provided "calm boxes" in every classroom as a space for students to practice regulation and grounding strategies when they were in need of a reset.

Among middle and high school grade levels, mental health curriculum delved into more specific topics, such as defining mental health, exploring specific mental health conditions, the science of brain development, navigating relationships, substance use and addiction, and suicide prevention. Some of the recurring topics for older students were establishing a definition for mental health, what it looks like, and overall mental health literacy. For these students, making the connection between mental health and other aspects of health, such as physical and sexual health, was another priority for several schools. For example, lessons on brain development, healthy relationships, and establishing healthy habits were integrated with the mental health curriculum. Though not the focus of the curriculum, there was also discussion of specific mental health conditions such as depression, anxiety, and suicide. Similar to the curriculum for younger students, educators elevated the importance of tying mental health education to practical applications. For older students, this included integration of mindfulness, developing coping skills strategies, preparing students for the transition from middle school to high school or high school to college, and even opportunities for service learning. One school district administrator emphasized the importance of hands-on learning, noting that when students were engaged in advocacy for mental health, it felt more personal to them and empowered them to make better health choices. Educators noted that hands-on learning through advocacy or through service opportunities provided students with a sense of purpose, helping them connect to their broader community and empowering them to become "global citizens," conditions and experiences that can serve as protective factors for their well-being.

WHAT CURRICULA ARE SCHOOLS USING?

While some educators trained in mental health topics developed their own curriculum for use at their schools, many of the schools relied on outside curriculum programs for their mental health instruction. We include some of the curricula here as examples.

Please note that inclusion of a curriculum or set of materials in this list is not an endorsement. Additionally, some of these programs require a subscription or other costs.

CURRICULUM NAME	GRADE LEVELS	DESCRIPTION
CASEL	K-12	The Collaborative for Academic, Social, and Emotional Learning model focuses on 5 main competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making.
1-2-3 Wellness	All ages	1-2-3 Wellness is a tool-based program that students, teachers, administrators, and others can use to support their emotional health. It also collects data from users throughout the program to provide a personalized wellness plan.
Wayfinder	K-12	Developed at Stanford Institute of Design, the Wayfinder program provides research-backed SEL curriculum for grades K-12. It also provides resources catered to the different levels of the Multi-Tiered System of Supports (MTSS) framework.
The Toolbox Project	K-6	The Toolbox Project is an SEL curriculum program that aims to build a child's resilience, self-mastery, and empathy through the development of 12 skills or practices.
Erika's Lighthouse	4-12	Erika's Lighthouse is a not-for-profit aiming to educate and raise awareness about adolescent depression and address stigma around mental health issues. They have educational programs that span grades 4 to 12 that begin with introducing what mental health is and building to deeper discussion on suicide and depression as well as help-seeking behaviors.
Satchel Pulse	K-12	Satchel Pulse SEL is a program that identifies students with SEL growth areas using a universal screener. The program then aims to support students through interventions, courses, and coaching.
Second Step	K-12	Second Step programs aim to support students' SEL through research-based programs. The programs are intended to work together throughout the different development stages.
Project School Wellness	6-12	The Project School Wellness curriculum is a skills-based health education program for middle and high school students. The program emphasizes skills such as goal setting, effective communication, and healthy decision making.
Character Strong	PK-12	Character Strong is a tiered curriculum intended to build SEL skills through research-based lessons that emphasize character development for students as well as professional learning and support for educators.
Kevin Love Fund	K-12	The Kevin Love Fund is an evidence-based organization focusing on research, education, and narrative change in mental health. The organization also provides an SEL curriculum program that involves 14 lessons on topics like cultivating empathy and destigmatizing emotions.
Prepare U	6-12	The Prepare U mental health curriculum is a 15-class curriculum program focused on experiential learning on topics like addiction and social media with the aim to increase students' sense of purpose and reduce the impacts of trauma and anxiety.

Educators also used other resources to complement their mental health instruction:

CURRICULUM NAME	GRADE LEVELS	DESCRIPTION
Bring Change to Mind	6-12	Bring to Change to Mind has programs for middle and high school students that empower them to discuss and advocate for mental health. The programs also encourage students to create a supportive school environment through providing resources, staff support, and funding for campus events.
NAMI on Campus Club	8-12	NAMI on Campus clubs are student-led, student-run mental health clubs on high school campuses. They provide opportunities for students to lead efforts on mental health education and awareness.
Know the Signs	N/A	Know the Signs is a California-wide suicide prevention campaign to educate Californians on how to recognize warning signs of suicide, how to communicate with someone experiencing a crisis, and where to find resources.
Dovetail Learning	N/A	Dovetail Learning is a nonprofit that provides training and resources on developing resilience through skill-building. Its sources aim to serve a wide array of individuals, including educators and healthcare providers.

Some schools and districts also utilized curriculum that supplemented mental health instruction with education on related topics, such as substance use and relationships.

One Love	K-12	One Love is an evidence-based curriculum that teaches young people how to identify an unhealthy relationship and teaches them skills so they know what to do when they encounter such relationships.
Safety First	8-12	Safety First is a comprehensive drug education curriculum composed of 13 lessons on alcohol, opioids, and other drugs that encourages abstinence and harm-reduction. Safety First was developed by Stanford as a harm reduction curriculum, they have also developed prevention curricula that can be found through the REACH Lab.

The Sonoma County Office of Education has also developed a mental health education curriculum framework, Foundations of Mental Health, that includes 8 lessons covering diverse topics.

Foundations of Mental Health	Secondary level	The Foundations of Mental Health curriculum provides instruction on mental health, destigmatizes such topics, and aims to normalize help-seeking behaviors. The curriculum involves topics such as identity & mental health, wellness, mental health advocacy, and mental health conditions.

This is not intended to be an exhaustive list of mental health curricula. We have also included an appendix of other mental health programs that are relevant, but were not specifically mentioned in the interviews.

Messengers matter. Who delivers the mental health curriculum is an important factor in implementation. Existing law defines "[i]nstructors trained in the appropriate courses" as "instructors with knowledge of the most recent evidence-based research on mental health," and specifies that mental health education must "[b]e coordinated with any existing on-campus mental health providers, including, but not limited to, providers with a pupil personnel services credential...."[15] This provides schools with the flexibility to determine which individual, or combination of individuals, are best situated to provide the instruction in their own school communities (for example, classroom teachers, school counselors, or some combination thereof). Among those we interviewed, several expressed that mental health education could be augmented by having educators with some background in mental health, such as those with an educational background in psychology, those trained as a mental health counselor, or educators with prior knowledge through training or even lived experiences. This knowledge helps these educators advance mental health education through a myriad of ways, including knowledge of mental health terminology, of the available mental health supports both in the school and local settings, and sometimes even, how to leverage available funding to support mental health curriculum in the schools.

Educators need support from the broader school community. Regardless of who delivers the mental health curriculum, those messengers also need support from the broader school and education community. Being able to navigate funding, for example, is often beyond the scope of work for educators, so having administrators to partner with to navigate such funding, and ensuring mental health curriculum is aligned and integrated with the school's overall approach, is vital in ensuring mental health education programming is sustained. This partnership between educators and school administrators can enable a stronger, systems-wide approach to mental health education. For example, one interviewee shared that their school included mental health curriculum as one tool within its overall Positive Behavior Interventions and Supports (PBIS) framework. Other schools shared that they structured mental health education as a Tier 1 support within the Multi-Tiered System of Supports (MTSS) model. Support from

administrators, both at the school and district level, allowed these schools to build in mental health education as just one part of a larger system of mental health support.

Peers are another source of messaging and support that schools can, and should, leverage. Some schools actively involve peer advocates in their mental health programming. For example, one interviewee shared that their school integrates peer support as one of their core pillars for their mental health education programming. Another school offers a peer advocacy class where students conduct trainings on suicide prevention, substance use, and mindfulness to support their peers. At this school, a student survey found that the peer advocates were the first people that students go to, and one student we interviewed noted that discussions on mental health among peers were especially helpful since they saw peers as equals as opposed to teachers, who they perceived as authority figures. Peers can play a critical role in not only catalyzing conversations among students that help dismantle stigma, but also in providing support and resources beyond the classroom.

Partnerships with outside organizations can be powerful tools. Some schools and districts shared that they benefited from partnerships with local organizations, such as local universities, in which mental health clinicians delivered mental health curriculum, to supplement mental health education provided by school staff on school campuses. One school partnered with graduate students from a local university to provide an after-school enrichment program that covered mental health topics. At another school, a partnership with a local university catalyzed the establishment of their mental health education program, with social work interns taking on teaching in classes where educators did not feel comfortable delivering the curriculum themselves. These partnerships also offered an opportunity for a train-the-trainer model, where educators could receive training from outside organizations, helping them feel more comfortable in delivering curriculum to their students. These partnerships were also helpful for supplementing mental health curriculum delivered by educators with instruction on connected topics that educators did not necessarily feel equipped to cover. For instance, one school partnered with a local organization to facilitate conversation on sexual health, and with an external partner to deliver discussion on online safety. While mental health curriculum delivery is centered in the classroom, partnerships within and beyond the schools can be significant in sustaining mental health education more broadly.

SCHOOL CULTURE & CONDITIONS FOR EFFECTIVE IMPLEMENTATION

Despite forward progress, mental health remains a stigmatized topic, and stigma deters many young people from seeking the help they need. Because of that, it is essential to create cultural conditions in which mental health is not only discussed, but prioritized. To do so, educators, students, administrators, and community members all have to come together and collaborate. The following lessons and recommendations were brought up by many of the educators and students we interviewed.

Trust is critical in effective implementation. Regardless of messenger, one recurring theme of the interviews was the importance of trust within school communities. A sense of trust between the educators and students, between administrators and educators, and between the community and the school was critical. School staff developed this trust in different ways. With students, some of the ways included creating a "cozy" physical safe space for students, while others shared their own stories with mental health to create a safe discussion space. Having a mechanism for feedback was another tool in fostering trust between educators, students, and the community of parents and caregivers. Examples included conducting student surveys, and offering public forums and listening sessions for families to engage with educators on this topic.

One school held community nights where parents and community members could join the school for dinner and to pick up resource materials. Trust between administrators and educators was also key. For schools, district administrators were not only critical in initiating mental health education programming, but also in funding its continuation. This trust between educators, students, and administrators also translated into another critical part of effective mental health curriculum, buy-in.

Buy-in from students, school community, and families is key. For mental health education to be effective, buy-in from both the school community and the broader community is essential. For schools, getting buy-in

is often a long, and ongoing, process. An interviewee shared that at an independent study-based school where the mental health curriculum was optional and where parents were the primary educators, the opt-in rate in the program's first year was 34%. In its third year, it was 45%. For this school, providing flexibility and meeting parents "where they were at" was critical in expanding buy-in.

When there was pushback, schools benefited from having a "champion" to increase buy-in. This advocate for mental health education could lead conversations with hesitant educators or unsure parents. Champions not only advocated for implementation of mental health education, they also brought in student, educator, and community feedback. Many interviewees we spoke to served in this champion role at their school. They navigated pushback by providing research and data on the efficacy of programming, conducting research to see which pieces of the curriculum received the most pushback, and reframing the discussion to help others better understand the purpose and benefits of mental health education. For schools, dispelling existing assumptions about mental health education - for example, that mental health education is unimportant and therefore not a priority — was the biggest barrier.

Both these components of cultural change surrounding mental health education - trust and buy-in - complement each other. When students and community members trust that educators and schools have the interests of youth well-being and success in mind, buy-in for mental health education grows. However, more must be done to emphasize the linkage between student success and mental health, to help increase understanding amongst school communities.

AREAS FOR GROWTH

Reframing mental well-being as part of student success. Interviewees identified a recurring barrier when it came to buy-in for mental health education and by extension, to effective implementation. This was the idea that mental health education is less important than traditional academic subjects, and that dedicating time to the mental health curriculum was not a priority. This belief perpetuates the already existing stigma surrounding mental health, and ignores the documented links between mental health and student engagement and performance. For the educators and students we spoke to, much of this issue came down to the need to reframe positive mental health as part of the excellence that schools strive to achieve. One educator and a student highlighted that when students are not able to feel comfortable in a classroom, or if they have peers who are struggling with their mental health, they are not able to pay attention in classes. This is reinforced by studies that identify "depression, stress, and anxiety" as the most common barrier to learning among students from 6th to 12th grade[16]. Another educator also noted that providing students with tools for their coping and emotional regulation reduces negative classroom behaviors that necessitate interventions later. For these educators and school staff, the mental health curriculum was intrinsically tied to students' engagement with other curricula. More work must be done to broaden the definition of student success, to foster the understanding that a young person's mental well-being is linked to their success, and to shift the narrative on mental health education. Only through this narrative shift can we ensure that mental health education is considered a priority.

Schools need funding to support mental health education. Narrative shift is important in shaping how people communicate about the importance of mental health education, and funding is how policymakers can indicate that it is worth investment and move implementation forward. Without proper funding, school administrators and educators are not able to provide the support needed for effective implementation. In contrast, if sufficient funding is available, schools can focus more on building out effective programs. One program administrator we interviewed was able to fund eight school districts in

their region, enabling a comprehensive model where each school district had a wellness director, and all grade levels received some level of mental health education. A school administrator we interviewed in a different region shared that their mental health curriculum was funded through braiding together various grants from their local county office of education. For this administrator, navigating funding and sustaining their mental health education program necessitated creating many different connections.

While effective and comprehensive mental health education requires an investment, the cost of foregoing it is much larger. On a broader scale, unmet mental health needs place children and youth at increased risk for many negative health outcomes, such as reliance on substances and worsened mental health conditions, as well as incarceration, unemployment, and early death.[17] For schools, untreated mental health needs can lead to decreased grades, truancy, chronic absenteeism, and school dropout.[18] This translates not only into costs in the form of learning loss and a cost in the young person's overall well-being and future prospects, but also a financial cost to schools in the form of funding loss due to decreased average daily attendance. With the significant rise in absenteeism since the pandemic, California school districts lose about $3.6 billion in annual funding due to student absences.[19] Funding for mental health education is not only critical for initiating and maintaining mental health education programming, it is also essential in developing ancillary supports needed by educators and students to make mental health education effective.

Educators need support to effectively implement mental health curriculum. Narrative shift and funding are two critical pieces needed for effective implementation of mental health curriculum. Among those we interviewed, another major concern is that educators are already overburdened. For schools to effectively implement mental health education, educators need support from others. This support can come in many different forms, such as having dedicated mental health educators or partnerships with organizations that can provide ongoing training and support to mental health instructors. These types of support are essential in ensuring that educators are not overwhelmed with integration of mental health education into their curricula, and ultimately, to avoid burnout among those delivering these programs.

Educators also need a community they can turn to for support in developing and implementing mental health programming. Several educators we spoke with mentioned their desire for a list or database of available curriculum that they could use to implement mental health education in their schools. Ideally, such a database could be a space for educators across the state to share materials with one another in an accessible way, including age-appropriate curriculum for each grade level. This could be supplemented by shared professional development and learning opportunities and a space for educators to connect and potentially collaborate with one another.

Students need access to support beyond the classroom. Mental health education is critical in helping students recognize mental health needs. Therefore, it is also critical that they can receive any needed mental health support. On average, California schools have one counselor per 527 students, which is double the recommended ratio of 250 students to one counselor.[20] These high student-to-counselor ratios, and other limitations on access to support, means that students in need of services must deal with long wait times, if they get to see a counselor at all. While mental health education is critical in educating students about their mental health and helpful in empowering students to recognize potential mental health needs, it should also be part of a continuum that connects students to school-based or school-linked care and services.

POLICY RECOMMENDATIONS

To strengthen the mental health and well-being of California students and create school cultures in which all students can thrive, we recommend the following:

EXPAND ACCESS TO MENTAL HEALTH EDUCATION, SO ALL CALIFORNIA STUDENTS — NOT JUST A SUBSET — CAN BENEFIT.

Under existing Education Code requirements (which mandate that middle and high schools that offer health courses include a mental health curriculum in those courses) only a fraction of California's 6 million students have access to this important instruction. This limitation contributes to inequities across the state. California should advance policy to ensure that *every* student at the elementary, middle, and high school levels has the opportunity to access mental health curriculum that supports their educational success and their overall health and well-being.

DEDICATE FUNDING FOR MENTAL HEALTH CURRICULUM AND FOR EDUCATOR SUPPORT.

Successful implementation of mental health instruction in schools requires time, energy, and staff capacity. The state should consider allocating funding to schools to help offset the costs of this process, such as purchasing instructional materials, staff time spent planning and delivering instruction, and professional development and training. The state should also consider offering more technical assistance to individual schools and districts to support implementation.

CREATE AND FACILITATE A STATEWIDE VIRTUAL COMMUNITY AND DATABASE OF MENTAL HEALTH CURRICULUM MATERIALS AND IMPLEMENTATION INFORMATION.

Given the many demands on educators' time, it is important to ensure that individual schools and/or teachers and school staff are not reinventing the wheel with regard to developing and delivering mental health curriculum. Educators across the state need practical ways to communicate, share materials and best practices, and trouble-shoot challenges together in real time. While individual districts and schools may use different approaches to mental health education to meet the specific needs of their school communities, a mutual starting point for information-sharing and discussion will make implementation more efficient and effective for school communities. This space should also provide opportunities to uplift curricula that are culturally-responsive, trauma-informed, and evidence-based, and that are designed to meet the needs of diverse student populations, including BIPOC youth, youth from low-income families, and youth who identify as LGBTQIA2s+. The state should take steps to create and support statewide communities of practice. It could consider doing so by building out the content and functionality of the existing website, California Health Education.

This virtual space could also be a space for sharing basic district-level implementation information. For example, districts could self-report simple data metrics, such as what curriculum they are using and with what grade levels, and identify a district-level and/or school-level points of contact. In addition to promoting transparency and accountability, this would help connect counterparts across the state and facilitate collaboration.

INCREASE AND LEVERAGE THE POWER OF SCHOOL-HEALTH PARTNERSHIPS.

Through the ongoing CYBHI and other initiatives, California has invested boldly in the expansion of school-based and school-linked mental health services. Many districts are implementing or considering partnerships between schools and outside entities, such as health plans and community-based mental health organizations, to expand access to care for their students. These partnerships can *also* be leveraged to support implementation of mental health education in the classroom. Collaboration between classroom teachers (the experts in delivering instruction to their students) and mental health professionals (the subject matter experts) can help ensure that students receive effective, impactful education, without teachers feeling overburdened or obligated to teach content that is newer to them.

CONTINUE TO UPLIFT THE IMPORTANCE OF MENTAL HEALTH EDUCATION AND SUCCESS STORIES.

Adopting and implementing effective mental health education can seem daunting for educators and administrators starting from the ground up. The state, through CDE, can support schools that are looking to implement a mental health curriculum by continuing to highlight the positive impact of mental health education on students, educators, and communities as a whole through sharing strategies and success stories from various California schools. Just as those we interviewed were the champions for mental health education at their individual schools and districts, the CDE can function as a champion for mental health education at the state level, uplifting the importance of mental health education as a vital tool in supporting overall youth mental health. Additionally, elevating comprehensive health education and existing health classes is another opportunity to ensure access to high-quality, relevant mental health education that integrates across other health topics.

MAKE SPACE FOR, AND LISTEN TO, STUDENTS.

Ultimately, the goal in providing mental health instruction is to help students achieve positive mental health and well-being. Student perspectives on their own needs are critical, but often undervalued, in the policy sphere. There must be more mechanisms in which student voice and leadership is integrated into how mental health education is implemented. Student involvement and leadership in this space can, and should, take many forms, from gathering data and research on students' views on mental health education to creating space for youth to provide input on how best to expand mental health education. One avenue to deepen student involvement could be through CDE leveraging the California State Superintendent of Public Instruction's Youth Advisory Council (Cali.YAC) to advise on next steps for mental health education.

APPENDIX

APPENDIX

Below is a list of additional resources highlighted by CDE and other mental health education advocates. As noted above, this is not an exhaustive list nor is it an endorsement of any specific curriculum.

CURRICULUM NAME	GRADE LEVELS	DESCRIPTION
Active Minds Peer-Powered Mental Health Curriculum	8-12	The Active Minds Peer-Powered Mental Health Curriculum for High Schools aims to prepare high school students with skills and knowledge to have discussions on mental health. It consists of 13 discussion guides for both student and adult facilitators with resources and questions across 5 focus areas: Action, Education, Awareness, Connections, and Community.
Wellness Education Lab	Students aged 11+	Wellness Education Lab (WEL) is offered by the non-profit organization Wellness Together. It is composed of mental health training modules for students, parents/guardians, and educators/other schools staff.
Work 2 Be Well	Students aged 13+	Word2BeWell (W2BW) is a mental health and wellness program that provides mental health resources and education for teens, parents, and educators to promote wellness and normalize discussing mental health.
Mental Health Literacy.Org	PK- 6	Mentalhealthliteracy.org gathers high quality mental health literacy information, educators, and resources including videos, brochures, and training programs. The materials are designed for children, youth, young adults, families, educators, and other community stakeholders.
Harmony Academy	PK-6	The Harmony Curriculum, an SEL program by National University, provides educators with instructional tools and resources to support SEL skills and promote healthy relationships. It has four components: Harmony Pre K-6th Grade Resources, Harmony At Home, Harmony Out-of-School Time, and Supplemental Resources.
Sanford Harmony Program	PK- 6	Developed at Arizona State University, the Sanford Harmony Program provides educators with tools to support social-emotional development for Pre K-6th students. The program focuses on communication, empathy, critical thinking, collaboration, and problem solving skills.
CalHOPE School Initiative resources	N/A	The CalHOPE School Initiative provides free resources to support youth, educators, and families including trauma-informed training, short stories, and toolkits.
Mental Health Education Institute at Geffen Academy at UCLA	N/A	The Mental Health Education Institute at Geffen Academy at UCLA provides a mental health curriculum rooted in a health education approach with frameworks that allow students to understand the differences between typical emotions and mental health disorders with additional focus on basic brain development and peer support.

ENDNOTES

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