

Mental Health Education in New York Schools

A REVIEW OF LEGISLATIVE HISTORY, INTENT AND
VISION FOR IMPLEMENTATION

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for Implementation

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Introduction

This paper is written for the purpose of recording the legislative history and intent of Chapter 390 of the Laws of 2016, referred to herein as Mental Health Education in New York Schools, and to articulate a vision for its implementation in New York State from the perspective of the Mental Health Association in New York State, Inc. (MHANYS), the principle advocates that advanced and promoted the legislation now part of the New York State Education Law. The paper is intended to provide the education and mental health communities with not only a historical context for the law, but also a framework and guiding principles for the implementation of the law. Both of these communities recognize the importance of students' overall wellness, which includes both their health and mental health. This is the purpose behind having a health curriculum to instruct young people about important public health topics such as the early detection of cancer and instruction about alcohol, tobacco and substances. These important elements of the school health curriculum have long been recognized as crucial knowledge for young people and have been specifically named and included in the State's education law for decades. It is long overdue that instruction in mental health should accompany these critical areas of instruction and made available to the young people of New York.

Summary of Provisions in the New Law

Section 1 of the law adds a new paragraph to Section 804 of the New York State Education Law to declare that mental health, as well as physical health, be included as part of health education in schools. Section 2 of the law makes the bill effective on July 1, 2018. The law also amends subdivision 6-c to clarify language directing the Board of Regents to modify the health curriculum as it relates to the development of skills for recognizing and coping with violent incidents in schools. Previous language made an unfortunate and misleading association between violence and mental illness. The new language eliminates this erroneous implied correlation.

It should be noted that the amendments to the Education Law requiring schools to begin teaching about mental health do not include provisions specifying curriculum content. The law simply states that mental health shall be included in the school health curriculum. The degree to which there will be additional guidance to schools regarding curriculum content, will presumably be a matter for the New York State Education Department (SED) to resolve under its statutory authority to implement the law.

Legislative Background

After five years of persistent legislative advocacy, New York lawmakers responded to the call for the inclusion of mental health instruction in the health curriculum of New York's schools. Legislation sponsored in the New York State Assembly by Assemblymember Catherine Nolan and in the New York State Senate by Senator Carl Marcillino passed both houses of the Legislature in June of 2016. The legislation was signed into law on September 30, 2016 by New York Governor Andrew Cuomo as Chapter 390 of the Laws of 2016¹, which, upon its effective date of July, 2018 requires all

¹ See addendum A for the full text of Chapter 390 of the Laws of 2016.
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elementary, middle schools and high schools in the state of New York to provide instruction about mental health to all students as part of the school health curricula.

The legislation had been riding an expanding wave of grassroots support for several years in response to a growing recognition that people in general, and young people more specifically, are not “mental health literate”. Mental health literacy is an extension of the concept of health literacy and is defined as “knowledge and beliefs about mental disorders which aid their recognition, management or prevention”² The term “mental health literacy” can be credited to the work of Australian researcher Anthony Jorm. This same body of research laid the groundwork for *Mental Health First Aid*³ training, which is growing in popularity and fast becoming recognized as the gold standard in evidence-based mental health training for the general public.

National Trends

While most states have laws addressing the teaching of health education in primary and secondary schools, few have passed laws requiring the teaching of mental health. The State School Health Policy Database⁴ maintained by the National Association of State Boards of Education, catalogs such requirements. States vary on several dimensions including how health education is defined, including how comprehensive and inclusive the definition is with regard to curriculum content, whether teaching health is mandatory or encouraged, how specific the law is, the extent to which details about required health curricula are included in the law, regulations or guidance documents and whether health education is required for graduation. Determining from a practical standpoint the extent to which states are in compliance with these laws and regulations presents significant challenges.

The Education Commission of States published a synopsis of mental health education legislation passed in states in 2013, which provides a sense of national trends regarding mental health initiatives in schools generally, with a small subset of legislation specifically geared toward teaching students about mental health.⁵ This document reinforces other evidence that the trend around mental health legislation as it pertains to schools has been more targeted toward teacher education and training, and funding for services as opposed to bringing knowledge about mental health directly to students.

Two notable examples of states other than New York that have passed legislation pertaining to mental health instruction in schools are California and Minnesota. Note however that unlike New York, neither of these laws mandate teaching about mental health and only either “encourage” or “recommend” that it be taught to students.

Health Education and the Mental Hygiene Movement

² Jorm, A.F. et al (1997)

³ *Mental Health First Aid USA* is a proprietary training program managed, operated and disseminated by the National Council for Behavioral Health.

⁴ State School Health Policy Database, National Association of State Boards of Education
http://www.nasbe.org/healthy_schools/hs/bytopics.php?topicid=1100

⁵ Thomsen, J. (2014, February). States Pass Diverse Slate of Mental Health Legislation in 2013. Retrieved from
<http://files.eric.ed.gov/fulltext/ED560980.pdf>

The idea to teach school-aged children about mental health is much older than one might assume judging by the fact that it took until 2016 for New York to first pass a law requiring such instruction. A 1928 recommendation to emphasize mental hygiene in school health curricula, though exceedingly enlightened for its time, soon became an afterthought not to be seriously considered again in school health policy until the present day.

The roots of early proposals to teach mental health in schools can be found in the context of the mental hygiene movement. The National Committee for Mental Hygiene was founded in New York in 1909 by a number of leading psychiatrists and Clifford W. Beers. Beers had himself been institutionalized in several mental hospitals where he experienced first-hand the deplorable conditions, which he ultimately documented in his autobiography *A Mind That Found Itself* (1913)⁶. The National Committee, which would in 1909 become today's Mental Health America (MHA), to which MHANYS is a state affiliate, sought to:

- Improve conditions in mental hospitals
- Stimulate research in psychiatry
- Improve the quality of psychiatric education
- Develop measures preventing mental illness
- Popularize psychiatric and psychological perspectives.

At the peak of the Mental Hygiene Movement, just seven years before Beers penned his autobiography and two years after New York created The Department of Mental Hygiene, education stakeholders were taking notice. In 1928, the *Sixth Yearbook* of the Department of Superintendents of the National Education Association outlined the following content guidelines for health education, including mental hygiene as its top recommendation:

- **Mental hygiene must be emphasized and protected;**
- The establishment of health habits depends upon the pupil's understanding something of the function of his own body;
- A discussion of the causes of disease merits a place in the secondary school program;
- A thorough study of nutrition should be placed in the upper grades.
- Posture should be emphasized.
- The hygiene of the home should be taught.
- Sex hygiene cannot be overlooked.

Around the same timeframe that the Mental Hygiene movement was shaping social constructs like health education (i.e., late nineteenth century and early twentieth century), the temperance movement was also influencing education. For example, school health programs stressed that children should learn about the effects of alcohol, tobacco, and narcotics on the human system.⁷ Health curricula during this era also stressed what were referred to as “daily chores”, which included the kinds of practical advice most of us take for granted today as common wisdom such as: wash hands before each meal; clean fingernails, brush teeth after breakfast and the evening meal and avoid

⁶ Beers, C. W. (1935). *A mind that found itself: An autobiography*. Garden City, N.Y: Doubleday.

⁷Allensworth, D., Lawson, E., & Nicholson, L. (1997). *Schools & Health: Our Nation's Investment*. Institute of Medicine (US) Committee on Comprehensive School Health Programs in Grades K-12. National Academies Press (US).
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accidents; look both ways when crossing the street, as well as some curious directives like “spend 11 hours in bed, with windows open”. But in spite of the recommendations of the *Sixth Yearbook* mental hygiene was notably absent from health curricula.

Another historic benchmark for health education in schools was “The School Health Education Study (SHES), which was a crucial event in transforming health education as practiced in American public schools. It has been called, “the most significant school health education initiative of the 1960s⁸ and was largely responsible for establishing the value of comprehensive health education rather than separate disease-specific units and in introducing the concept-based approach to education in general. Most health curricula developed since have followed the model set by the SHES in its School Health Curriculum Project⁹”

Unfortunately, though the SHES did define health as a dynamic, multidimensional entity, it failed to explicitly acknowledge mental health as an instructional content area, only highlighting the following:

- Human growth and development;
- Personal health practices;
- Accidents and disease;
- Food and nutrition;
- Mood-altering substances, and;
- Role of the family in fulfilling health needs.

Presently, in New York, and until July, 2018 when the Mental Health Education in Schools law becomes effective, there is no requirement in the State Education Law that schools must provide instruction about mental health as part of the school health curricula. However, the regulations for “Health, Physical Education and Recreation” does include mental health as reflected in the following definition of health education contained in the regulations: “(j) Health education means instruction in understandings, attitudes and behavior in regard to the several dimensions of health. This instruction relates to alcohol, tobacco and other drugs, safety, mental health, nutrition, dental health, sensory perception, disease prevention and control, environmental and public health, consumer health, first aid, and other health-related areas.”¹⁰ Outside of the reference to mental health in this definition, Part 135 of the regulations provides no other reference to mental health or specific guidance relative to a curriculum. This does not appear to be because the regulations in Part 135 are not prescriptive generally as evidenced by significant regulatory guidance provided relative to the subject areas of, for example, HIV and physical education.

The Case for Mental Health Instruction

Unrecognized, untreated and late treated mental illness elevates the risk of mental health crises such as suicide and self-injury, diminishes prospects for recovery and contributes to substance abuse and other damaging negative coping behaviors. The first signs and symptoms of mental health

⁸ Allensworth, D., Wyche, J., Lawson, E., and Nicholson, L. (1995). *Defining a Comprehensive School Health Program: An Interim Statement*. Washington, DC: National Academy Press.

⁹ Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J. (Eds.) (1997). *Schools & Health: Our Nation's Investment*. Washington, DC: National Academy Press.

¹⁰ Commissioner's Regulations Part 135, Subchapter G, Health and Physical Education.

problems, some of which develop to the point of becoming diagnosable mental illness, begin, on average, at about 14 years of age. Many adults miss or dismiss these early signs and symptoms and young people are even less likely to recognize or understand what is happening to them. And even when there is some recognition that a young person is struggling, stigma often causes people to ignore, dismiss or rationalize a child’s true need for help. The result is often as tragic as it is unnecessary.

Mental Health Prevalence Rates

“Abnormal is the new normal - at least for mental health” opined a recent writer for a news article¹¹ reporting on fresh studies¹² of mental health prevalence rates in the United States, Switzerland and New Zealand. Surprisingly the article claimed that based on these new studies “only a small share of the population stays mentally healthy from age 11 to 38. Everyone else experiences a mental illness at some point.” More conservative, and routinely cited statistics, place the ratio of people diagnosed with mental illness over the course of a year at one in four people in the United States. That’s approximately 61.5 million people.

And despite the image conjured in most peoples’ minds of a person with mental illness behaving strangely, hearing voices and hallucinating the most common mental illnesses are anxiety disorders, not psychosis. In fact, 18.2% of people have an anxiety disorder while 6.8 % of people have a major depressive disorder and only about one percent have schizophrenia. Thus, the majority of the one in four people with a mental illness have either anxiety or depressive disorders or both. Certain populations are at even greater risk. About 20% of Iraq and Afghanistan veterans have PTSD and/or depression¹³, and in long-term care facilities, 49% of residents have depression¹⁴. Critical for appreciating the relationship between teaching about mental health and its role in ameliorating substance use among young people (a topic that will be discussed at greater length later in this report), is the comorbidity prevalence rates of mental health diagnosis and substance use. Compared with the general

Table 1

Prevalence of Mental Illness by Diagnosis	
Anxiety disorders	18.1%
Major depression	6.9%
Bipolar disorder	2.6%
Schizophrenia	1.1%

Table 1 shows the prevalence of four mental illness diagnosis or diagnostic groups in the U.S. Though there are many other mental health disorders, this table illustrates how much more common mood disorders are (i.e., anxiety and depression disorders) as compared to disorders such as schizophrenia and bipolar disorders which have psychotic features and are perhaps more generally representative of social images of mental illness.

¹¹ Bower, B. (2017). Mental illness may be a common life experience: Study suggests most people suffer at least one bout of depression, anxiety or other disorder. Science News for Students. Retrieved July 13, 2017, from <https://www.sciencenewsforstudents.org/article/mental-illness-may-be-common-life-experience>.

¹² Schaefer, J. (February 2017). Enduring mental health: Prevalence and prediction. *Journal of Abnormal Psychology*, 126.

¹³ Tanielian, et al., (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: RAND Corporation. From <https://www.rand.org/pubs/monographs/MG720.html>. Also available in print form.

¹⁴ Harris-Kojetin L, Sengupta M, Park-Lee E, Valverde R. (2013). Long-term care services in the United States: 2013 overview. National Center for Health Statistics. *Vital Health Stat* 3(37).

population, patients with mood or anxiety disorders are about twice as likely to also suffer from a substance use disorder and patients with substance use disorders are roughly twice as likely to be diagnosed with mood or anxiety disorders.¹⁵

Age of Onset of Mental Health Disorders

Contrary to a common misconception, mental illnesses are not exclusively experienced by adults. While it may be true that most mental illnesses are not properly diagnosed until later in life, signs and symptoms of many mental illnesses can begin very early in life. This reality is central to the subject of this report and the need to teach young people about mental health as a means of early intervention and prevention.

It's well established that half of all chronic mental health conditions begin by age 14¹⁶, half of all lifetime cases of anxiety disorders begin as early as age 8 and some 22 % of youth aged 13-18 experience serious mental disorders in a given year.¹⁷ If these statistics seem startling, it's because the reality of when most mental illnesses begin is obscured from our view because most of us don't recognize the signs and symptoms when they appear, ignore them or mistakenly confuse them with other characteristics of adolescence such as changes associated with puberty. This is a tragedy for two main reasons: 1) early intervention and treatment of mental illnesses hold the best prospect for treatment efficacy and recovery, and 2) adolescence is such a crucial developmental stage of life.

Impact of Untreated, Late-treated and Under-treated Mental Illness

Only about 40 percent of people with a diagnosable mental illness will seek treatment in a given year. Among this group, the average latency period for getting help averages about 10 years from the first onset of symptoms. About 60 percent of people with mental illness will not receive professional help. Still others will fail to maintain prescribed treatment plans through recovery or will only receive partial treatment. This unfortunate reality has profound implications not only for each individual person impacted but for society as a whole. Consider the following statistics concerning the impact of untreated mental illness”

- According the World Health Organization (WHO), depression is the leading cause of disability worldwide.
- 90% of people that complete suicide suffer from depression and other mental disorders, and substance-abuse disorders (Insel, 2015).
- Less than one percent of the United State is comprised of military, yet 20% of all completed suicides are by veterans (U.S. Department of Veterans Affairs, 2013).

¹⁵ Conway KP1, Compton W, Stinson FS, Grant BF (February, 2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry*.

¹⁶ Ranna Parekh, M.D., M.P.H. (September, 2015). Warning Signs of Mental Illness. American Psychiatric Association. From <https://www.psychiatry.org/patients-families/warning-signs-of-mental-illness>.

¹⁷ Insel, T (May, 2015). Post by Former NIMH Director Thomas Insel: Mental Health Awareness Month: By the Numbers. MIMH. From <https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2015/mental-health-awareness-month-by-the-numbers.shtml#2>

- The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States.¹⁸
- Depression, anxiety, and other mental illnesses are costing the world upwards of \$1 trillion per year.¹⁹

The reality of unrecognized and untreated mental illness among young people is perhaps even more troubling as previously eluded to in relation to adolescence as a crucial developmental stage of life:

- Over 60% of young adults with a mental illness were unable to complete high school.
- Transitional Age Youth (youth between the ages of 16 and 24) with mental illness are 4 times *less* likely to be involved in gainful activities (e.g. employment, college or trade school).
- Those with a psychiatric disability are three times more likely to be involved in criminal justice activities.
- Nationally, each year, approx. 157,000 youth between 10 and 24 years of age receive medical care for self-inflicted injuries at emergency departments across the U.S.²⁰
- 1 in 12 high school students have attempted suicide.²¹

The cost of not teaching young people about mental health cannot be overstated. When mental illness, or even merely the early seeds of illness, go unrecognized and untreated a cascade of unfortunate and sometimes tragic events is set in motion. These can include: reduced prospects for recovery, the development of negative coping behaviors including substance use and other risky behavior, the increased chance of legal trouble and consequent criminal records, compromised academic performance and lower graduation rates. And most troubling of course is the increased risk of mental health emergencies such as suicide and self-injury.

Mental Illness as a Risk Factor for Substance Abuse

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.

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

¹⁸ The Neglect of Mental Illness Exact a Huge Toll, Human and Economic (March, 2012). Scientific America. From <https://www.scientificamerican.com/article/a-neglect-of-mental-illness/>.

¹⁹ Investing in treatment for depression and anxiety leads to fourfold return (April, 2016). World Health Organization news release. From <http://www.who.int/mediacentre/news/releases/2016/depression-anxiety-treatment/en/>

²⁰ Suicide Among Youth. Centers for Disease Control and Prevention. Retrieved July 13, 2017 from <https://www.cdc.gov/healthcommunication/toolstemplates/entertainment/tips/suicideyouth.html>.

²¹ Suicide: Facts at a Glance (2015). National Center for Injury Prevention and Control: Division of Violence Prevention. From <https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>.

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 Comorbidity 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.²²
- 43% of adults aged 26 to 49 with past year substance use disorder also had a diagnosed mental illness.²³

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

- Individuals with psychiatric disorders purchase approximately 44% 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%.

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.

²² Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen HU, Kendler KS. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. *Arch Gen Psychiatry*.

²³ Sarra L. Hedden, Sarra (et. Al) (2014). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.

The Role of Mental Health Literacy

The construct of mental health literacy includes the assumption that people who experience symptoms of mental health disorders frequently do not seek help. A literary review of the barriers to, and facilitators of, help seeking behavior concluded that “adolescents and young adults frequently experience mental disorders, yet tend not to seek help”, and further concluded that “...strategies for improving help-seeking by adolescents and young adults should focus on improving mental health literacy, reducing stigma, and taking into account the desire of young people for self-reliance.”²⁴

“It is important to note that mental health literacy is not simply a matter of having knowledge (as might be conveyed in an abnormal psychology course). Rather it is knowledge that is linked to the possibility of action to benefit one’s own mental health or that of others.” - Anthony F. Jorm

Australian researchers in the mid-1990s began to explore alternative approaches to the prevailing wisdom that the primary need in fostering more timely treatment of mental illness was to improve training for general practitioners (GPs) and other primary healthcare workers to better identify and manage mental disorders. The work of Anthony Jorm and others focused instead on a neglected area of research for which they coined the term “mental health literacy”.²⁵ This body of research distilled several core components to mental health literacy including:

- a. knowledge of how to prevent mental disorders;
- b. recognition of when a disorder is developing;
- c. knowledge of help-seeking options and treatments available;
- d. knowledge of effective self-help strategies for milder problems, and;
- e. first aid skills to support others who are developing a mental disorder or are in a mental health crisis.²⁶

These components are central to *Mental Health First Aid*²⁷ training as well as the recommendations for mental health instruction in schools included in this report. The Jorm study showed that efforts to raise mental health literacy in educational settings resulted in:

- An increase in the proportion of students willing to seek help from professional sources;
- Significant improvements in students’ (and their parents’, friends’ and neighbors’) awareness of mental health issues; and,

²⁴ Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*. Retrieved from <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/1471-244X-10-113>.

²⁵ Jorm, A. F. (2011, October 31). *Mental Health Literacy: Empowering the Community to Take Action for Better Mental Health*. *American Psychologist*. Advance online publication. doi: 10.1037/a0025957

²⁶ Jorm, A.F. et al (2011).

²⁷ *Mental Health First Aid* “is an 8-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives you the skills you need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.” - Mental Health First Aid USA is managed, operated, and disseminated by the National Council for Behavioral Health.

- Significant increases in student knowledge and attitudes.

The prevalence rates of mental illness, its early age of onset and the impact of untreated mental illness warrants a strategic public policy response that goes beyond only advocating for increased access to mental health services in schools or through community linkages. Mental health literacy research strongly suggests a role for public health education in schools aimed at providing students with the information they need to protect and preserve their own mental wellness and the mental wellness of those around them. It was within this context that MHANYS sought to add mental health education to other ongoing efforts to strengthen the state's response to the challenge of achieving mental health for all New Yorkers.

Mental Health Instruction in New York State Education Law

Mental health advocates recognized a number of compelling realities that led to the public policy initiative to amend the State Education Law to include instruction in mental health, notwithstanding the fact that such a requirement already exists in regulation. These include the following:

Mental health instruction is a public health imperative: Historically, public health subjects such as alcohol, tobacco and drugs, the early detection of certain cancers and HIV have been added to the State Education Law as subjects of instruction because they were recognized as public health crises of the day. Mental health is a public health issue of great importance as evidenced not only by its high prevalence rates relative to many other disease states, but also its propensity, especially when untreated, to cause significant damage to individuals and society as a whole. In other words, mental health and its attendant corollaries such as suicide, disability and substance abuse warrant explicit recognition in the law as one of today's biggest public health crises.

Prior to the passage of Chapter 390 of the Laws of 2016, which amends Section 804 of Article 17 of the New York State Education Law, Section 804 mandated the inclusion of just two specific courses of instruction as part of the school health curriculum. These are the subjects of alcohol, drugs, tobacco abuse and the prevention and detection of certain cancers. Without the insight of recorded legislative intent with regard to the justification for the inclusion of these two subject areas, we can only assume that these were considered public health priorities of the day (as they remain) that lent themselves to a public health approach to instruction. Both are issues that warrant an early life understanding rooted in the objective of prevention. Advocates for the addition of mental health instruction in schools believed similarly and fought for its inclusion under the same rationale. With time as a teacher we now know, and should acknowledge, that instruction about alcohol, drugs, tobacco abuse, in particular, should never have occurred absent instruction about mental health given its inextricable role in addiction.

Statutory inclusion sends a powerful and clear message to schools: Explicitly including mental health in the law governing health education communicates to schools that teaching about mental health is not only a priority and a requirement, it is allowable and within schools' proper role as educators. Feedback from educators to MHANYS supports the notion that teachers and school administrators are often unsure about their proper role in talking about subjects like mental health or suicide and may not be comfortable in the absence of statutory or regulatory guidance on the subject. The passage of the

law requiring that mental health be taught in schools eliminates this ambiguity and sends a clear “green light” signal to educators that carries the imprimatur of state lawmakers. Further, these subjects are unfortunately fraught with negative connotation, misunderstanding, fear and stigma. Ironically, this reality exists in part precisely because as a society we do not talk about these issues much less teach them to our children. Consequently, most of us are uncomfortable with these issues and it is understandable that teachers, administrators and parents may harbor attitudes that create barriers to talking about mental health with students absent a clear directive.

Lack of substantive guidance in the regulations: As already mentioned, outside of a reference to mental health as part of the definition of “health education” in Part 135 of the State Education Regulations, there is little other mention of mental health or guidance for educators thereof. Subject areas such as alcohol, tobacco and drugs and HIV for example, enjoy significantly more attention in the regulations no doubt owing to the fact that the imperative to teach both of these subjects is included in statute;

Many schools are not teaching about mental health: As a general rule, many schools throughout New York State are not teaching students about mental health even though the regulatory definition recognizes it as part of health education. Admittedly, this claim is anecdotal in nature. Through its statewide affiliate network MHANYS is aware of some schools that have taken steps to include instruction in mental health. This awareness exists because some MHAs work in partnership with schools and function as resources to schools and in some cases provide instruction themselves under agreements with schools. Rockland County, Ulster County, and Erie County MHAs are notable examples. Our experience is that without individuals within a school who champion the cause of teaching about mental health and who persevere through resistance from administration and/or parents, the subject matter is simply avoided.

Toward Implementation

MHANYS is committed to the successful implementation of Chapter 390 of the Laws of 2016. The association understands that the passage of the law in and of itself will not assure that schools will be prepared with the necessary knowledge and resources to effectively implement mental health instruction as part of the health curriculum. Schools will need support in identifying relevant curriculum content, community resources and appropriate training and education for designated health and mental health teachers. And, as previously discussed, there are few if any similar experiences in other states from which to help New York plot its course.

MHANYS avails itself and its 26 MHA affiliates who are active in 50 counties across New York to the State Education Department and schools as a resource for implementation and ongoing support. Toward this end MHANYS has developed recommendations to help inform schools in the development of mental health curricula. These recommendations include both general principles and recommendations for more specific elements that together represent a framework for curricula development that is public health oriented, evidence-based and consistent with the legislative intent of Chapter 390 of the Laws of 2016.

Mental Health Education in Schools Summit 2017

On March 16, 2017 MHANYS convened a Mental Health Education in Schools Summit in Albany, New York as a means of symbolically initiating the implementation of Chapter 390 of the Laws of 2016. The Summit provided a forum wherein several objectives could be pursued. These included:

1. Assembling representatives from the education and mental health communities around the topic of the new law (see addendum A for a list of invited organizations). The passage of Chapter 390 of the Laws of 2016 provided a common purpose around which these two communities could coalesce in an unprecedented manner. Education and school associations joined with Mental Health Association affiliates, teachers and high school students. Stronger relationships between educators and mental health professionals and advocates will be crucial for school success in implementing the new law;
2. Providing a forum for state officials to share the State's vision for implementing Chapter 390 of the Laws of 2016. The Summit audience heard presentations from the New York State Education Department (SED) and the New York State Office of Mental Health (OMH). As the lead state agency charged with implementing the new law, the SED Commissioner shared some preliminary thoughts on the steps SED would take to implement the law. An OMH representative articulated the State's vision for mental health broadly and children's mental health more specifically. The audience had an opportunity to ask state officials a variety of clarifying questions. The Summit was therefore a vehicle to communicate to the audience that the State is serious about the new law and how it will be implemented;
3. Giving current educators and mental health professionals an opportunity to share experiences of how mental health education is already underway in some schools. Although certainly not the norm, there are some schools and mental health advocates that already have some experience teaching about mental health and suicide prevention in schools. Summit organizers assembled a panel of these educators and advocates to discuss their successes and challenges. These "real world" examples of mental health being taught in schools provided tangible examples of what the newly implemented law might look like in schools across New York. Later in the day the audience heard directly from three high school students who presented about their own mental health challenges and why teaching about mental health in schools is so important to them. All of these presentations lent a very human element to the Summit and were well received by the audience as reflected in post-Summit evaluations;
4. Creating a public forum that allowed MHANYS to give historical context to the passage of the new law, articulate the urgency and need of mental health education, establish and record legislative intent, share MHANYS vision for implementation and provide a framework of guiding principles for curriculum development, and;
5. Although the focus of the Summit was mental health education in schools, pursuant to the new legal requirement, there was considerable discussion around broader mental health issues in schools such as student mental health challenges, how to support students and engage caregivers, the importance of community partnerships, and school-wide mental

health initiatives that are inextricably linked to educating students about mental health. For example:

- a. When educating students about mental health results in a heightened awareness of their own and others' mental health, schools may notice an increase in students identifying perceived mental health challenges in themselves and their peers. As such, it is imperative that educators have a better understanding of mental illness, be able to identify strategies for improving student wellness, and be aware of school policies related to mental health referrals and response to mental health crises. As an approved provider of Continuing Teacher and Leader Education (CTLE), MHANYS is committed to educating teachers and staff about adolescent mental health and wellness;
- b. Schools are encouraged to identify strategies for engaging families in supporting youth mental health and wellness, and partnering with community resources to enhance access and support aftercare. Each school should employ strategies that are congruent with the characteristics and strengths of their school community, and be responsive to current trends and research. For example, much attention has been given to the effects of adverse childhood experiences (ACEs). Community partners can support school efforts to educate staff about the educational impact of ACEs and to develop trauma-informed learning strategies;
- c. School-community partnerships are critical to the development of a comprehensive, school-based mental health and wellness strategy. Schools are encouraged to rely on community partners for the purpose of educating students and building collaborative relationships that can connect students and families with community resources for the purposes of treatment and support. For some schools, this may be a Community School model, for others it may include co-locating a community behavioral health provider on school property. Several MHANYS' affiliates are committed to collaborative relationships with schools, providing mental health education and treatment to students and families, and;
- d. Several Summit participants referenced existing school initiatives that support a culture of mental health and wellness, such as Social Emotional Learning and Positive Behavioral Interventions and Supports (PBIS), among others. Social Emotional Learning promotes self-awareness, emotional regulation, responsible decision-making and help-seeking skills all of which are important to student mental health and wellness. Through modeling and reinforcement, PBIS provides lifestyle choices and appropriate social interactions.

Recommendations for School Mental Health Curricula

- Guiding Principles

MHANYS recommends that curricula and lesson plans developed in accordance with the new law, and the legislative intent of the law, should:

1. Assume a public health approach to teaching about mental health geared toward providing students with life-long skills and resources that transcend a young person's present role as a student. Such curricula should strive to equip students with knowledge about mental health so as to maximize each student's own mental wellness and the mental wellness of others, and instill an awareness of when and how to access treatment or other services as needed for oneself and others;
2. Assure that the primary mental health educator(s) tasked with providing instruction about mental health has a minimum of knowledge, education, and training in mental health consistent with the curriculum elements outlined in this guidance document;
3. Draw upon and involve the participation of mental health experts, advocates, providers and recipients (past and/or present) of mental health services from the general community outside the school itself, in addition to instruction provided by the primary mental health educator(s), and;
4. *Not* have as learning objectives teaching students to diagnose, treat or otherwise provide counseling to people with mental illness.

- *Curriculum Elements*

Core elements in school mental health curricula should include:

1. The concept of wellness including self-care and personal responsibility for one's own mental health and wellness.
2. The concept of mental health as an integral part of health.
3. The recognition of the signs and symptoms of developing mental health problems.
4. Instruction in the awareness and management of mental health crises such as the risk of suicide, self-harm and other mental health crises.
5. The relationship between mental health, substance use and other negative coping behaviors.
6. The negative impact of stigma and cultural attitudes toward mental illness on treatment seeking behavior and as a contributing factor in discrimination against people with mental illnesses.
7. The concept of recovery from mental illness.
8. The implications of risk factors, protective factors and resiliency on wellness, mental health and recovery.
9. Instruction in identifying appropriate professionals, services and family/social supports for treating and maintaining recovery from mental illness.

Concluding Remarks

The passage of Chapter 390 of the Laws of 2016, requiring all schools in New York to teach students about mental health represents a profound legislative achievement of which many future generations of students will be the fortunate beneficiaries. They will be fortunate because they will have vital knowledge against which to process their own life experiences, mental health challenges and in some cases mental illnesses. They will be fortunate because they will have tools and resources to recognize when they or others are moving from wellness to illness and how to get help early. They will be fortunate because they will understand that mental illness is not something to be ashamed of, kept secret, ostracized for or feared. They will be fortunate because the truth about mental health will cultivate stigma-breaking empathy for others. They will be fortunate because they will know that there is hope for recovery and meaningful, purposeful living in spite of mental health challenges. They will be fortunate because times of crisis, acute mental anguish and desperation will be tempered by an assurance that there are life-sustaining alternatives to the false idea that suicide, self-harm and substance abuse are their only recourse. And they will be fortunate because they will be better equipped with healthful knowledge that will serve them, their families, friends and neighbors for a lifetime.

This will be the legacy not merely of legislation signed into law last September of 2016, but of the work that remains and will be required to bring the purpose and intent of the law to fruition. This is the challenge before each of us. MHANYS invites all of New York's educators, parents, mental health professionals, advocates and most importantly, students, to join us in this most noble pursuit.

About MHANYS

The Mental Health Association in New York State, Inc. (MHANYS) is a 501 (c)(3) not-for-profit organization with 26 local affiliate MHAs serving 50 counties in New York State. MHANYS and its affiliate network serve New York State communities by offering innovative and effective programming that addresses a wide range of mental health challenges and increases mental health knowledge.

MHANYS is an agency of support, education and advocacy for mental health issues, and has been for over fifty years. As part of its mission, MHANYS advocates for change in the mental health system ensuring access for all New Yorkers, fights stigma through community-based partnership programming, and provides information on mental health issues and services.

MHANYS has led advocacy efforts in NYS resulting in such laws as Mental Health Education in Schools, the Mental Health Awareness Tax Checkoff, the Mental Health Awareness License Plate and Timothy's Law. The Mental Health Education in Schools Law requires all elementary, middle and high schools to begin teaching about mental health by July, 2018. The Tax Checkoff and License Plate laws raise funds to end discrimination against mental illness, and Timothy's Law mandates mental health parity. These laws are part of a long, full, and varied history of advocacy, organizing, and grassroots efforts that improved the lives of all New Yorkers.

MHANYS also creates and maintains projects that, in the past and present, share the common theme of educating the public about mental illness and reducing the stigma of the illness. Such projects include the Community Business Outreach Program, the Project AWARE: Community Grant for the Capital Region, Wellness Recovery Action Plans (WRAP), MHANYS Engagement Services, Justice-Involved Initiatives, Parents with Psychiatric Disabilities Initiatives, Jail Diversion Initiative, The Empowerment Project, Families Together, Parent Support Network, the Community Mental Health Promotion Project, Mental Health First Aid, Self Help Clearinghouse, the Mental Health Information Center, Building Connections: Sexual Assault and Mental Health Project, and the CarePath Program. Several of these projects, including The Empowerment Project and Families Together, have spun off into successful freestanding organizations.