



Addressing the Youth Mental Health Crisis:

**THE URGENT NEED FOR MORE EDUCATION,
SERVICES, AND SUPPORTS**

Acknowledgments

Mental Health America (MHA) was founded in 1909 and is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated services and supports for those who need them, with recovery as the goal.

MHA dedicates this report to mental health advocates who fight tirelessly to help promote well-being and equity for people with mental health conditions. To our affiliates, thank you for your incredible advocacy and dedication to promoting recovery. We also want to acknowledge and thank all of the young leaders taking action and transforming their schools and communities. Lived experience leadership is core to our history and values and continues to improve the design and outcomes of mental health programs, policies, and organizations.

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Executive Summary

Overview and Purpose of the Report

Indicators of youth mental health and well-being indicate a growing public health crisis that has only been worsened by COVID-19. Yet, public policy has been slow to respond at the state and national levels. This report seeks to document the alarming trends in youth mental health and the disparities in access to care. The report then addresses several innovative state legislative solutions to promote school-based mental health education, supports, and services. The report also highlights the effect of these policies on advancing equity and the role of youth leadership in securing legislation. The information is designed to guide advocacy at the state level and begin to create a framework for federal policy.

YOUTH MENTAL HEALTH IS WORSENING, AND DISPARITIES ARE PERSISTING

In 2019, data from the National Survey on Drug Use and Health indicated that the percentage of youth ages 12-17 who reported experiencing a past-year major depressive episode (MDE) had doubled over the past decade. Disparities continue, and Black and Latinx children are less likely than white youth to receive treatment for their depression, including inpatient treatment, though they are no less likely to have major depressive disorder.

COVID-19 worsened these alarming trends among youth and adolescents. From March to October of 2020, CDC data indicates children's visits to the emergency room for mental health conditions increased significantly. COVID-19 also revealed ongoing disparities. Mental Health America's online screening data indicates that youth ages 11-17 who identified as Native American or American Indian and those who identified as multiracial had the highest rates of depression. The largest increases in the proportion of youth experiencing suicidal ideation between 2019 and 2020 were for Black or African American screeners and Hispanic or Latinx screeners.



STATES HAVE ENACTED POLICIES REQUIRING MENTAL HEALTH EDUCATION, SERVICES, AND SUPPORTS THROUGH EXCUSED ABSENCES FOR MENTAL HEALTH

Schools are a critical setting for mental health policy. States have enacted policies, but the vast majority of states lack comprehensive policies in at least one category, and additional policies are needed to effectively address youth mental health needs.



Mental Health Education:

New York led the way with the nation's first statute requiring K-12 mental health education. Virginia soon followed with a legislative requirement for high school students. Florida enacted rules that require every Florida public school to provide students in grades 6-12 with at least five hours of mental health instruction. Mental health education is designed to address the gap of 11 years between symptoms and treatment by educating students to help themselves and their friends. Social-emotional learning interventions have been proven to promote well-being and academic achievement.



Mental Health Services:

Access to mental health services begins with early intervention by school personnel. Some states have enacted and funded lower ratios of counselors and social workers to students to improve the number of health professionals in schools. Only 14 states have fully expanded Medicaid to cover services outside of those detailed in an Individualized Education Plan (IEP), though several others are in progress. Very few children have an IEP.

In addition to reimbursing for school personnel, some states have enacted programs to promote community-based mental health providers delivering services in schools. Minnesota and Kansas have effective programs encouraging school-based services by community providers with strong outcomes. These programs are particularly helpful in addressing inequity, and data indicates that students of color gain access to mental health care when treatment is provided at school. Given workforce shortages, telehealth is particularly helpful in a school setting, and approximately half the states have specified that schools are eligible sites of service under their Medicaid programs.



Excused Absences for Mental Health:

Students need support when they are feeling unwell and unable to attend school for mental health as well as physical health reasons. Oregon's legislature passed the first bill in 2019, amending the excused school absence policy to include mental and behavioral health as a valid reason for an excused absence. Other states that have passed legislation regarding excused absences for mental/behavioral health include Colorado, Maine, Utah, Connecticut, and Virginia.

YOUTH LEADERSHIP HAS PLAYED A KEY ROLE IN DEVELOPING AND PASSING LEGISLATION

Youth in Oregon led the effort to enact excused absences for mental health with assistance from lobbyists for Providence Health and Services. Youth leaders were responsible for the Virginia education law. They drafted the statute, secured a prominent sponsor, and advocated for passage of the bill. Youth in New York received training in their government class and advocated for mental health education in schools by reaching out to their legislators and telling their stories.

RECOMMENDATIONS FOR THE FUTURE

1.

Promote Youth Leadership at the Local, State, and National Levels to Improve Youth Mental Health in Schools

Youth leaders have driven changes in state policies affecting youth mental health and schools. Partners have supported these efforts by providing training and assistance in accessing the levers of government to achieve policy changes. The next phase of work should include mobilizing more youth across the country to advocate for change and supporting their initiatives and leadership.

2.

Advocate for and Achieve More State Legislative Victories in Key Areas of Mental Health Education, Access to Services, and Mental Health Excused Absences; and Ensure Follow-up, Evaluation, and Effective Implementation

Although there has been innovation in the states, many of these initiatives have only spread to a few states. Advocates should carefully review their policies and build on existing structures for greater impact. Most states have significant gaps in policy regarding school-based mental health, and additional policies are needed to comprehensively address youth mental health needs, so there is much work to be done. In addition, advocates need to follow up and ensure evaluation and implementation even in states that have policies.

3.

Continue Innovation and Research on Evolving State Statutes and Programs to Improve Early Intervention in Youth Mental Health, Particularly in the Areas of Screening and Peer Support

Similar to physical conditions, mental health conditions are easier to treat early. Two areas of state innovation that can be helpful in ensuring intervention at the beginning of a mental health condition are screening and peer support. Youth are interested in screening for mental health conditions, especially during the pandemic, and are more likely to talk to a friend than anyone else when experiencing mental health symptoms. Some states have begun to consider these policies, and further research in these areas is needed.

4.

Draw on State Experiences to Inform a National Strategy and Implementation to Improve Youth Mental Health with an Emphasis on Youth Leadership, Equity, and School Initiatives

This report is limited to state policy, but the alarming trends in youth mental health are a national crisis and require a national strategy across and within agencies. The federal government needs to learn from the state initiatives profiled in this report and develop a national strategy, specific goals, a data collection process for measuring progress, and a specific implementation plan across agencies to improve youth mental health and promote equitable outcomes for LGBTQ+ and BIPOC youth, especially in schools. Specific agencies also need to prioritize youth mental health, coordinate to promote mental health education and services, and support and incorporate youth leadership.

Conclusion

With youth mental health declining and worsening during COVID-19, more urgency is needed at the local, state, and national levels. The efforts highlighted here should be enacted in communities and across states, and policy initiatives led by youth must be further developed at all levels of government.

I. Introduction and Target Audience for the Report

Although the mental health and well-being of children and adolescents had been declining substantially before the pandemic, COVID-19 has accelerated these concerning trends. Depression, anxiety, and suicidality rates are all moving in the wrong direction, according to multiple data sources. In addition, youth dying by suicide have been getting younger, especially Black youth. While these worsening outcomes are generally acknowledged in the press and by policymakers, there has been no coordinated, public health response focused on improving well-being and resilience. A public health crisis requires a public health response.

Basic tenets of public health include prevention and providing services where they are easily accessible. For children and youth, schools are the most obviously accessible places to reach them. Research indicates that mental health services are much more likely to be initiated if provided in schools, and students of color disproportionately access their mental health care at school. The COVID-19 pandemic made this especially apparent – without school, a critical touchpoint for reaching children with needed services was lost, with some of the most significant impacts on those with the least access to resources otherwise. Although not all youth are best reached in school, this setting should be a critical part of a comprehensive public health response to addressing the increasing mental health conditions in young people.

Schools already play an important role in promoting health literacy and good health practices. Virtually all schools have a health education curriculum, including topics such as sexuality and reproduction, healthy eating, exercise, and more. Many schools have also prioritized healthy practices with respect to food and beverage options offered to students and opportunities for exercise. Yet, there has not been a similar effort on mental health literacy and healthy practices for mental health.

Listening to youth voices provides invaluable guidance on what should be included in school-based initiatives. For example, Mental Health America asked youth ages 14-24 what mental health supports they need. The results revealed that access to mental health professionals and mental health breaks as part of work or school were the top resources young people requested to support their mental health. Learning about mental health was also one of the highest-ranked supports requested by youth.

Youth have also played a significant role in enacting state legislation on these key issues. States have begun moving forward in these areas, and state policy is often a critical step toward federal legislation. This report and the tools embedded within it are designed to assist state policymakers, youth, families, educators, administrators, mental health professionals, and others in advocating for a package of state reforms to move closer to a public health response to the mental health needs of our youth.

TARGET USER OF THIS REPORT:

- **State policymakers**
- **Advocates**
- **Youth**
- **Families**
- **Administrators**
- **Mental Health Professionals**
- **Educators**



To understand the scope of tools needed and the best approach to this issue, MHA held a series of meetings with an Advisory Board and additional experts in schools, mental health, equity, youth empowerment, and grassroots advocacy. From these conversations and a review of documents and articles, these themes emerged:

PRINCIPLES TO GUIDE SCHOOL-BASED MENTAL HEALTH EFFORTS:

1. Use a strengths-based, asset-driven approach.

Well-being, resilience, connection, and inclusion should be the goals, not safety and discipline.

2. Frame educational equity as health equity.

Emphasize the connection between learning and health, including mental health, and use an equity lens to improve educational and health outcomes for BIPOC and LGBTQ+ youth through mental health initiatives.

3. Empower youth as a key measure of success.

Include young people in planning, understanding needs, developing policies, and implementation. Educate youth on the legislative process so they can fully participate in policy change.

4. Work within or build on top of existing structures,

Including state legislation/health education requirements, curriculum, and interests. Synthesizing and respecting existing efforts, such as social-emotional learning (SEL) and suicide prevention programs, builds momentum.

5. Consider implementation, evaluation, and ongoing innovation as important as initial policy.

Provide adequate technical assistance regarding effective curriculum, processes, and comprehensive training for all school personnel, families, and students as critical components of implementation. Encourage innovation, such as telehealth, digital tools, and new ideas generated by students and others. Consider evidence-informed approaches and measurement of outcomes to ensure all students benefit.

6. Leverage policy changes for a whole school/whole community/whole child approach.

Conduct comprehensive assessments, address gaps, and connect to community resources to improve student mental health, resilience, and well-being.

Based on these themes, research on what youth want, and current policy initiatives in the states, this report focuses on:

- » data that describes the need for additional action to address youth mental health;
- » key state-level policy opportunities for advancing mental health in schools; and
- » an advocacy case study for changing state policy for mental health education in schools.



PRINCIPLES FOR COMPREHENSIVELY ADDRESSING YOUTH MENTAL HEALTH NEEDS IN SCHOOL:

Sydney Daniello,
Mental Health America

Sydney Daniello, an author of this report, discusses six guiding principles for school districts and policymakers to incorporate in the planning, implementation, and evaluation of effective school-based mental health services and supports.

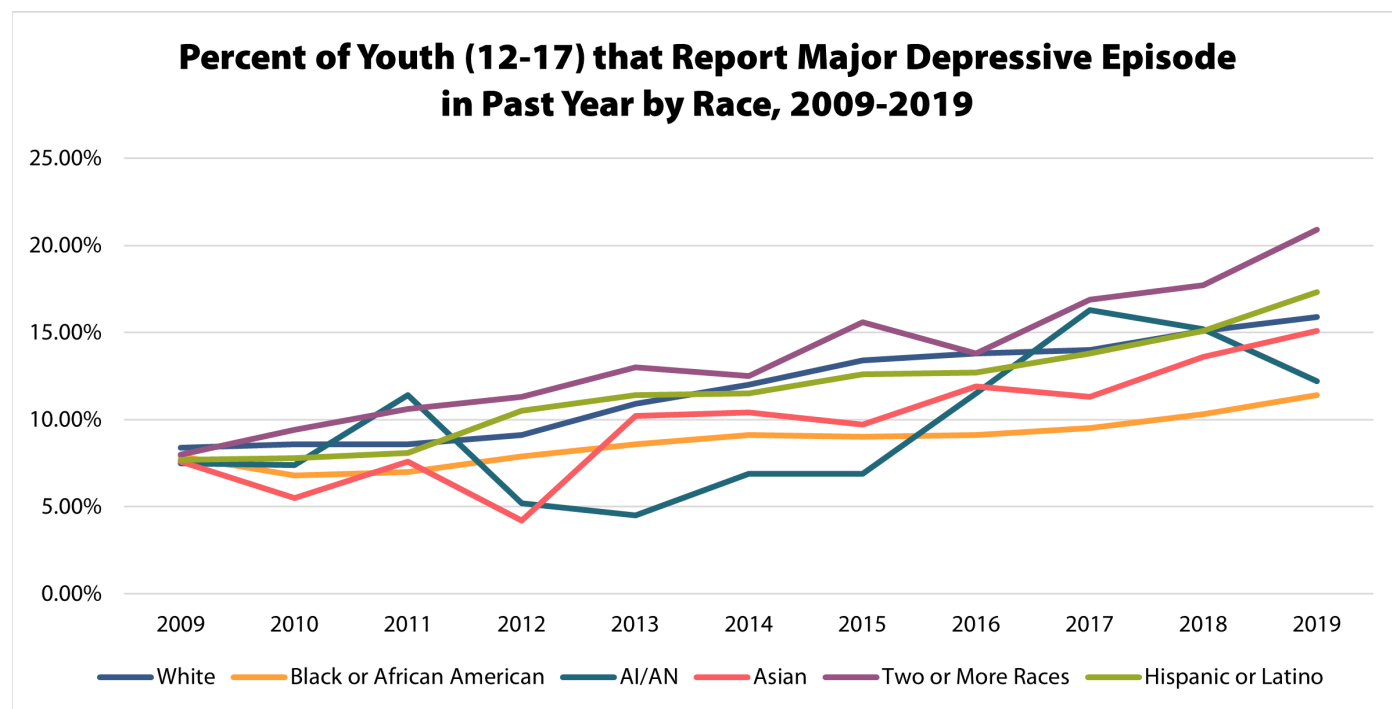
[VIEW VIDEO](#)

II. The Need for Action to Address the Youth Mental Health Crisis

GENERAL TRENDS IN YOUTH MENTAL HEALTH:

Over the past decade, even prior to the COVID-19 pandemic, adolescents in the United States began to experience greater rates of mental health problems. In 2019, 16% of youth ages 12-17 reported experiencing a past-year major depressive episode (MDE), compared to 8% in 2009, double the previous rate.¹ Rates of children's emergency department visits related to deliberate self-harm increased 329% between 2007 and 2016.² Deaths by suicide among youth increased by over 30% between 2014 and 2017.³

COVID-19 is worsening these alarming trends among youth and adolescents. From March to October of 2020, children's visits to the emergency room for mental health conditions increased 31% for those 12-17 years old and 24% for children ages 5-11 compared to the same period in 2019.⁴



In 2020, nearly 1 million youth ages 11-17 took a clinically validated mental health screen through the MHA Online Screening program, a 628% increase over 2019. Not only are the number of youths searching for help with their mental health increasing, but throughout the COVID-19 pandemic, youth ages 11-17 have been more likely than any other age group to score for moderate-to-severe symptoms of anxiety and depression than any other age group. Eighty-four percent of 11-17-year-olds who took an anxiety screen in 2020 scored with symptoms of moderate-to-severe anxiety, and 91% of youth who took the PHQ-9 for depression scored with symptoms of moderate-to-severe depression. These rates were 7% and 9% higher than the rates among adults over 18 for anxiety and depression, respectively.⁵

MHA asked youth ages 11-17 who were taking a mental health screen what was contributing to their mental health concerns, and these were some of their responses:

"I feel so disconnected and confused and alone"

"Feeling so lost and alone"

"Feeling like no one else is feeling what I'm feeling, or feeling like no one is there for me"

"...wondering what is wrong with me because no one else seems to feel this way"

"Not knowing how to get help"

"I know people who I fear risk suicide but I don't know how to help"

"I don't know what's happening to me but I need help. I'm not okay."

"Never had enough help to know"

INCREASING MENTAL HEALTH DISPARITIES:

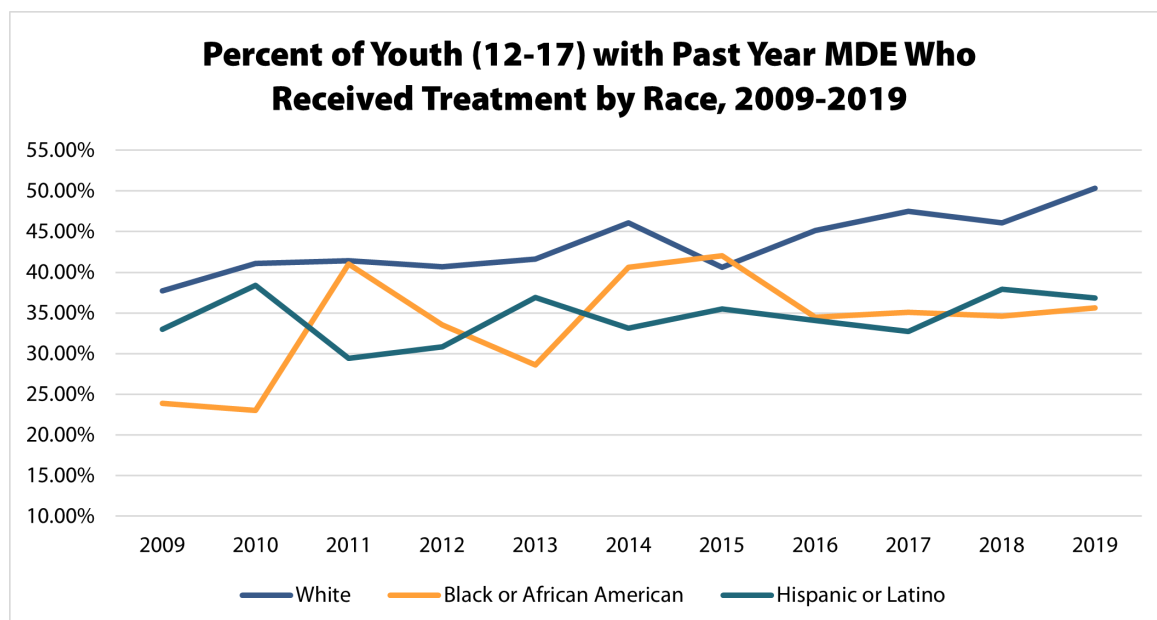
The aggregate statistics mask stark disparities – in 2019, 46.8% of youth that identify as gay, lesbian, or bisexual reported seriously considering suicide – more than three times the rate of youth identifying as heterosexual (14.5%).⁶ Further, in 2019, 25.5% of American Indian or Alaskan Native youth, 11.8% of Black youth, and 8.9% of Hispanic⁷ youth reported attempting suicide in the past year in 2019, compared to only 7.9% of white youth.⁸ Black youth, and especially Black boys and younger Black youth, have demonstrated rapid increases in suicide attempts and suicide deaths over the past decade, leading to the disparities observed today.⁹⁻¹⁰ The Congressional Black Caucus highlighted the troubling trends for Black youth in their path-breaking report, *Ring the Alarm, the Crisis of Black Youth Suicide In America*.

Mental Health America's (MHA's) online screening data indicates further inequities in mental health during the COVID-19 pandemic. For example, youth screeners ages 11-17 who identified as Native American or American Indian and those who identified as multiracial had the highest rates of depression, with 93% scoring for moderate-to-severe depression in 2020. The proportion of people reporting frequent thoughts of suicide or self-harm was also highest among youth who identified their race as "Other" (57%), youth who identified as Native American or American Indian (57%), and Asian or Pacific Islander (54%) in 2020. The largest increases in the proportion of youth experiencing suicidal ideation between 2019 and 2020 were for Black or African American screeners (5% increase) and Hispanic or Latinx screeners (4% increase).¹¹

Rates of suicidal ideation reported on MHA Screening are also highest among youth, especially LGBTQ+ youth. In 2020, over half (51%) of 11–17-year-olds reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks, totaling nearly 160,000 youth. Rates of frequent suicidal ideation were even higher among LGBTQ+ youth, with 62% reporting frequent thoughts of suicide or self-harm, totaling nearly 60,000 individuals.

TRENDS IN ACCESS TO CARE:

Despite increasing awareness of the mental health crisis in young people, access to care remains a significant challenge. Only 43.3% of all youth with a past year major depressive episode (MDE) received any mental health treatment in 2019. Overall, access to care has improved over time, as the percentage of all youth with past-year MDE receiving treatment increased 9% from 2009 to 2019. However, when examined by race and ethnicity, improvements in the receipt of care among youth with MDE are inconsistent, especially for Black and Hispanic youth. Despite inconsistent improvement, almost two-thirds of youth of color that need help still do not receive care, revealing important disparities in access by race. Only 50.3% of white youth with past-year MDE received mental health services, and the percentages were even worse for children of color, with 35.6% of Black and 36.8% of Hispanic youth with past-year MDE receiving mental health treatment in 2019.¹² Note that this only describes whether youth report any access to treatment while having MDE – it does not indicate whether they received sufficient care or whether that care was effective for them.



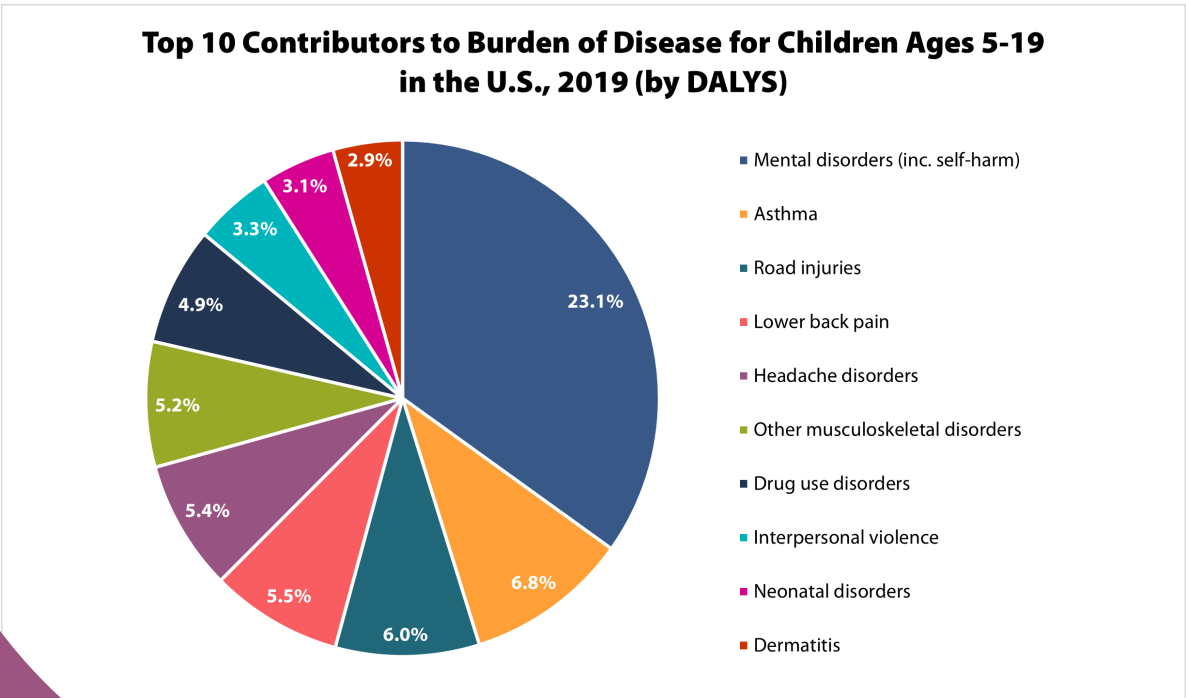
MENTAL HEALTH SERVICES IN SCHOOLS REDUCE DISPARITIES AND IMPROVE ACCESS TO CARE:

Youth of color are more likely than white youth to receive mental health services in educational settings, as opposed to general or specialty medical settings. School-based services reduce barriers such as transportation and health insurance that disproportionately affect youth of color. Despite the fact that youth of color comprise less than half of the total population of youth with MDE, 52% of youth with MDE who only received care in educational settings were youth of color, including 22% Hispanic youth and 20% non-Hispanic Black youth.¹³ In a recent study of a large urban Midwest school district of over 20,000 students, researchers found that BIPOC students in grades K-8 were over 2.5 times more likely to receive school mental health services compared to their white peers.¹⁴ Given this data, increasing access to school-based mental health services can promote equity and reduce disparities in access to care.

It is unknown how COVID-19 has impacted access to care nationally, as many children lost access to health insurance and schools, but access to virtual care options also improved substantially. Centers for Medicare & Medicaid Services (CMS) data indicates that for youth under 18 covered by the Medicaid program, there were 14 million (34%) fewer mental health services in 2020 compared to 2019, but CMS did not analyze the impact from declines in school mental health services and not all school services are reimbursed by Medicaid.¹⁵ Increasing access to school-based mental health services would be an important way to reach much of the youth who may have been affected by the pandemic, especially youth of color.

COMPARISONS WITH OTHER PUBLIC HEALTH CONCERNS OF YOUTH:

Mental health conditions and self-harm are the greatest contributors to the burden of disease for young people by a substantial margin. The Institute for Health Metrics (IHME) at the University of Washington uses a measure of disability-adjusted life years (DALYs) to quantify the burden of different diseases throughout the lifespan. For people ages 5-19 in the United States in 2019, mental health conditions and self-harm contributed 23.1% of the total DALY burden. Asthma and road injuries, the second- and third-greatest burdens, contributed only 6.8% and 6.0%, respectively.¹⁶ See figure below.



TOOLS YOU CAN USE:

Infographic (**Appendix A**)

Fact Sheet on data for children’s mental health (**Appendix B**)

III. State Policy Recommendations and Examples

To address this growing youth mental health crisis, states can leverage schools as a touchpoint for promotion of mental health to avoid problems from developing, as well as early intervention and treatment to meet needs when they do arise. The sections below analyze (1) prevention and mental health promotion options for states with a focus on mental health in schools, (2) early intervention and treatment integrated into schools, and (3) youth empowerment to drive cultural shifts in schools.

A. Prevention and Promotion: Mental Health Education & Social-Emotional Learning

Mental health education in K-12 classrooms often includes both social-emotional learning and mental health literacy, with younger grades beginning with social-emotional learning and mental health literacy included in health education classes for older students.

MENTAL HEALTH EDUCATION AND MENTAL HEALTH LITERACY:

Mental health literacy curriculum is designed to be provided to all students and often includes information about mental health conditions, wellness skills, and how to seek help. Australian researchers have demonstrated that people, particularly students, who receive mental health education are more likely to recognize and seek help for the symptoms of a mental health challenge. The researchers coined the term mental health literacy, which is, they explain, an extension of health literacy and is defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention.”¹⁷

There are several studies indicating that mental health education generates positive, meaningful outcomes. For example, a recent meta-review of effective suicide prevention strategies concluded that educating high school students with a mental health curriculum was one of the few policies that was proven to reduce suicide attempts and suicidal ideation.¹⁸ A randomized controlled study of a suicide education program provided to diverse technical high school students showed students who received the intervention were 64% less likely to report a suicide attempt after three months than those in the control group.¹⁹

Another study compared states with school mental health policies to those lacking these policies. States that mandate more mental health policies in public schools overall have significantly lower adolescent and young adult suicide and substance abuse rates, but one subset of policies was particularly impactful. State-mandated school-based mental health centers, social-emotional curricula, and school professional development in suicide prevention were all associated with significantly lower adolescent and young adult suicide and substance abuse rates.²⁰

Surveys consistently show that youth are aware of their own mental health challenges and those of their peers, and as such, are interested in mental health education. A 2019 study by the Pew Research Center found that anxiety and depression top the list of challenges teens see among their peers.²¹ In a survey of teens ages 13-17, 70% said that anxiety and depression were major problems among themselves and their peers, outranking other significant social problems such as bullying, substance use, teen pregnancy, and even poverty. This finding suggests that because teens themselves recognize their own mental health challenges, they may be more motivated to learn about mental health in order to increase their own ability to recognize signs and symptoms and to get help.

SOCIAL AND EMOTIONAL LEARNING:

According to the Collaborative for Social and Emotional Learning (CASEL), SEL is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions. SEL can include both classroom curricular content and approaches to classroom management, such as rules that reinforce positive behaviors. More recently, trainings have become available to ensure that SEL activities are unbiased and culturally responsive for students and educators of racially and ethnically varied backgrounds.

Two meta-analyses of studies of social-emotional learning interventions found significant improvements for students. The first study, in 2011, found that compared to controls, students demonstrated enhanced skills, attitudes, and positive social behaviors following intervention and fewer conduct problems and had lower levels of emotional distress. Academic performance was significantly improved by 11% in the subset of studies measuring this outcome.²² A 2017 follow-up study found that gains endured over time and social and emotional learning interventions had an effect on promoting positive outcomes, such as improving skills, positive attitudes, prosocial behavior, and academic performance and avoiding negative outcomes, including conduct problems, emotional distress, and substance use. These gains were achieved across racially and socioeconomically diverse student populations.²³

POLICY OPTIONS FOR ADVANCING MENTAL HEALTH EDUCATION:

Part IV of this report offers a lengthy case study of policy change in New York State for mental health education in schools. In addition to New York State, there are several other states that have laws or regulations requiring mental health education, and in the coming years, more will likely be added. It is expected that the federal government will begin providing more technical assistance and guidelines to improve mental health literacy in schools. States have taken similar strategies specific to social and emotional learning as well. Ideally, these approaches will be combined with school-wide integration of services, as described in subsequent sections. Youth leadership has been critical to these efforts.

Many of these laws build upon existing curriculum and requirements. For example, Virginia's statute ([HB 1604](#)) adds the following language after the state code's general support for physical and health education in the schools:

Such health instruction shall incorporate standards that recognize the multiple dimensions of health by including mental health and the relationship of physical and mental health so as to enhance student understanding, attitudes, and behavior that promote health, well-being, and human dignity.

YOUTH EMPOWERMENT

Angela Wallace of Massachusetts



Angela Wallace of Massachusetts discusses her experience as a Black female student in a racially homogenous school district in Massachusetts and why she was driven to speak out about her challenges regardless of shame and bias. Angela has provided expert witness testimony for the Massachusetts Legislative Committee on Mental Health and Substance Use Recovery in favor of mental health education legislation.

[VIEW VIDEO](#)



▶ **Virginia Students,
Legislative Sponsors,
and Governor**

The bill further provides that the State board of education will review and update the health standards of learning for students in grades nine and 10 to include mental health education and requires the state to consult a wide array of stakeholders in developing the new standards, including providers, the state mental health agency, and advocacy and peer organizations.

Importantly, Virginia's process was entirely youth-led. Students who were aware of the New York law secured sponsors in the Virginia legislature and advocated for the bill. They approached Virginia State Senator, Creigh Deeds, who sponsored the bill. Senator Deeds had a son who died by suicide after being denied psychiatric services in 2013. Finding a very motivated and well-positioned sponsor was a key factor in moving the bill forward.

Just as in New York, getting a law passed was only the first step toward progress. Advocacy organizations highlighted the students' success and worked with the board of education to spur the agency to prioritize conducting the required review and update of the standards. Unlike New York's law, the Virginia statute does not include funding for a technical assistance center, which has hampered widespread implementation and tracking of progress. In Virginia, advocates and policymakers have continued to build on the student education requirement and a [bill](#) to require teacher training passed in 2020.

In Florida, the state board of education voted to require every Florida public school to provide students in grades 6-12 at least five hours of mental health instruction. The board specified both the number of hours and the general content of the instruction. The instruction must include: awareness of signs and symptoms; process for getting or seeking help for themselves or others; awareness of resources (i.e., Fortify Florida app and the National Suicide Prevention Hotline: 1-800-273-8255); and what to do or say to peers struggling with mental health disorders.

This requirement was championed by First Lady Casey DeSantis as part of her Hope for Healing Florida, an initiative to promote mental health and avoid addiction. Again, having a high-profile sponsor for the initiative was very helpful. With respect to the new education requirement, the First Lady said:

Ron and I have traveled the state and have heard from many families who voice concern about the struggles that adversely affect so many of our children. We know that 50% of all mental illness cases begin by age 14, so we are being proactive in our commitment to provide our kids with the necessary tools to see them through their successes and challenges. Providing mental health instruction is another important step forward in supporting our families.²⁴

In Florida, mental health education is one of several components addressing school-based mental health and resiliency. The Hope for Healing initiative has also included partnering with the state's athletic teams to promote resiliency and create a peer-to-peer student mentoring program.²⁵

Although the shooting at Marjorie Stoneman Douglas High School increased statewide awareness of the need for mental health education and supports in Florida, it also has led to an over-reliance on law enforcement, requiring every school to have an armed staff member or a law enforcement officer. This has resulted in higher rates of arrests, especially for students of color.²⁶ Focusing on mental health and wellness instead of safety is critical to ensuring equity in state reforms.

In Appendix C of this report is a state-by-state chart with every state and its respective current mental health curriculum requirements. CASEL also offers [resources on state efforts related to SEL](#).²⁷

In addition to these strategies, the Every Student Succeeds Act (ESSA) gives states new flexibility in administering federal grants for schools that serve low-income families and allows for greater focus on student health and well-being. This also gives advocates additional opportunities to advance mental health in schools. For example, ESSA gives states flexibility in selecting a “non-academic” indicator of school success to track, which can include a measure related to student mental health. ESSA also allows some of the school funding and professional development dollars to go toward student well-being, opening the door to funding programs and staff training in mental health education in schools. Advocates can work with their state departments of education to ensure that their ESSA plans promote student mental health and well-being. More information is [available in this issue brief](#).²⁸

After the COVID-19 pandemic, the American Rescue Plan Act (ARPA) creates other opportunities. [ARPA offered over \\$200 billion](#) in additional investment in K-12 public education, with a specific requirement that some of these funds must respond to students’ academic, social, and emotional needs.²⁹ Advocates can work with state departments of education that are administering these programs to ensure that these funds go toward building the necessary infrastructure and training to integrate mental health education in schools.

Lessons Learned From State Policy Efforts Seeking Mental Health Education Requirements:

Build on what exists. Review the state-by-state chart to see where your state is and see what you can add to what you already have regarding health curriculum requirements. Try to increase coverage to K-12 students but at a minimum cover 6-12. Include a technical assistance center to implement the requirement or as a stand-alone if the curriculum requirement is not moving forward.

Empower youth leadership because they can powerfully articulate the need for this legislation and reach legislators in their districts.



Angela Wallace and Lucas Johnson testifying before Massachusetts State Legislature

Find a high profile, motivated, and effective sponsor in the legislature or executive branch because that can be very impactful.

Be vigilant with implementation. Getting a bill passed is only the first step. So if your state has any requirements, find out if they are being implemented. Ensure that equity is considered in all aspects of implementation.

Leverage student education requirements to have a more holistic approach, either through technical assistance and training or more comprehensive initiatives for programs such as peer support or staff training. Ensure equity within reform efforts through a wellness and mental health focus.

TOOLS YOU CAN USE:

State-by-State Mental Health Education Legislation Chart (**Appendix C**)
Playbook: State Laws for K-12 Mental Health Education (**Appendix D**)

B. Early Intervention and Treatment: School-Based Mental Health Services

Mental health education is a universal intervention, but schools must be able to respond when students reach out for help. An adequate response includes school mental health personnel, who can provide early interventions and coordinate care, as well as treatment professionals, who can be part of a school-based health center, a community partner, or other arrangements. These different levels of response are often referred to as Multi-Tiered Systems of Support (MTSS), with Tier 1 addressing universal needs, Tier 2 for students at risk or in need of early intervention, and Tier 3 for students who need individualized treatment and support for mental health and substance use conditions.³⁰ School personnel are generally involved in all tiers, and community providers may provide general education in Tier 1 but more likely provide services in Tiers 2 and 3.

In 2019, the ACLU released a comprehensive [report](#) detailing the lack of school mental health personnel using data provided by the Department of Education and noted that 14 million students were in schools with a police officer, but no counselor, nurse, school psychologist, or social worker.³¹ Over 90% of schools failed to meet professional standards for school counselors. The report noted that low-income students and students of color are more likely to get their mental health services at school and are disproportionately harmed by the low ratio of school personnel. The report also noted the importance of school-based mental health centers and the ability of students to access services on site. With COVID-19, there continues to be a strong interest in telehealth, and financing remains a critical need to support school-based personnel and community treatment options.

We found several effective state policy strategies for advancing school-based mental health services, including laws or policies setting ratios of students to school personnel, Medicaid policy approaches, using telehealth to provide school-based services, and policy proposals improving school-based mental health services from community providers. Note that, across all of these approaches, federal relief funds from ARPA offer new opportunities, including additional funding for schools to integrate mental health services, to purchase telehealth equipment, to provide training for school staff, and to fund mental health services that could be integrated within schools.

LAWS OR POLICIES SETTING RATIOS OF STUDENTS TO SCHOOL PERSONNEL

There are statutes and board of education policies at the state level setting ratios of students to school personnel. Policy analysts studying counselor ratios and state policy initiatives have concluded, “the relationship between these policy levers and a state’s median school counselor ratio is striking. For instance, of the seven states with the highest median ratios (least access), none have mandated a maximum student-to-counselor ratio. Conversely, of the six states with the lowest median ratios (greatest access), all either have a mandated student-to-counselor ratio or a recommended ratio with dedicated state funding to help support counselor access.”³²

Improving school ratios is another area where students have provided leadership. In one district, the advocacy of a group of students doubled the number of school mental health professionals through testimony designed to ensure that the allocation of new resources to the district was spent to promote mental health.

Advocates seeking to understand their state requirements can review the ACLU report and the American School Counselor Association’s [list](#) of state-by-state legislation and mandates. For a better understanding of equity and school counselor ratios, this [fact sheet](#) provides information on the 38 states that are failing to provide adequate counselors for their students of color and low-income students and has specific steps for advocates to address these shortfalls.³³ The National Association for College Admission Counseling has developed [maps](#) at the school district level with 2015-2016 data for school counselors.



YOUTH EMPOWERMENT Melanie Zhou of Colorado

Melanie Zhou of Colorado discusses the burden of experiencing a classmate die by suicide. This motivated her to push for student representation on the board of education and to advocate for funding to address the mental health needs of students in her school district. She successfully advocated for millions of dollars in funding for mental health professionals and subsequently founded a mental health student healing group.

[VIEW VIDEO](#)

Some of the most favorable ratios in the state bills are in Colorado and Virginia. In 2019, Colorado passed a [statute](#) creating a pilot program in 10 schools to achieve a ratio of 250 students per mental health professional and evaluate the results on the students' physical and mental health. In 2020, Virginia passed a [statute](#) lowering the ratios of school counselors to 1:325 for K-12 beginning in the 2021-2022 school year. The state has progressively worked to lower the ratios, and advocates may want to look at their state policies over time. In addition, counselors can spend much of their time in administrative duties, and Arkansas passed a [bill](#) to limit such work to 10% of the time and specify the student contact activities that counselors should be doing.

There is much work to be done, particularly for schools serving children of color and low-income students. According to the ACLU report, more than 67,000 schools lacked any social worker, and more than 24,000 schools (25%) reported having no counselor on staff. In addition, 43% of public school students were enrolled in a school that did not have a school psychologist.³⁴

MEDICAID POLICY APPROACHES

In 2014, the Centers for Medicare and Medicaid Services (CMS) reversed longstanding policy and issued a [letter](#) to State Medicaid Directors allowing states to bill for school services for any Medicaid eligible child, not just those who had an Individualized Education Plan (IEP) and had qualified for services under the Individuals with Disabilities Education Act (IDEA). In 2019, CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a [joint informational bulletin](#) offering additional guidance to states on how to bill for school services if they chose to do so.³⁵

To date, 14 states have chosen to take advantage of the ability to bill Medicaid beyond IEPs, and several others are in progress. These states are listed in a state policy dashboard in Appendix E. Some states have specifically enacted legislation to enhance mental health benefits, and advocates can find details on state efforts in this [report](#) from the Healthy Schools Campaign.³⁶ Michigan, for example, passed [SB 149](#), appropriating \$30 million to pay for school mental health professionals and an additional \$1.3 million for the state to issue a state plan amendment to CMS to be able to draw down more Medicaid dollars for mental health services. The relevant provision read:

Sec. 31n. (1) From the school mental health and support services fund money appropriated in section 11, there is allocated for 2018-2019 for the purposes of this section an amount not to exceed \$30,000,000.00, and from the general fund money appropriated in section 11, there is allocated for 2018-2019 for the purposes of this section an amount not to exceed \$1,300,000.00. Not later than February 15, 2019, the department and the department of health and human services shall establish a program to distribute this funding to add licensed behavioral health providers for general education pupils and shall seek federal Medicaid match funding for all eligible mental health and support services.

Early results show significant increases in behavioral health staff. As of May 2021, the Michigan state team working on this initiative reported behavioral staff increased from 1,738 to 2,975, a 71.17% increase. In addition, reimbursement also significantly increased by \$6.17 million from Medicaid expansion.³⁷ This Michigan [case study](#) provides additional details for states seeking to make similar changes.³⁸

USING TELEHEALTH TO PROVIDE SCHOOL-BASED SERVICES

In addition to expanding funding for Medicaid, some states have expanded access to services by specifically adopting Medicaid policies indicating that schools can be an originating site for telehealth. According to a Spring 2021 [report](#) from the Center for Connected Health Policy, 27 states and the District of Columbia expressly have policies allowing schools to be originating sites, although sometimes restrictions apply.³⁹ These states are listed in Appendix E.

According to the Center’s analysis, “the most common modality allowed in schools is live video, and only four states allow a store-and-forward modality to be used (NC, NM, OK, and GA). Eleven of these states require parent informed consent for a minor to participate.” Services vary from state to state, but the most common services are therapy services, which include mental health therapy as well as speech, occupational, and physical therapy.

Texas has maximized the use of telehealth to provide school-based mental health services. In 2019, the state legislature passed [Senate Bill 11](#), creating the Texas Child Mental Health Care Consortium, a collaboration of the state’s higher education institutions, nonprofits, and service providers. The Texas Higher Education Coordinating Board was the administrative agency tasked with receiving and appropriating the funds for Consortium initiatives.

One of the initiatives relevant to school-based mental health was the Texas Child Health Access Through Telemedicine (TCHAT) program. This program is built on existing telehealth programs in the state, including a consultative [pediatric mental health access program](#) funded in part by Health Resources and Services Administration (HRSA) and operating in many states. The team includes licensed professional counselors, licensed clinical social workers, a child psychologist, licensed vocational nurse, child psychiatrists, and community health workers. They collaborate to assess, refer, and treat students, who can receive up to four sessions from the program at no charge to families.

Key elements of the program include a partnership between the team and schools, the provision of counseling services and telepsychiatry to students, and guidance to school professionals in assessing, supporting, and referring students.⁴⁰

As of October 15, 2020, 96 school districts in Texas were actively involved with TCHAT, covering 1,124 schools and a total student population of 842,422. It is anticipated that the total number of covered students will expand to 1.33 million once the memoranda of understanding in progress are fully executed. Funding for the fiscal year 2020 and 2021 is approximately \$37 million. The program is too new to have outcomes, but anticipated data may include numbers reached, number of services, satisfaction, reduced mental health needs, reduced school absences, and improved graduation rates.⁴¹

POLICY PROPOSALS IMPROVING SCHOOL-BASED MENTAL HEALTH SERVICES FROM COMMUNITY PROVIDERS

One of the most effective policy changes has been state grant programs that provide school-based mental health services through partnerships between community providers and schools. These programs eliminate the need for transportation, parents having to take off work, wait times, and other barriers. Youth are also more likely to complete treatment in schools compared to other settings.⁴²

These programs have demonstrated very positive effects on access and other outcomes, such as graduation rates and academic achievement. For example, the 2018 Kansas legislature passed a [statute](#) creating a pilot program that they have continued to fund at increased levels. The Mental Health Intervention Team (MHIT) pilot program began with nine school districts and provided resources for school-based mental health liaisons and for case managers and therapists at the community mental health centers (CMHCs). The local education authority and the community mental health centers entered into memorandums of agreement, and the Kansas State Department of Education created the payment mechanism and the database to track outcomes.⁴³ Creating the database within the state agency saved resources and allowed for customization to meet the program’s needs.

A summary report from the Kansas State Department of Education at the end of the first fiscal year stated:

At the end of fiscal 2019, over 1700 students were receiving CMHC services through the MHIT project, including 212 foster students. Overall improvement was shown in academics, attendance, and behavior in many of the students. Feedback from families, students, and teachers was positive, and families appreciated the convenience of the school-based partnership with the local CMHC. Students appeared to understand their personal issues and how to effectively change their own behavior. Teachers and school staff also reported fewer disruptions in the classroom which improved the school climate.⁴⁴

REDUCING DISPARITIES

Bernadeia Johnson of Minnesota

As superintendent of Minneapolis Public Schools, Bernadeia Johnson intentionally set out to improve access to mental health services through schools, especially for underserved BIPOC students. By spearheading an initiative with community stakeholders and education leaders, she successfully secured additional supports for marginalized students and families to receive mental health services and supports on school campuses, where they were most likely to benefit from it.

[VIEW VIDEO](#)



The program tracks outcomes, and results from the past two years indicate similar positive outcomes. Approximately two-thirds of children improved their attendance, and over half improved internalized behaviors; roughly 60% improved their academic performance, and approximately 70% improved external behaviors.⁴⁵ Given the positive early outcomes, the legislature has continued to invest in the program. For the 2020-2021 school year, 56 school districts and 212 schools are participating in the mental health intervention team program.⁴⁶

Minnesota has one of the oldest school-linked programs in [statute](#), first passed and funded by the 2007 legislature. Over the years, the program has expanded substantially to cover more schools and has increased its focus on evidence-based practices such as trauma-focused cognitive behavioral therapy.⁴⁷ Advocates in Minnesota credit the educational community for the expansion, noting that school superintendents and teachers have been some of the most vocal advocates for the program at the legislature because they have seen the impact on their schools and communities.⁴⁸

Under the program, the Department of Human Services, not the state education agency, distributes grant funds to local community mental health agencies to “offer mental health services in schools, including assessment, treatment and care coordination, teacher consultation, and school-wide trainings.”⁴⁹ These community mental health agencies bill both public and private insurers for clinical services so that the grant funds are used for students who do not have health coverage or are underinsured. Funds can also be used to pay for the services that are not typically reimbursable, such as in-service training and outreach to families and communities.⁵⁰ Funds can also be used for equipment, connection charges, on-site coordination, and other expenses to set up telehealth programs. Advocates and providers worked to address the bidding process to ensure more consistency in funding from year to year for community mental health agencies.⁵¹

Importantly, the program has been effective in meeting the needs of children who had previously been underserved. Almost half of the children (47%) had not received mental health services before they were provided care under the school-linked program. This percentage was even higher for children of color, and 58% of children of color had not received any mental health services before participating in the program. School-linked programs can begin to narrow the access gaps for mental health care for children of color.⁵² Of the children newly identified, half of those were children with serious emotional disturbance, indicating that many children with very high needs are not identified without school-linked programs.

One of the recent recommendations for improving the program included youth leadership and voice. Stakeholders recommended utilizing the Minnesota Youth Council or another youth advisory process “to review implementation practices, methods, and barriers to school-linked programs to gain youth perspective on successful access to services. Actively involving young people in a consultation process can create an opportunity to get reliable information about young people’s needs and everyday experiences accessing mental health services.”⁵³ The Minnesota Youth Council Committee was created by Minn.Stat. 124D.957, to provide advice and recommendations to the legislature and the governor.

Lessons Learned From School Policies Increasing Access to School-Based Mental Health Services

Seek sustainable funding for community mental health providers. Medicaid policies should encourage payment, and private insurers should be required to pay their fair share of school services, allowing state grant funds and other resources to be used for training and services for children who lack insurance or are underinsured. Telehealth should be permissible as a way to reach students more easily. Resources should go directly to the community mental health providers rather than the schools for the funding areas related to services.

Measure outcomes to support expansion of the program. In both Kansas and Minnesota, strong outcomes led to increased funding and more schools covered. The Kansas Department of Education developed a database to ensure adequate tracking of key outcomes.

Design programs to increase access to mental health care and address inequity. In Texas, the TCHAT program is reaching children in parts of Texas that lack mental health providers and is providing immediate access to care in crisis situations. The Kansas MHIT program included children in the foster care system as a key target for the program. Minnesota data indicated that over half of the children served had not received mental health services prior to the school program, and almost 60% of children of color had not received any services before participating in the program.

Engage beneficiaries of the legislation in advocating for the program. In Minnesota, education stakeholders have been particularly effective in reaching out to their legislators to increase funding to allow expansion of the program to more schools.

TOOLS YOU CAN USE:

School-Based Mental Health State Policy Dashboard (**Appendix E**)

School Mental Health Services Chart (**Appendix F**)

Ensure youth have a key role in advocacy and implementation of the program. In Minnesota, a stakeholder group evaluating the school-linked program recommended an existing Youth Advisory Council or other similar body provide ongoing input into implementation.

C. Youth Empowerment: Driving School Culture Change

Youth empowerment is a key strategy for effective state school mental health policy. With respect to New York and Virginia mental health education legislation, young people were key advocates with the legislature, and for the Virginia bill, they were the driving force behind the legislation. This youth involvement ensures that the policy will be effective and tailored to meet the current needs of young people. Youth-led initiatives are also very responsive to the immediate needs of young people and reflect policies that they believe are going to help. Youth empowerment can play a crucial role. Given the opportunity, young people are able and have the desire to provide school administrators, public health officials, and legislators a clear idea of what interventions they need *right now* to improve their mental health and well-being.



▲ Lori Riddle, Hailey Hardcastle and Derek Evans testifying before Oregon State Legislature

The fastest, most efficacious, and most equity-focused way to meet the needs of young people is to give them the space and the encouragement to ask for what they need. Youth-led initiatives are better suited to address and reflect the needs of LGBTQ+ students and students of color. For example, advocates for LGBTQ+ youth have noted that youth-led activities better incorporate and reflect their needs because traditional evidence-based strategies are based on aggregate data that often leaves out the needs of those students.

According to Mental Health America's 2020 Young People's Mental Health Report, when surveyed on the top three things that young people felt would be most helpful to their mental health, high school students (ages 14-18) reported that learning how to support their own mental health in their daily lives (48% of respondents) access to mental health professionals (53%), and mental health breaks and absences as part of school and work (53%) were most important.⁵⁴

In this report, we have already addressed mental health education and increasing access to mental health services in schools. The last of the three areas that young people have identified as being important to improving their mental health is the concept of excused absences for mental/behavioral health, also known as mental health sick days. The data shows that high school students (ages 14-18) feel that being able to take a break to care for their mental health is **equally as important** as having access to mental health professionals (tied for the top survey response as mentioned above).

OREGON AND OTHER STATES:

Not only is it clear that young people care deeply about excused absences for mental health, they are also taking action to implement these policies. In Oregon, for example, a group of teen mental health advocates was the driving force behind the passage of [HB 2191](#), the 2019 bill that expanded Oregon's excused school absence policy to include mental and behavioral health as a valid reason for an excused absence. The group of students, including Hailey Hardcastle (view her TED Talk [here](#)) and Derek Evans, partnered with Providence Health and Services, a major health system in the state, and advocated for the Oregon legislature to pass the bill in response to the youth mental health crisis facing the state.

Just as many of the mental health education laws build upon a state's current health education policy, excused absence laws can also amend existing policy. Oregon state law already had a section on excused absences, so HB 2191 added the phrase "including the mental or behavioral health of the pupil" in order to include mental health-related absences in the law. It is important to note that the new bill did not actually change the number of excused absences a student can take in a given period of time. In Oregon, students are permitted no more than five excused absences per three-month term. Now, as a result of the passage of HB 2191, students can access these five excused absences per term for physical or mental health.

The language for the bill was drafted by Students for a Healthy Oregon (a group of approximately 30 students) with the help of a lobbyist for Providence. The bill was introduced in January of 2019, signed into law by the governor in June of that same year, with an effective date of one month later (July 2019). Importantly, the bill had no fiscal impact. From introduction to enactment, the bill took only six months and cost zero dollars.

Other states followed closely behind Oregon, passing similar legislation often driven by young advocates within their respective states. Other states that have passed legislation regarding excused absences for mental/behavioral health include Colorado, Maine, Utah, and Virginia. States with legislative movement on excused absences for mental health are listed in Appendix E.

▼ Sam Adamson, Hailey Hardcastle, Derek Evans, Bailey Wiggins, Lori Riddle at the Oregon State House of Representatives



HOW TO ENCOURAGE YOUTH INVOLVEMENT:

Oregon, Colorado, and other states with youth-led advocacy efforts for mental health excused absences provide a model for how to encourage and support youth involvement in mental health advocacy. In Oregon, a group of students formed a coalition known as Students for a Healthy Oregon. The partnership between these students and Providence is an excellent example of how adults can support youth empowerment in mental health advocacy. Students drove the entire process from the conception of the idea to the bill to the writing to the introduction and advocacy for its passage. Providence supported these students by providing training and resources that helped the students be successful. For example, a lobbyist from Providence worked with the students to produce legislative language that addressed the students' issues. Experienced advocates at Providence helped to train small groups of students about the rules and procedures for meeting with state legislators, as well as aided in developing talking points for how to tell their individual stories and prepare for difficult questions and arguments. Robin Henderson, PsyD, Chief Executive of Behavioral Health at Providence, explained, "students completely led the 'what,' while Providence supported them with the 'how.'"⁵⁵

This has repeatedly been a successful strategy – empowering young people to lead the effort with support from health or advocacy organizations when needed. Advocacy organizations and others interested in helping young people advocate for what they need can support youth advocacy efforts by actively seeking out young people who are already doing the work and offering guidance or resources as needed, rather than trying to recruit young people to advocate for the organization's existing agenda. This allows young people to be empowered to create the changes they truly want to see in their communities. A framework entitled [Hart's Ladder of Participation](#) was created for UNICEF and shows the pathway to greater empowerment and engagement of youth. UNICEF also has created an extensive [toolkit](#) to guide youth advocacy.

Another key part of encouraging youth advocacy is to give all young people, not just leaders or members of youth councils, etc., the opportunity to have their voices heard. Mental Health America's Young People's Mental Health Report is a good example of how to amplify the voices and ideas of young people in a way that is approachable not just to natural leaders but also to those who may still be actively struggling with mental health concerns. MHA surveyed just under 2,000 young people between the ages of 14 and 24 about what they believe would make a positive difference in their mental health. Surveys and reports like this that ask not just what the problems are but how young people want to see them solved can play a key role in encouraging youth advocacy.

Another example of widespread input is The [YouthScan](#) Project, a program created by the organization Youth Roots, which teaches young people the skills they need to gather relevant data in their communities that can then be used for policy development. Programs like these are incredibly helpful for gathering up-to-date, relevant information and can help to elevate the voices and ideas of young people whose voices might not be heard through more traditional data collection methods.

▶ **Lori Riddle, Derek Evans, Taylor Hayes, Keren Weisenborn, Senator Rob Wagner**



Lessons Learned From Policy Initiatives to Allow Excused Absences for Mental Health:

Empower youth leadership. In Oregon, Students for a Healthy Oregon led the effort from conception of the idea to writing the bill to testifying and were driving the change.

Support young people by providing training and resources on the state and local processes and how to use these procedures successfully to change policy. Providence provided assistance with bill drafting and helped prepare the students for questions they might be asked when they testified.

Incorporate ways to hear the voices of all young people, not just leaders or members of councils. MHA surveyed thousands of young people about what they believe would make a difference.

Involve young people in gathering data in their local communities to inform public policy. The Youthscan Project is one example of a program that empowers young people to gather relevant data that can be used to inform public policy.

TOOLS YOU CAN USE:

School-Based Mental Health State Policy Dashboard (**Appendix E**)



IV. Case Study in School-Based Mental Health Education

Background

The Mental Health Association in New York State, Inc. (MHANYS), an affiliate of Mental Health America, advocated for and helped to pass and implement the first law in the nation requiring schools to teach students about mental health. As a nonprofit advocacy organization, MHANYS shares important advocacy strategies that may be helpful to other states wishing to pursue similar legislative solutions to enhance mental health literacy among youth nationally. A post-legislative strategy that was used to implement New York's new mental health education law is also discussed.

UNDERSTANDING THE EXISTING POLICY STRUCTURE:

Understanding a state's existing policy structure relative to health, mental health, and education is an important first step in planning an advocacy strategy for mental health education in schools. This understanding has implications for identifying potential legislative champions, creating a legislative proposal, and ultimately for bill drafting.

In New York, the policy structure was straightforward since a foundation in health instruction in schools already existed in law. Since the 1970s, New York State Education Law has included a requirement that schools provide instruction in health (Appendix G). The law requires health instruction in grades kindergarten through 12, albeit without prescription regarding curriculum content with two notable exceptions. The law mandates that health instruction must include 1) alcohol, drugs, tobacco abuse, and 2) the prevention and detection of certain cancers. Although little legislative history exists to indicate the legislative rationale behind the specific inclusion of these two requirements, it is believed that they represented significant public health concerns historically.

The same rationale would ultimately prove useful in supporting the addition of mental health among these requirements, as mental health is arguably the most significant public health crisis among youth presently.

Most states, to varying degrees, have some sort of legal requirement for schools to teach about health.⁵⁶ Forty-six states require health education for all grade levels. Some states, like Massachusetts, for example, lack an existing law mandating health instruction. As a result, advocates in Massachusetts are instead seeking to build upon the state's physical education requirements. Again, the key to developing a legislative proposal is to first identify the best existing foundation in state law to build upon.

BUILD UPON LOCAL EXPERIENCE AND CONSIDER COALITION STRATEGY IN THE PATHWAY TO LEGISLATION:

State legislative ideas often come from on-the-ground local experience. MHANYS began its mental health education legislative campaign in 2010, spurred by the pioneering work of educators from MHANYS Nassau County MHA affiliate and an MHANYS board member. Educators from the Nassau County MHA had experience teaching about mental health conditions in Long Island, New York schools and were seeking a legislative mandate to require similar teaching in all New York schools. With the help of MHANYS Board member Sylvia Lask, the group approached MHANYS staff for legislative advocacy support.



▲ Former MHANYS Board Member Sylvia Lask, pictured on the left outside of NY State Capitol

Initial efforts to form a coalition of like-minded mental health advocates to lead the campaign proved problematic as significant philosophical differences among coalition members emerged, primarily around whether mental health instruction would be geared toward an illness, versus a wellness paradigm. MHANYS strongly believed that the effort should reflect wellness and elected to pursue legislation alone without a coalition. This decision underscores the importance of strategy formation for advocates seeking similar legislation in other states. Advocates should weigh the relative merits of retaining ultimate control of the strategy or relinquishing some of that control to join allied mental health and education advocates. The decision should account for the degree to which multiple groups share a similar vision for legislation. The [Community Toolbox](#) at the Center for Community Health and Development at the University of Kansas provides helpful resources on navigating the dynamics of building a coalition that others can use in making these choices.

Advocates also need to consider new partners outside of traditional mental health groups. In retrospect, cultivating a relationship with education stakeholders before pursuing legislation could have been an effective strategy. It was only after the legislation passed in New York that MHANYS began building relationships with school groups, discovering in the process that the mental health of youth had been a growing priority among several key education groups.

RESISTANCE TO MANDATES:

Generally, two versions of legislation existed between 2011 and 2016 (see Appendix H for bill versions). First introduced in 2011/12, S.7030-A (McDonald)/A.9880-A (Nolan) mandated that mental health be added to existing education law requiring schools to provide instruction in health. However, MHANYS was concerned that an outright mandate had doomed the bill to inaction, pitting its efforts against powerful education stakeholders who resisted a mandate. Consequently, MHANYS worked with the primary bill sponsor to change the bill language by replacing “schools shall” (provide mental health instruction) with “schools are encouraged” (to provide mental health instruction) [i.e. S.5359-A (Flanagan)/A.7727-A (Nolan)].

MHANYS presumed that legislation “authorizing” schools to voluntarily teach about mental health instead of an outright mandate would be more acceptable to school stakeholders; however, in spite of the change, they still opposed the bill. There are hundreds of education-related bills introduced each year in New York. School groups track all of these, ferreting out anything that appears to be a mandate and voicing opposition to protect their members. MHANYS mental health legislation was simply one such bill in a sea of legislation.

As previously acknowledged, had MHANYS established communication with education groups representing key constituencies early in the legislative campaign, they could possibly have avoided misunderstandings. In the end, the strategy to encourage rather than mandate made no difference since school stakeholder groups failed to differentiate between the two approaches.

Ultimately, the bill sponsor had a close relationship with education stakeholders and was able to work with them to allow MHANYS’s preferred bill with a mandate for K-12 mental health education to move forward. In addition, over the years that the bills were pending, more educational stakeholders had recognized the impact of mental health on students, and support grew among these groups.

ADVOCACY ACTIONS AND THE KEY ROLE OF YOUTH ADVOCATES:

MHANYS advocacy strategy began by approaching the chairs of the Mental Hygiene and Education Committees in the respective legislative houses. A potential “champion” was found in the State Assembly Education Committee (New York State refers to the lower house of its legislative body – the equivalent to the US House of Representatives – “the Assembly”). This was a logical choice since state education law would have to be amended to add the requirement of mental health instruction in schools (Appendix G). A complete understanding of a state’s education, health, and mental hygiene policy structure can help guide the identification of a legislative champion in the right committee. It is very important to find someone who is on the right committee and has a track record of moving legislation forward and forming relationships with key stakeholders.

MHANYs developed two key documents that embodied its main arguments. Their primary issue brief (Appendix I) identified the problem and how mental health literacy provided a way to address the problem. A second issue brief (Appendix J) argued the importance of teaching about mental health in concert with instruction in alcohol, tobacco, and substances (already required in the law) because of the interconnectedness of the two courses of study. This second issue brief proved to be a compelling line of argument for several key legislators given that New York, like the rest of the nation, was at the peak of the opioid crisis, and lawmakers were seeking solutions. The two issue briefs were primary tools that clearly articulated MHANYs key arguments and formed the basis for other tools, including memorandums of support, press releases, and calls to action.

For two consecutive years, from 2013 to 2015, the New York State Senate passed the mental health education legislation, but the bill stalled in the Assembly Education Committee. Ironically, the Chair of the Education Committee that introduced the bill did not move it out of committee. At the time, there were numerous curriculum-based bills sponsored by members of the Committee that competed for attention. MHANYs needed to make the case that mental health education was a priority among these competing areas of instruction. Mobilizing MHANYs' grassroots advocacy network and especially youth voices was critical at this stage to move the legislation to the front of the line among these competing bills.

A centerpiece for mobilizing MHANYs grassroots advocacy efforts included the use of their annual legislative day – [Mental Health Matters Day](#). Over the course of several years, MHANYs was able to attract interest from New York schools and their students by billing the event as an opportunity for schools to enhance youth experience in both the topic of mental health as well as participation in government instruction. MHANYs learned that youth were both eager and willing participants in advocating for mental health to be taught in their schools. This message coming from the youth themselves was extremely compelling for many lawmakers.

A turning point was reached during the 2016 legislative session when the Assembly Education Committee moved the bill out of Committee. The legislation rapidly moved through numerous other committees, passed the Assembly, and made its way to the governor for his signature.

POST LEGISLATION IMPLEMENTATION:

The MHANYs experience indicated how critical it is to have a post-legislative strategy that helps assure successful implementation. Such a strategy should include a means of preserving and advancing the original legislative intent and a plan to shepherd the new law through the regulatory process.

Immediately after the governor signed the law and, buoyed by local and national media reports of the landmark legislation passing, MHANYs began taking steps to help assure the law's successful implementation.



▲ John Richter and Glenn Liebman, of MHANYs, pictured with NY students outside NY State Legislature

MHANYS TOOK THE FOLLOWING ACTION STEPS:

1. MHANYS generated a policy [report](#) that sought to capture for posterity the rationale and justification for the law as well as recommendations on key elements that schools could consider including in their mental health education curricula. These elements were grounded in health literacy research and served to answer the question, “what does it mean to teach about mental health?” Since being published, the paper has been widely distributed and has been referenced in numerous news articles nationally.
2. MHANYS convened a School Mental Health Education Summit in Albany in March of 2017. Both mental health and education stakeholders from around the state were in attendance, along with leadership from the State Education Department (SED) and the Office of Mental Health (OMH). The summit sparked a growing partnership between the Commissioners of SED and OMH and led to the idea of convening a Mental Health Education Advisory Council.
3. Working in partnership with SED and OMH, MHANYS helped to establish a Mental Health Education Advisory Council, which was comprised of over 50 stakeholder representatives from education and mental health. The Council was tasked with developing mental health instruction guidelines and resources for schools. They began their work by surveying schools to help determine school readiness and attitudes about the new law. Eight hundred responses from schools helped to inform the Council’s work. The summit and this council built a strong, ongoing relationship between mental health and education groups.
4. In 2018, MHANYS secured legislative funding to create a [School Mental Health Resource and Training Center](#) to help schools successfully implement the new law. The proposal for a resource center is in Appendix K. Resources from the Center were created and made available to all New York State public and private schools at no cost to schools. This timely launch of the Center was critical as schools were challenged with developing their mental health education curricula in time for the fall semester. Since 2018, MHANYS has received an additional \$500,000 in the Executive Budget for each subsequent year, including 2021. Appendix L shows school utilization data of the Resource Center from July 2018 through January 13, 2021. Interest from school communities, including families, school personnel, teachers, and other community members, has been very high, with over 88% of school communities contacting the Resource Center.
5. MHANYS continues to involve youth voices in its annual Mental Health Matters legislative event focusing on advocacy for Resource Center funding and other mental health legislative initiatives, including teacher training, mental health excused absences, and suicide prevention legislation. Also, the Resource Center has provided schools with lesson plans about mental health advocacy, and as part of Mental Health Matters Legislative Days 2021, a panel discussion centered on youth voices in public policy.

TOOLS YOU CAN USE:

School-Based Mental Health State Policy Dashboard (**Appendix E**)

Mental Health Education Bill Text (**Appendix G**)

NY Issue Brief: Mental Health Education in Schools (**Appendix I**)

NY Issue Brief: Health Curricula (**Appendix J**)

NY School Mental Health Resource Center Proposal (**Appendix K**)

NY School Mental Health Resource Center Impact Statement (**Appendix L**)

VISION FOR THE FUTURE:

MHANYs' original vision for the Resource Center's lifespan was a minimum of three years. They recognized that building quality curriculum for K-12 grades, especially in a new subject area, is not something that would be achieved overnight. MHANYs is now committed to being a resource to schools indefinitely, provided there is access to ongoing funding.

During the time that MHANYs was pursuing legislation, their goal was broadly focused on mental health literacy and did not include reference to emerging youth mental health issues. Since the passage of the mental health education law, new challenges have emerged from the COVID-19 pandemic and its impact on youth mental health. In addition, there is growing interest in the unique needs of at-risk subgroups of youth such as LGBTQ+ youth and BIPOC youth, both disproportionately impacted by health disparities. The Resource Center has provided a vehicle through which to address changing and emerging mental health needs of young people. This is another reason why a post-legislative strategy that includes an ability to evolve and meet emerging needs is so critical. The Resource Center has been a very valuable tool that advocates should consider as a complement to required mental health education or even as a first step in some states where a requirement is not possible.



V. Conclusion and Recommendations for the Future

The changes to youth mental health over the past decade have been alarming, and the isolation and impact of COVID-19 have only worsened mental health conditions in youth and exacerbated disparities. In response to these trends, youth leadership has emerged and influenced state policies to improve mental health education, access to services, and supports through excused absences for mental health. Although some states have led the way, no state has fully enacted a set of laws and policies that would comprehensively improve youth mental health. The recommendations below reflect the principles defined in the first section of this report and the legislative activity detailed in the later sections. More advocacy is urgently needed at all levels of government to make progress on these critical issues and advance mental health equity.

▼ Young mental health advocates pictured outside NY State Capitol



1.

Recommendation 1: Promote Youth Leadership at the Local, State and National Levels to Improve Youth Mental Health in Schools

This report has described how youth leaders have driven changes in state policies affecting youth mental health and schools. Partners have supported these efforts by providing training and assistance in accessing the levers of government to achieve policy changes.

Youth in Oregon led the effort to enact excused absences for mental health with assistance from lobbyists from Providence Health and Services. Youth in New York received training in their government class and advocated for mental health education in schools by reaching out to their legislators and telling their stories. Youth have indicated that more of this practical information would be helpful to leverage youth power in policy and practices. The next phase of work should include mobilizing more youth across the country to advocate for change and supporting their initiatives and leadership.

YOUTH EMPOWERMENT

Ben Ballman of Maryland

Ben Ballman of Maryland, MHA's Inaugural Outstanding Youth Advocate Awardee, created a coalition of students across his school district to advocate for more trained mental health professionals. He did so after conducting a public opinion survey for students whose feedback highlighted the lack of in-school supports for students with mental health needs.

[VIEW VIDEO](#)



2.

Recommendation 2: Advocate for and Achieve More State Legislative Victories in Key Areas of Mental Health Education, Access to Services, and Mental Health Excused Absences; and Ensure Follow-up, Evaluation, and Effective Implementation

Although there has been innovation in the states, many of these initiatives have only spread to a few states. Mental health education in schools, for example, is only required in legislation in a handful of states. Most states have weak regulations that are not fully enforced. Advocates should carefully review their policies and build on existing structures for greater impact.

Providing mental health services in schools increases accessibility and promotes equity in mental health care, yet currently, only 14 states are fully using Medicaid to fund such services. Roughly half the states have been clear that telehealth can be billed under Medicaid in schools. The vast majority of states do not meet recommended ratios for school mental health personnel, and those with state laws and regulations on the issue do better. Finally, programs that bring community mental health providers into schools are showing very positive outcomes in reaching children that otherwise lacked access and in improving academics and symptoms of mental health conditions. These programs require relatively modest investment for significant gains, yet most states lack these programs across all of their schools.

Youth have led efforts to enact state legislation to make excused absences inclusive of mental health, but this initiative is just getting started, with Oregon leading the way and several states following. Many more should be considering this legislation.

The vast majority of states have significant gaps in policy regarding school-based mental health, and additional policies are needed to comprehensively address youth mental health needs, so there is much work to be done. In addition, advocates need to follow up and ensure evaluation and implementation even in states that have policies. Youth leaders and state coalitions of children, education, and mental health organizations need to examine what their state currently has enacted and work to expand public policies in these key areas.

3.

Recommendation 3: Continue Innovation and Research on Evolving State Statutes and Programs to Improve Early Intervention in Youth Mental Health, Particularly in the Areas of Screening and Peer Support

Similar to physical conditions, mental health conditions are easier to treat early. Discrimination and shame around these conditions often leads to significant delays between symptoms and treatment. Accordingly, it is very important to intervene as early as possible. Two areas of state innovation can be helpful in ensuring help at the beginning of a mental health condition: screening and peer support.

Youth are interested in screening for mental health conditions, especially during the pandemic. People who accessed Mental Health America's screening in 2020 were younger than the 2019 average. Forty-two percent of screeners from January-December 2020 were youth ages 11-17, a 13% increase over 2019 (29%). These screens were online, and additional issues of privacy and use of the information must be considered for schools. Some states have begun to consider these policies, and further research to implement screening and early intervention in school is needed.

Data indicates that youth are more likely to talk to a friend rather than anyone else when experiencing mental health symptoms. Some schools have begun to offer peer support programs, which allow for early conversations and access to support from students from diverse backgrounds. A recent [report](#) from the Christensen Institute, *Peer Connections Reimagined: Innovations Nurturing Student Networks to Unlock Opportunity*, noted that "it's networks—not just diplomas and degrees—that lead to opportunities and fulfilling lives. Peer connections are a critical resource as K–12 schools and postsecondary programs look to support students' well-being and growth, enrich their learning experiences, and expand career options."⁵⁷ Additional research in the policy, funding, and implementation of peer support programs would be helpful and effective in reaching youth early.

4.

Recommendation 4: Draw on State Experiences to Inform a National Strategy and Implementation to Improve Youth Mental Health with an Emphasis on Youth Leadership, Equity, and School Initiatives

This report is limited to state policy, but the alarming trends in youth mental health are a national crisis and require a national strategy across and within agencies. National advocacy groups have suggested several initiatives, from a national taskforce or council on school mental health to a Children's Office at the White House. The Department of Health and Human Services (HHS) has recently formed a Behavioral Health Coordinating Council (BHCC). They have not announced specific goals for the BHCC, but youth mental health would be a good early choice.

Specific agencies also need to prioritize youth mental health, coordinate to promote mental health education and services, and enhance and incorporate youth leadership. All agencies should consider how to benefit from youth leadership and receive input from youth leaders from a cross-section of youth from diverse communities and those who may be unengaged in traditional avenues for leadership.

Agencies should also draw on their knowledge in other areas of public health for youth. The Centers for Disease Control and Prevention (CDC) has several programs that provide technical assistance and public health expertise to state and local education agencies that could be significantly expanded to include and emphasize mental health. A centralized hub at the agency is needed to prioritize prevention and early intervention in mental health. CDC works with other agencies within HHS on sex education and pregnancy prevention, including school programs and curriculum standards. Mental health education would benefit from similar focus and coordination.

The Centers for Medicare and Medicaid Services should update their guidance and facilitate billing for school-based mental health services in person and through telehealth, and the Substance Abuse and Mental Health Services Administration should renew their focus on youth and expand their work with schools. Finally, the Department of Education should focus more on mental health curriculum (including social and emotional learning) and mental health services and supports.

The federal government needs to learn from the state initiatives profiled in this report and develop a national strategy, specific goals, a data collection process for measuring progress, and a specific implementation plan across agencies to improve youth mental health and promote equitable outcomes for LGBTQ+ and BIPOC youth, especially in schools.

With youth experiencing a doubling in the rates of depression in the past decade and with increasing mental health concerns and disparities from COVID-19, more urgency is needed at the local, state, and national levels. This report highlights some foundational work in states that should be expanded and further developed at all levels of government.



Appendices

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**TO DOWNLOAD A PRINT
VERSION OF APPENDICES A-F,
please go to mhanational.org/YouthInCrisis.**

YOUTH MENTAL HEALTH

OVER THE LAST DECADE, YOUTH MENTAL HEALTH
HAS BEEN WORSENING

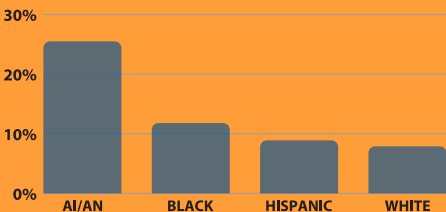
From 2009 to 2019, the percentage of youth ages 12-17 who reported having a past-year major depressive episode (MDE)

**DOUBLED FROM
8% TO 16%**

In 2019, 46.8% of youth that identify as gay, lesbian, or bisexual reported seriously considering suicide

MORE THAN 3X
the rate of youth identifying as heterosexual (14.5%)

In 2019, 25.5% of American Indian or Alaskan Native youth, 11.8% of Black youth, and 8.9% of Hispanic youth reported attempting suicide in the past year in 2019, compared to only 7.9% of White youth



COVID-19 EXACERBATED THESE TRENDS

In 2020, 51% of 11-17-year-olds reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks on MHA Screening

**TOTALING NEARLY
160,000 YOUTH**

Rates of frequent suicidal ideation were even higher among LGBTQ+ youth



**62% REPORTED
FREQUENT THOUGHTS
OF SUICIDE IN 2020**

Compared to 2019, in 2020 children's visits to the emergency room for mental health conditions increased

31% FOR THOSE
AGES 12-17

24% FOR THOSE
AGES 5-11

BUT ACCESS TO CARE IS STILL LACKING

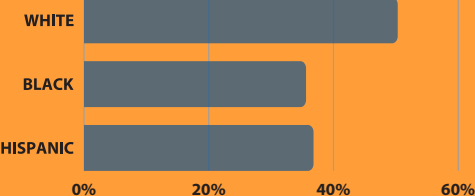
Only 43.3% of all youth with a past year major depressive episode (MDE) received any mental health treatment in 2019



Of youth who do receive mental health services, 70-80% receive them at school



While 50.3% of White youth with past year MDE received mental health services, only 35.6% of Black and 36.8% of Hispanic youth with past year MDE received mental health treatment in 2019



Appendix B - Fact Sheet

FACT SHEET ON DATA FOR CHILDREN'S MENTAL HEALTH

YOUTH WERE ALREADY EXPERIENCING WORSENING MENTAL HEALTH

16% OF YOUTH

ages 12-17 reported experiencing a past-year major depressive episode (MDE) in 2019, compared to 8% in 2009, double the previous rate.

Deaths by suicide among youth **INCREASED OVER 30%** between 2014 and 2017.

In 2019, 46.8% of youth that identify as gay, lesbian, or bisexual reported seriously considering suicide - **MORE THAN 3X THE RATE** of youth identifying as heterosexual (14.5%).

HIGHER NUMBERS

of American Indian or Alaskan Native youth (25.5%), Black youth (11.8%), and Hispanic youth (8.9%) reported attempting suicide in the past year, compared with White youth (7.9%) in 2019.

COVID EXACERBATED THOSE TRENDS

OVER HALF

(51%) of 11-17-year-olds on MHA Screening reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks, totaling nearly 160,000 youth.

Rates of frequent suicidal ideation were even **HIGHER AMONG LGBTQ+ YOUTH**, with 62% reporting frequent thoughts of suicide or self-harm, totaling nearly 60,000 individuals.

The highest proportion of youth reporting frequent thoughts of **SUICIDE OR SELF-HARM**

was among those who identified their race as "Other" (57%), and who identified as Native American or American Indian (57%).

From March to October of 2020, children's visits to the emergency room for mental health conditions

INCREASED 31% for those 12-17 years old **INCREASED 24%**

for children ages 5-11 compared to the same period in 2019.

BUT KNOWLEDGE AND ACCESS IS LACKING

50%

of mental health conditions onset before age 14 and 75% by age 24. There is on average an 11 year gap between onset of symptoms and treatment.

ONLY 43.3%

of all youth with a past year major depressive episode (MDE) received any mental health treatment in 2019.

ABOUT HALF

(50.3%) of White youth with past year MDE received mental health services, while

ONLY 35.6%

of Black youth and

ONLY 36.8%

of Hispanic youth with past year MDE received mental health treatment in 2019.

Of those who receive mental health services,

70-80%

of youth receive them at school.

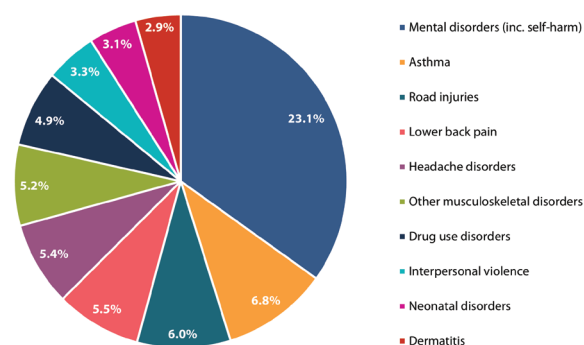
MENTAL HEALTH HAS A GREATER BURDEN THAN OTHER PUBLIC HEALTH CONCERNS

For people ages 5 to 19 in the United States in 2019,

MENTAL HEALTH CONDITIONS AND SELF-HARM CONTRIBUTED 23.1% OF THE TOTAL DALY BURDEN.

Asthma and road injuries, the second and third greatest burdens, contributed only 6.8% and 6.0% respectively.

Top 10 Contributors to Burden of Disease for Children Ages 5-19 in the U.S., 2019 (by DALYS)



Appendix C - Mental Health Education Chart

KEY: Yes – Bill signed into law | **Tracking** – Bill introduced but not yet passed | **Standards and Regulation** – State administrative requirements are in place

| State | Mental Health Education Leg. | Notes | Current Legislative Session Status (AS OF 6/21/21) |
|----------------------|------------------------------|--|--|
| Alabama | | | Adjourned |
| Alaska | Tracking HB 60 | This bill would “encourage” each district to create a k-12 MH program that follows statewide guidelines for MH education according to representatives from various Alaskan MH orgs. This bill is nearly identical to HB 181 that was introduced in 2019 but not passed. Alaska state legislature is currently in a special session, which is why movement on the bill is still being tracked. | In Special Session |
| Arizona | | State has established a school safety task force who are exploring mental health education legislative options | In Regular Session |
| Arkansas | Standards | Health education required for graduation, curriculum standards include mental/emotional health component | Adjourned |
| California | Tracking SB 224 | Bill would require students grades 1-12 to receive “medically accurate, age-appropriate mental health education from instructors trained in the appropriate courses at least once in elementary school, at least once in junior high school or middle school, as applicable, and at least once in high school” | In Regular Session |
| Colorado | Standards | Teacher recertification requirements that mental health for youth be taken. Additionally, mental health and emotional wellness is required in the health curriculum. | Adjourned |
| Connecticut | Yes | “Connecticut law requires public schools to offer health and safety as a required subject area in its program of instruction. Mental and emotional health, including youth suicide prevention, is a subtopic in this required subject area (CGS § 10-16b). State law does not specify which subject areas must be offered by grade, nor does it prescribe a specific curriculum that teachers must follow when delivering instruction in this subject area. Rather, districts develop their own grade specific curricula with support from the State Department of Education (SDE). Districts may utilize a 2006 SDE-developed framework when designing their curricula.” (via Connecticut General Assembly) | Adjourned |
| District of Columbia | Standards | | |
| Delaware | | | In Regular Session |
| Florida | Yes and Regulation | School districts must annually provide a minimum of five (5) hours of instruction to students in grades 6-12 related to youth mental health awareness and assistance, including suicide prevention and the impacts of substance abuse. | Adjourned |
| Georgia | | | Adjourned |
| Hawaii | Standards | | Adjourned |
| Idaho | Standards | | Adjourned |

Appendix C - Mental Health Education Chart

KEY: **Yes** – Bill signed into law | **Tracking** – Bill introduced but not yet passed | **Standards and Regulation** – State administrative requirements are in place

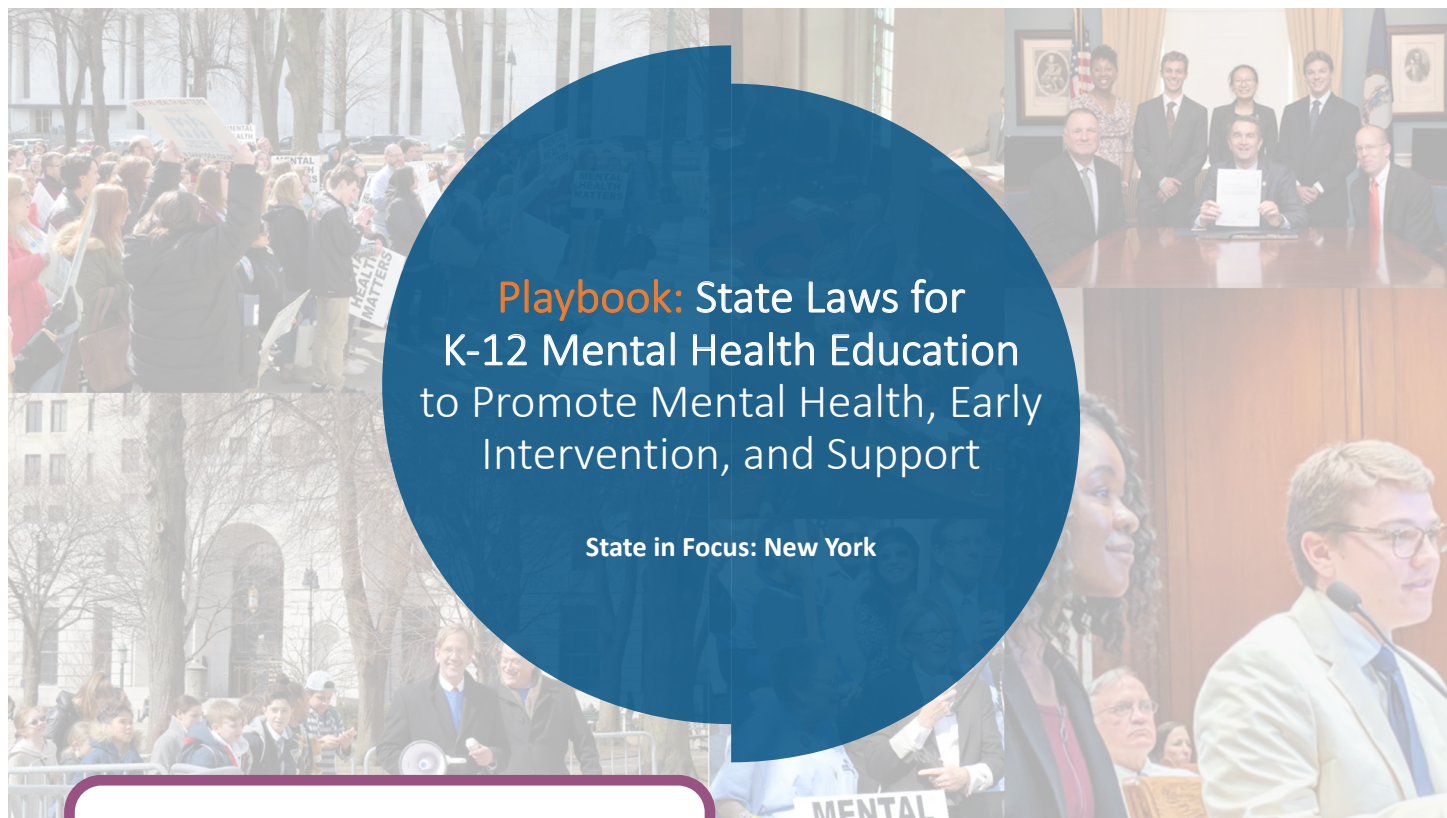
| State | Mental Health Education Leg. | Notes | Current Legislative Session Status (AS OF 6/21/21) |
|---------------|------------------------------|--|--|
| Illinois | | | Adjourned |
| Indiana | | | Adjourned |
| Iowa | | | Adjourned |
| Kansas | | | Adjourned |
| Kentucky | Regulation | 704 KAR 8:030 is a regulation that created required academic standards for health education which include mental health | Adjourned |
| Louisiana | | | Adjourned |
| Maine | Yes | Requires k-12 health education to include mental health and the relationship between physical and mental health, as well as reducing the stigma around mental illness. | Adjourned |
| Maryland | Standards | | Adjourned |
| Massachusetts | Tracking H.2084 | | In Regular Session |
| Michigan | | | In Regular Session |
| Minnesota | Yes; Not Mandatory | This statute is simply an "encouragement"; it does, however, require that the school commissioner release mental health education materials, including model curricula, every two years for schools to use if they so choose. | In Special Session |
| Mississippi | Standards | | Adjourned |
| Missouri | Pilot Program | Missouri passed a bill establishing a pilot program to provide social and emotional health education in elementary schools (starting 2020). | Adjourned |
| Montana | | | Adjourned |
| Nebraska | | | Adjourned |
| Nevada | Yes | Among other crisis and suicide prevention requirements, this bill requires a course in health to include instruction concerning mental health, and specifies consequences for public and private schools who fail to adopt this policy. | Adjourned |
| New Hampshire | Regulation | A regulation was adopted in which it is stated that mandatory health education standards are supposed to include mental health, though it is not specified in the standards themselves. | In Regular Session |
| New Jersey | Yes | Requires public k-12 health education to include mental health. | In Regular Session |
| New Mexico | Standards | Grades 9-12 only; health ed is a graduation requirement, BRIEFLY addresses mental health in standards | Adjourned |
| New York | Yes | This bill added the following text to their existing laws on health and drug/alcohol education: "All schools under the jurisdiction of the department shall ensure that health education programs recognize the multiple dimensions of health by including mental health and the relation of physical and mental health so as to enhance student understanding, attitudes and behaviors that promote health, well-being and human dignity." This bill calls on school districts to ensure that their health education programs recognize the multiple dimensions of health by including mental health and the relation between mental and physical health in health education" | Adjourned |

Appendix C - Mental Health Education Chart

KEY: Yes – Bill signed into law | **Tracking** – Bill introduced but not yet passed | **Standards and Regulation** – State administrative requirements are in place

| State | Mental Health Education Leg. | Notes | Current Legislative Session Status (AS OF 6/21/21) |
|----------------|------------------------------|---|--|
| North Carolina | | | In Regular Session |
| North Dakota | | SB 2311 was passed earlier this year, and in the first version of the bill that was introduced, the bill stated that students K-12 should receive age appropriate instruction on mental health and suicide prevention, but the version of the bill that got enrolled was ammended and no longer included any mention of mental health education for students. | Adjourned |
| Ohio | | | In Regular Session |
| Oklahoma | Yes | Among other things, this bill mandates that certain curriculum include mental health instruction beginning in a certain school year, and also directs the State Board of Education to revise certain standards to include focus on mental health. It also allows schools to enter into partnerships with local mental health agencies. | Adjourned |
| Oregon | Standards | Address mental health as a dimension of health | In Regular Session |
| Pennsylvania | | | In Regular Session |
| Rhode Island | | | In Regular Session |
| South Carolina | Yes; Not Mandatory | This bill instructs the department of education to offer an optional mental health and wellness course in middle school and states that students in high school must complete one course related to mental health or wellness, but specific mental health education is not required. | In Special Session |
| South Dakota | | | Adjourned |
| Tennessee | | | Adjourned |
| Texas | Yes, Not Mandatory | School districts are required to offer enrichment curriculum (not required for graduation) on health, including an emphasis on mental health topics such as mental health conditions, substance abuse, skills to manage emotions, establishing and maintaining positive relationships, and responsible decision-making, and suicide prevention, including recognizing suicide-related risk factors and warning signs. | Adjourned |
| Utah | | | Adjourned |
| Vermont | Yes | The statute mandated that the education standards include mental health in the definition of required health education | Adjourned |
| Virginia | Yes | Requires health instruction to incorporate standards that recognize the multiple dimensions of health by including mental health and the relationship of physical and mental health so as to enhance student understanding, attitudes, and behavior that promote health, well-being, and human dignity. The bill also directs the Board of Education to review and update the health Standards of Learning for students in grades nine and 10 to include mental health. This bill is identical to SB 953. | Adjourned |
| Washington | Standards | | Adjourned |
| West Virginia | | | Adjourned |
| Wisconsin | | | In Regular Session |
| Wyoming | | | Adjourned |

Appendix D - Playbook



Playbook: State Laws for
K-12 Mental Health Education
to Promote Mental Health, Early
Intervention, and Support

State in Focus: New York

**TO DOWNLOAD A PRINT
VERSION OF THE PLAYBOOK,**

please go to mhanational.org/playbook.

Appendix E - School Mental Health State Policy Dashboard

| State | Mental Health Education Legislation | Mental Health Excused Absence Legislation | School as Authorized Originating Site for Telehealth Under Medicaid | Medicaid Billing Beyond IEP | Current Legislative Session Status (AS OF 6/21/21) |
|----------------------|-------------------------------------|---|---|-----------------------------|--|
| Alabama | | | | | Adjourned |
| Alaska | Tracking | | | | In Special Session |
| Arizona | | Yes | | In Progress* | In Regular Session |
| Arkansas | Standards | | Yes | | Adjourned |
| California | Tracking | Tracking | Yes | Yes | In Regular Session |
| Colorado | Standards | Yes | | Yes | Adjourned |
| Connecticut | Yes | Yes | | Yes* | Adjourned |
| District of Columbia | Standards | | Yes | | |
| Delaware | | | Yes | | In Regular Session |
| Florida | Yes, not a bill | Introduced; not passed | | Yes | Adjourned |
| Georgia | | | Yes | | Adjourned |
| Hawaii | Standards | | | | Adjourned |
| Idaho | Standards | | Yes | | Adjourned |
| Illinois | | Yes | | In Progress* | Adjourned |
| Indiana | | | | In Progress* | Adjourned |
| Iowa | | Introduced; not passed | Yes | | Adjourned |
| Kansas | | | | | Adjourned |
| Kentucky | Regulation | | Yes | Yes | Adjourned |
| Louisiana | | | | Yes | Adjourned |
| Maine | Yes | Yes | | | Adjourned |
| Maryland | Standards | Introduced; not passed | Yes | | Adjourned |
| Massachusetts | Tracking | Tracking | | Yes | In Regular Session |
| Michigan | | | Yes | Yes | In Regular Session |
| Minnesota | Yes, not mandatory | | Yes | Yes | In Special Session |
| Mississippi | Standards | | Yes | | Adjourned |
| Missouri | Pilot Program | | Yes | Yes | Adjourned |
| Montana | | | | | Adjourned |
| Nebraska | | | | | Adjourned |

Appendix E - School Mental Health State Policy Dashboard

| State | Mental Health Education Legislation | Mental Health Excused Absence Legislation | School as Authorized Originating Site for Telehealth Under Medicaid | Medicaid Billing Beyond IEP | Current Legislative Session Status (AS OF 6/21/21) |
|----------------|-------------------------------------|---|---|-----------------------------|--|
| Nevada | Yes | Yes | Yes | Yes | Adjourned |
| New Hampshire | Regulation | | | Yes | In Regular Session |
| New Jersey | Yes | Introduced; not passed | | | In Regular Session |
| New Mexico | Standards | Introduced; not passed | Yes | | Adjourned |
| New York | Yes | Introduced; not passed | Yes | | Adjourned |
| North Carolina | | | | Yes | In Regular Session |
| North Dakota | | | | | Adjourned |
| Ohio | | | Yes | | In Regular Session |
| Oklahoma | Yes | | Yes | | Adjourned |
| Oregon | Standards | Yes | Yes | In Progress* | In Regular Session |
| Pennsylvania | Tracking | Tracking | | | In Regular Session |
| Rhode Island | | | | | In Regular Session |
| South Carolina | Yes, not mandatory | | Yes | Yes | In Special Session |
| South Dakota | | | Yes | | Adjourned |
| Tennessee | | | Yes | | Adjourned |
| Texas | Yes, not mandatory | | Yes | | Adjourned |
| Utah | | Yes | | In Progress* | Adjourned |
| Vermont | Yes | | Yes | | Adjourned |
| Virginia | Yes | Yes | Yes | In Progress* | Adjourned |
| Washington | Standards | | Yes | | Adjourned |
| West Virginia | | | Yes | | Adjourned |
| Wisconsin | | | | | In Regular Session |
| Wyoming | | | Yes | | Adjourned |

PLEASE NOTE: More details on mental health education legislation can be found in Appendix C

*For more details on limitations and progress in each state, see <http://bit.ly/freecareupdate>

Appendix F - Examples of School-Based Mental Health Services Chart

| State | Legislation/Program | Notes |
|------------|---|---|
| Arkansas | Act 190 | "School Counseling Improvement Act of 2019" This bill is meant to reduce administrative duties of school counselors so they can spend 90% or more of their working hours face to face with students, providing services rather than doing paperwork. |
| California | SB 75 | The Mental Health Student Services Act (MHSSA) is a grant program established to encourage, through funding, partnerships between county behavioral health departments and school districts for the purpose of increasing access to mental health services in schools, where they are most accessible to students and their families. The California Mental Health Services Oversight & Accountability Commission awards grants totaling \$75 million dollars over a four-year grant cycle, and the awarded funds must be used to provide support services that include, at a minimum, services provided on school campuses, suicide prevention services, drop-out prevention services, placement assistance and service plans for students in need of ongoing services, and outreach to high-risk youth, including foster youth, youth who identify as LGBTQ, and youth who have been expelled or suspended from school. |
| Illinois | SB 565 | This bill requires social and emotional screenings for children as a part of their school entry examinations. |
| Indiana | SB 246 | This bill requires schools to have a partnership with a community mental health organization that can provide services to students before they can apply for grants awarded from the Secured School fund. |
| Kansas | Sub SB423 | This program was first piloted in the 2018-2019 school year in 9 schools; the idea was to increase access to mental health service providers in schools, especially in Western Kansas where the need is no where near met by school personnel alone; the program allowed schools to partner with community mental health centers to provide services students. |
| Maryland | HB0496 | \$10M allocated to expansion of mental health services within schools (among other measures + stipulations) |
| Minnesota | Minnesota Statutes 245.4901 | Fifty-seven mental health providers were awarded a total of \$11 million per year for three years to bring mental health services to over one-half of Minnesota schools. Grantees offer mental health services in schools, including assessment, treatment and care coordination, teacher consultation and school-wide trainings. |
| Texas | SB 11 (See TCHATT) | Texas Senate Bill 11 established the Texas Child Mental Health Consortium (TCMHC), who were responsible for the creation of five major child mental health initiatives, one of which is a school-based health access program called Texas Child Health Access Through Telemedicine (TCHATT). Services provided through TCHATT include assessment and triage, connections to care, and brief mental health interventions. |

PLEASE NOTE: These are examples of an array of state initiatives for providing mental health services in schools. States that are not listed here may still have legislation or programs regarding school-based mental health services, as this is not meant to be a comprehensive list given the complexity of the topic.

Appendix G - NY Mental Health Education Bill Text

Article 17 New York State Education Law Section 804

(words in red were added by the legislation. Deletions shown as strikethrough)

§ 804. Health education regarding mental health, alcohol, drugs, tobacco abuse and the prevention and detection of certain cancers. 1. All schools shall ensure that their health education programs recognize the multiple dimensions of health by including mental health and the relation of physical and mental health so as to enhance student understanding, attitudes and behaviors that promote health, well-being and human dignity.

2. All schools shall include, as an integral part of health education, instruction so as to discourage the misuse and abuse of alcohol, tobacco and other drugs and promote attitudes and behavior that enhance health, well being, and human dignity.

3. Instruction regarding alcohol, tobacco, and other drugs shall be included in the health education provided for all elementary school pupils and shall be taught by the classroom teachers or by teachers certified to teach health education. Such instruction shall be designed according to the needs and abilities of the pupils at successive grade levels with the purpose of developing desirable health behavior, attitudes, and knowledge as well as self-reliance and problem solving capacity.

4. Instruction regarding alcohol, tobacco, and other drugs, in addition to continued health guidance in the junior high school grades and the senior high schools, shall be an integral part of a required health education course at each of these levels in the secondary schools curriculum. Students shall be required to demonstrate knowledge in the subject area through the use of a test, graded project or report, or any drugs, and tobacco. Any such course shall be taught by teachers holding a certificate to teach health. Related courses in the secondary school curriculum shall be taught in a manner supportive of health education regarding alcohol tobacco, and other drugs. In addition, instruction regarding the dangers of driving while under the influence of alcohol or drugs shall be an integral part of a required health education course in the senior high schools. Such instruction shall be provided in all senior high schools whether or not these schools also provide driver education courses.

5. Instruction regarding methods of prevention and detection of certain cancers, including but not limited to breast cancer, skin cancer, testicular cancer and other cancers where certain preventive measures have become generally accepted and certain detection methods have been adopted and recommended generally to the public. Such instruction shall be an integral part of a required health education course at the senior high school level, in addition to continued health guidance in senior high schools. Any such course shall be taught by teachers holding a certificate to teach health.

6. a. The commissioner may prescribe in regulations such health education courses which include instruction regarding alcohol, tobacco, and other drugs as the commissioner may deem necessary and desirable for the welfare of pupils and the community. The contents may be varied to meet the needs of particular school districts, or portions thereof, and need not be uniform throughout the state, provided, however, that school districts shall utilize either the curriculum for health education instruction regarding alcohol, tobacco and other drugs prescribed by the

Appendix G - NY Mental Health Education Bill Text

commissioner or a course approved by the commissioner in accordance with criteria established by the commissioner. The commissioner is authorized to make recommendations to the board of regents beginning December first, two thousand fourteen and every three years thereafter relating to the modernization of such instruction required pursuant to subdivision one of this section, to include the most up to date age appropriate information available regarding the misuse and abuse of alcohol, tobacco and other drugs, including but not limited to heroin and opioids. Such instruction shall include, but not be limited to, information regarding drugs and other substances that are more prevalent among school aged youth. Such recommendations shall be the result of a collaboration between the department, the office of alcoholism and substance abuse services and the department of health. If the board of regents adopts such curriculum, the curriculum requirement shall take effect no later than the next school year after such curriculum has been adopted.

b. The commissioner shall make available an interpersonal violence prevention education package for grades kindergarten through twelve, which package may consist of student pamphlets, parent pamphlets, videotapes and other informative materials to be distributed to school districts, and shall encourage the use of such material as part of the health or other related curricula or programs.

c. The regents shall review the health curriculum requirements in existence on the effective date of this paragraph for the purpose of streamlining such curriculum and identifying any outdated components that may be eliminated or consolidated in order to ensure that students have sufficient time and instruction to develop skills to address issues of violence prevention and mental health. To the extent appropriate, the regents shall modify the existing curriculum to provide greater focus on the development of skills, by no later than middle school, that are needed to recognize, cope with and address potentially violent incidents including an understanding of ~~students~~ **student** roles in emergency situations ~~what to do when confronted with another student who is experiencing a mental health problem~~, and other related skills designed to reduce the threat of violence in schools.

7. School authorities shall provide the needed facilities, time, and place for the instruction set forth herein and shall provide learning aids and curriculum resource materials which contribute to effective teaching methods and learning in health education regarding alcohol, tobacco, and other drugs.

8. All pre-service training programs in the state for elementary teachers shall include adequate preparation regarding the instruction in alcohol, tobacco, and other drugs set forth herein, and no teacher shall be licensed except upon satisfactory demonstration of the competencies included in the institutional proposals approved by the department.

9. Nothing contained in this section shall be deemed to diminish or impair the duties of the commissioner with respect to the continuing program for critical health problems established by chapter seven hundred eighty-seven of the laws of nineteen hundred sixty-seven as amended. The commissioner shall coordinate actions taken under authority of this section with the provisions of said chapter as they relate to health education in schools, inservice training and training programs, and curriculum or syllabus development regarding the deleterious effects resulting from the use, misuse, and abuse of alcohol, tobacco, and other drugs.

Appendix H - NY Bill Versions

2011/2012 S.7030-A (McDonald)/A.9880-A (Nolan)

Relates to clarifying health education.

2013/14 S.5359-A (Flanagan)/A.7727-A (Nolan)

Relates to encouraging school districts to include a mental health curriculum in their course of instruction.

2015/16 S.6046-A (Marcellino)/ A.3887-B (Nolan)

Relates to clarifying health education.

Appendix I - NY Issue Brief: Mental Health Education in Schools

Mental Health Education in Schools

Legislative Issue Brief – 2016

Mental health issues impact each of us daily either personally or through the experiences

Mental health is critical to overall physical health and healthy living, and should be included as an integral part of health education in schools. Our public education system in New York has long recognized the value of health education. In more recent times we have updated this statutory imperative to include education in alcohol, drugs, tobacco abuse and the prevention and detection of certain cancers. The time has come to include mental health education as well.

of family members, loved ones, or friends. One in five adults and children have a mental health diagnosis. In New York, over 300,000 of our youth are living with a serious mental health condition that significantly impairs their daily functioning. Still our education laws show little if any recognition of the need to teach our youth about this critical aspect of overall health.

Failing to talk about mental health or to provide basic public mental health instruction has consequences. Over 60% of young adults with a mental illness were unable to complete high school. Young people aged 16 to 24 with mental illness are 4 times less likely to be involved in gainful activities like employment, college or trade school, and are three times more likely to be involved with the criminal justice system. It is therefore critical to begin teaching young people about mental health early in life since about half of all chronic mental health conditions begin by age 14, half of all lifetime cases of anxiety disorders begin at age 11, and 22% of youth aged 13-18 experience a serious mental disorders in a given year.

Appendix I - NY Issue Brief: Mental Health Education in Schools

Lack of knowledge coupled with stigma deters many people from taking full advantage of today's treatment options in a timely manner. In fact, almost 2 out of every 3 adults that need mental health services do not receive them and 50% of those that do delay getting treatment for an average of 10 years. This is very serious and disturbing since untreated mental illness tends only to become more severe over time and, in extreme cases, too often ends in suicide completion or self-injury. According to the Centers for Disease Control, 1 in 12 high school students have attempted suicide. Over 90% of youth who die by suicide completion were suffering from depression or another diagnosable and treatable mental illness at the time of their death. We do young people a disservice by remaining silent about mental health conditions like depression, eating disorders, and PTSD.

Unfortunately, there is little teaching or discussion of mental health in most public school health classes in New York. We believe that New York lawmakers hold the key that is needed for this to change. Without legislative intervention and a clear policy direction from lawmakers on this issue, there is little hope of breaking the silence. This is because the subject of mental illness is still an uncomfortable subject to discuss for many in our society. Teachers can be equally uncomfortable or uncertain as to the boundaries around what they can and cannot teach. This leads to a "when in doubt leave it out" mentality and causes confusion about the schools proper role in teaching such subjects. MHANYS supports amendments to the law that will help clarify the schools role and will free teachers to instruct on the subject with the full imprimatur of the State.

MHANYS seeks legislation that would allow maximum flexibility in the way each school or school district addresses the change in the statute. Our objective is to clarify that mental health is as integral to one's overall well-being as is physical health, and as such, should be reflected in the law guiding health instruction.

By ensuring that young people are educated about mental health, we increase the likelihood that they will be able to more effectively recognize signs in themselves and others, including family members, and get the right help. Further, as we begin to teach the facts about mental health and openly discuss the issues from a health perspective, we will begin to lessen the stigma surrounding mental illnesses. Young people and their families would feel more comfortable seeking help, academic performance for all students would be enhanced, and ultimately lives can be saved. As New York works to restructure and integrate systems of health and mental health care, shouldn't we also be preparing our citizens of tomorrow to think differently about the role that mental health plays in their lives?

Mental health, as we understand it in 2016, is an integral part of our overall health and can no longer be ignored in New York's public education law. If we ignore it, then we fail to adequately prepare consumers of the future to be informed and active participants in the very systems we are building today. We possess the knowledge and tools necessary to increase awareness in young people about mental health, how to recognize signs and symptoms in themselves and others and how to get help. Why in the world would we withhold this lifesaving information from our youth?

Recommendation: Support S.6046(Marcellino)/A.3887-A(Nolan), which relates to clarifying that health education includes mental health as part of the school health curriculum.

Appendix J - NY Issue Brief: Health Curricula

Why School Health Curricula Should Include Mental Health Instruction Along With the Required Instruction in Alcohol, Drugs and Tobacco

Legislative Issue Brief – 2016

For decades the New York State Education Law has required that elementary, junior high and senior high schools teach about alcohol, drugs and tobacco abuse as part of the health curriculum. Considering everything we now know about the comorbidity of substance use and mental illness it no longer makes sense to teach about alcohol, drugs and tobacco without concurrently teaching about mental health.

MHANYs is calling upon the legislature to update New York’s education law to reflect current knowledge about the linkages between the misuse of alcohol, tobacco and substances and mental health, by including instruction about mental health in school health curricula.

The use and abuse of alcohol, tobacco and substances does not occur in a vacuum. The “just say no” approach to ameliorating substance use and abuse among young people in the absence of a broader understanding of the link with mental health does a great disservice to youth because it perpetuates the idea that young people begin to use substances primarily for recreational use and/or because of peer pressure. In reality, we now understand that much substance abuse is related to people, usually unknowingly, attempting to “self-treat” or “self-medicate” the symptoms of undiagnosed mental illness. Consider the following:

- Several epidemiologic survey studies conducted in the past 15 years have demonstrated that many psychiatric disorders and substance use disorders co-occur far more commonly than would be expected by chance alone. In the Epidemiologic Catchment Area Study, an estimated 45% of individuals with an alcohol use disorder and 72% of individuals with a drug use disorder had a least one co-occurring psychiatric disorder.
- In the National Co-Morbidity Study (NCS), probably the best known of the recent survey studies, it was found that approximately 78% of alcohol-dependent men and 86% of alcohol-dependent women met criteria for another psychiatric disorder, including drug dependence and antisocial personality disorder.
- 60 percent of people who abuse drugs and/or alcohol also have some form of psychiatric disorder. Particular conditions found in association with drugs or alcohol include depressive disorders and anxiety disorders (which also happen to be the most prevalent mental disorders).

Further, according to the National Institute of Drug Abuse (NIDA):

- individuals with psychiatric disorders purchase approximately 44 percent of all cigarettes sold in the United States
- In young smokers, the behavior appears to be strongly associated with increased risk for a variety of mental disorders.
- In clinical samples, the rate of smoking in patients with schizophrenia has ranged as high as 90 percent.

Appendix J - NY Issue Brief: Health Curricula

And, according to the American Psychiatric Association (APA):

- Patients with mood or anxiety disorders are about twice as likely to also suffer from a drug disorder.
- Patients with drug disorders are roughly twice as likely to be diagnosed with mood or anxiety disorders.
- The high rate of comorbid substance abuse and mental illness points to the need for a comprehensive approach that identifies, evaluates, and simultaneously treats both disorders.
- The health care systems in place to treat substance abuse and mental illness are typically disconnected, hence inefficient. Physicians tend to treat patients with mental illnesses, whereas a mix of providers with varying backgrounds deliver drug abuse treatment.

The same disconnect in our health care system and our treatment approaches to mental health and substance use disorders (what we now refer to collectively as behavioral health) is unfortunately mirrored in the way we teach young people about substances and addictions, completely ignoring the role of mental health.

Recommendation: Amend State Education Law with respect to school health curricula to enhance the existing requirement regarding instruction in alcohol, drugs and tobacco to incorporate the interrelationship between mental health and the misuse of, and addiction to, alcohol, drugs and tobacco, including a greater emphasis on highly addictive and potentially lethal drugs including opioids.

For more information on the legislative initiative to include mental health instruction in school health curricula, please contact John Richter, Director of Public Policy, MHANYS at 518-434-0439, ext. 229

Appendix K - NY School Mental Health Resource Center Proposal



Mental Health Association in New York State, Inc.

Glenn Liebman, MA
CEO

Ellen Pendegar, MS, RN
Board Chair

School Mental Health Resource and Training Center

The passage of Chapter 390 of the Laws of 2016, effective July 1, 2018, will require all New York State schools to include mental health instruction as part of the K-12 health curricula. Schools in the state have varying levels of expertise, if any, on how and what to teach students about mental health. Also, the 2016-17 enacted State budget amended Education Law section 2801-a including a requirement that staff annually receive training in the school emergency response plan, and specifically requires training in mental health. Educators and other school personnel need quality, evidence-based mental health training that is freely and conveniently accessible. Finally, schools need assistance identifying local mental health services for students in need.

A School Mental Health Resource and Training Center shall be established and available to all New York State public and private schools at no cost for a period of three years. The Resource Center shall help schools identify evidence-based resources to develop mental health curricula, provide resources and guidance to support schools' ability to comply with the required mental health education of students, make available and accessible mental health training for staff, and provide schools with assistance identifying local mental health services for students in need. This proposal seeks \$1 million in funding for each year that the Resource Center is in operation. It is recommended that the Resource Center operate for a minimum of three years at which point authorization for funding to continue operation would be accessed based on school need.

The Resource Center will be established and maintained by the Mental Health Association in New York State, Inc. (MHANYS), a statewide entity with: 1) competency and experience providing mental health and wellness training to the general public as well as professionals, including teachers; 2) familiarity with the provisions and legislative intent of chapter 390 of the Laws of 2016 and corresponding regulations and guidelines; 3) an understanding of the assistance that schools will need to comply with these provisions; 4) established relationships with education stakeholders in New York and; 5) have the ability to foster local partnerships with community-based mental health providers, which includes a network of 26 affiliates.

The Resource Center would include the following program features and methods of service and support delivery of:

- Project Manager and trainers as needed;
- phone and web-based information and referral services;
- web-based training, additional resources and information available and regularly updated on the Resource Center webpage;

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Appendix K - NY School Mental Health Resource Center Proposal

School Mental Health Education Resource and Training Center

- consultation with individual school districts over a three-year period;
- three regional summits per year;
- four webinars per year hosted live, archived, and available through the Resource Center webpage;
- in-person professional development (through MHA local affiliates), and;
- select trainings, webinars, and summit workshops will be eligible for CTLE credits.

The Resource Center would make available the following training, technical assistance, resource development and process evaluation services and supports:

- Teachers and school staff mental health training, to include an understanding of:
 - mental health as an integral part of overall health,
 - typical adolescent development as it relates to possible signs and symptoms of an emerging mental health problem,
 - risk and protective factors,
 - strategies for supporting student stress management skills,
 - school-wide resources for supporting student mental health and wellness, and
 - how to recognize the signs of crisis, emotional trauma, and other related mental health issues.
- Assistance with implementation of Chapter 390 of the Laws 2016:
 - ongoing maintenance of resources for mental health education curriculum development that are evidence-based and consistent with current mental health literacy knowledge, understanding, and best practices,
 - sample mental health lesson plans for K-12 health education,
 - process evaluation of the Resource Center through annual school surveys to determine:
 - how well the Resource Center is supporting mental health and wellness in schools
 - what can the Resource Center do to support the implementation of Chapter 390 of the Laws 2016
 - other school mental health implementation considerations, e.g., resources to assist school districts and schools in the development of a school culture and climate of mental health and wellness; parental communication and notification; responding to mental health crisis, etc.
- Facilitating collaboration between schools and community partners (e.g., community-based mental health providers, county governments, prevention education providers, hospitals, rehabilitation, etc.) for the purpose of creating linkages between students and their families, and mental health-related services.

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Appendix L - NY School Mental Health Resource Center Impact Statement



Since July 2018, we have provided technical assistance and training to help schools deliver mental health instruction as part of the K-12 curriculum through a comprehensive website and quality educational events that meet the individual needs of the entire school community.



88% of schools communities in NY have utilized the Resource Center

Every member of a school community has a role in supporting youth mental health - educators, parents and caregivers, and providers. By supporting common understanding and shared language, MHANYS is committed to helping communities support the mental health of students.

BUILDING CAPACITY TO INCREASE MENTAL HEALTH LITERACY



246,398

webpage views
on the website



59,598

unique users of
the website



6,000+

students received
mental health instruction



3,387

registered
professionals online

Professional Development

🧡 **292** events/activities with **22,157** participants
🧡 **1,443** learners completed online, self-paced training modules

Outreach

🧡 Hosted **40** exhibits (in-person & virtual) at conferences/events with nearly **9,000** youth, families and professionals in attendance.

RESPONDING TO COVID-19 PANDEMIC

Educators took advantage of the myriad of resources and professional development opportunities following move to remote learning in response to Covid-19. MHANYS School Mental Health Resource and Training Center facilitated **55** live webinars serving **8,715** participants and **72%** of the educators who took our self-paced, online training did so since March 2020.

*this data is included in the professional development section

Statistics on this document include data from July 1, 2018 to January 13, 2021

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Appendix L - NY School Mental Health Resource Center Impact Statement

A PROJECT DESIGNED
FOR ALL NEW YORK
STATE SCHOOLS



BUILDING SCHOOL-COMMUNITY RELATIONSHIPS

In 2020, MHANYS received a one-year grant from Mother Cabrini Health Foundation to support a Family Education Project enhancing our ability to raise awareness about youth mental health concerns among parents and caregivers, and reduce stigma. The project included monthly 30-minute webinars and a Fall Learning Community series that was attended by educators, parents and caregivers, and community providers. Success of the project led to a second year of funding in 2021.

🎗️ 42 events

🎗️ 4,287 live views

🎗️ 825 viewed recordings

Collaborated with National partners to educate school professionals about mental health and mental health education:

- ➡️ Participated in PsychU panel discussion reaching **1,000** participants
- ➡️ Co-sponsored two day conference with SAMHSA'S Mental Health Technology Transfer Centers reaching **900** participants

We are proud of the many National, State and Local partnerships that support our work:

| | |
|--|--|
| Catholic School Administrators Association of NYS | NYS Education Department |
| Center for School Improvement at the UAlbany School of Education | NYS Executive Chamber |
| New York State Council of Education Associations | NYS Insurance Reciprocal |
| NYS Association for College Admission Counseling | NYS Legislature |
| NYS Association for Health, Physical Education, Recreation and Dance | NYS Office of Mental Health |
| NYS Association of School Nurses | NYS Parent Teacher Association |
| NYS Association of School Psychologists | NYS Rural Schools Association |
| NYS Association Psychiatric Rehabilitation Services | NYS School Boards Association |
| NYS Bar Association | NYS School Counselor Association |
| NYS Center for School Health | NYS United Teachers |
| NYS Council of Religious and Independent Schools | School Administrators Association of NYS |
| NYS Council of School Superintendents | Suicide Prevention Center of NY |
| | And more! |



Presented nationally:

- Massachusetts Joint Education Committee
- Massachusetts Community Behavioral Health Promotion and Prevention Commission
- Mental Health America
- National Center for School Mental Health

AWARD WINNING



- Association of Community Living's 2019 Leadership & Advocacy Award
- National Council for Behavioral Health's 2019 Excellence in Advocacy - Organizational Achievement

Statistics on this document include data from July 1, 2018 to January 13, 2021

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