Mental Health Promotion in Schools: What Should Pennsylvania Do?

by

Kimberley Susanne Elliott

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This thesis was presented

by

Kimberley Susanne Elliott

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and approved by

Patricia I. Documet, MD, DrPH, Behavioral and Community Health Sciences

Julie M. Donohue, PhD, Health Policy and Management

Thesis Advisor: Martha Ann Terry PhD, Behavioral and Community Health Sciences

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Kimberley Susanne Elliott, MPH

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Mental health is an essential component of overall health. When mental health becomes very poor, mental illness occurs. Mental illness causes a burden to the individual and to society. The four most common mental illnesses in children are attention deficit/ hyperactivity disorder, behavioral disorders, anxiety disorders, and depression. Mental health issues in children have been on the rise, especially in minority groups, and states are beginning to mandate programs and services for their schools.

New York, Virginia, Florida, and New Jersey have mandated mental health education be included in health curricula. Oregon is one state that has begun allowing excused absences for mental health reasons. Texas funds a telemental health program. Kansas and Minnesota provide grants that bring providers into the schools. Michigan has amended its Medicaid plan to allow all Medicaid eligible students, not just ones with an IEP, to bill Medicaid.

Pennsylvania has not taken these steps yet; however, there is evidence suggesting that these initiatives are effective. It can look to the successful process New York state went through to achieve policy change, which Pennsylvania could use as a model when pursuing similar actions. Also, there are programs Pennsylvania could adapt for a mandatory mental health education program. The FRIENDS program is one of these that shows potential in preventing mental illness as well as promoting good mental health.

Pennsylvania can be doing more to improve the mental health of its students.

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Preface

       I would like to thank my committee: Dr. Documet, Dr. Donohue, and Dr. Terry (chair) for their patience and their good advice. I would also like to thank my family for supporting me throughout my graduate school experience.

1.0 Introduction

Mental health constitutes an integral part of overall health according to the World Health Organization (WHO) (1946). In the preamble of WHO's constitution, the authors state that "[h]ealth is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1946, p. 1). One implication of this definition is that physical, mental, and social health all work together in making a person healthy. If one of these facets of health fails, the others will likely follow.

So, mental health is vital to a person's well-being, but what exactly is it? Bhugra, et al. (2013) specify that mental health is a "state of equipoise where the individual is at peace with themselves, is able to function effectively socially, and is able to look after their own basic needs as well as higher function needs. Positive functionality means managing change, relationships, and emotions in a constructive manner" (p. 3). When these conditions are not met mental illness can occur.

Mental illness represents a burden to the individual and to society. It causes inestimable suffering for those who experience it. People have described this in their own words. For instance, Abraham Lincoln described what historians believe to have been depression in a letter (1841) to a colleague, stating "I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on the earth. Whether I shall ever be better I can not tell; I awfully forebode I shall not. To remain as I am is impossible; I must die or be better, it appears to me" (Lincoln). Another description of mental illness comes from Vincent van Gogh in a letter (1889) to his brother while he (Vincent) was at a mental hospital. He writes:

Now the shock had been such that it disgusted me even to move, and nothing

would have been so agreeable to me as never to wake up again. At present this

horror of life is already less pronounced, and the melancholy less acute. But I

still have absolutely no will, hardly any desires or none, and everything that

has to do with ordinary life, the desire for example to see friends again, about

whom I think however, almost nil. That's why I'm not yet at the point where I

ought to leave here soon (van Gogh).

Upon reading quotes about people's subjective experience with mental illness it is clear

that mental illness causes immense distress. This alone is reason enough to intervene, but at its

worst mental illness can be very disabling, interfering with people's everyday life and leading to

a significant drain on resources. These resources are often expenses relating to "health care,

reduced workplace productivity, and missed days at work; in costs of the criminal justice and

juvenile justice systems; and in costs associated with lost educational opportunities and the need

for special education" (Mendelson, et al., 2012, p. 461). In the case of children, poor grades and

absences from school are analogous to reduced workplace productivity and missed days at work.

According to an Eaton, et al. study (2012) even common mental illnesses can be disabling. In fact,

according to one metric used by the same study some anxiety disorders caused moderately high

disability and moderate levels of depression fell between deafness and multiple sclerosis in levels

of disability (pp. 14-16).

Mental illness too often leads to death, typically in the form of suicide. Suicide is the

second leading cause of death for people between the ages of ten and 24, and the suicide rate for

that age range has been going up (Curtin, et al., 2019). For most of the 2000s suicide rates for the

10 to 24 age range stayed steady, and then between 2007 to 2017 they increased 56% (Curtin, et

al., 2019). Also of note is that the suicide rate among girls increased more than it did for boys in that period (12.7% vs 7.1%) (Ruch, et al., 2019). In addition to suicide, people with mental illness are more likely to be the victims of violence than those without it (Rossa-Roccor, et al., 2020). These people are also at risk of being killed by police responding to 911 calls as nearly one in four people shot and killed by police have a mental illness (National Alliance on Mental Illness, 2022).

Public health experts now know that mental illness often starts in childhood. In fact, half of all lifetime cases start before age 14, and three-quarters start before age 24 (Kessler, et al., 2005). Because early identification and treatment are crucial in obtaining the best outcomes, interventions that target children are necessary. Otherwise, mental health conditions can persist into adulthood, and the longer they continue without treatment the likelihood of complete recovery diminishes (Young, 2015). Additionally, this suggests that any program hoping to prevent mental illness of the course of a lifetime must start early. Schools are a logical location for these interventions to occur since most children go to school and spend much of their time there. A variety of different interventions exist that both promote mental health and encourage early treatment, but one of the more efficient ways to achieve these goals is to bring mental health into the classroom itself by teaching a combination of social emotional learning and mental health literacy.

At the state level, legislators are beginning to recognize the value of mandating mental health education in public schools. Beginning in 2018 and continuing to 2020, New York, Virginia, Florida, and New Jersey have all required their public schools to include mental health topics in their health curricula. Pennsylvania is one state that has yet to implement mandated mental health education, but it needs to consider doing so. Both social emotional learning and mental health literacy have proven to be effective ways to promote mental health and encourage early treatment.

Other initiatives that Pennsylvania should consider are allowing excused absences for mental health reasons, using telehealth in schools and partnerships with community providers to increase access, and amending Medicaid to allow schools to bill it when students receive services there, even if the students do not have an Individualized Education Plan (IEP).

2.0 Background

In the general public a common misconception is that children cannot suffer from mental illness. This is untrue, and it is a harmful belief that needs to be dispelled. This belief can lead to families not getting help for a child who needs it and allows society to undervalue the use of preventative measures. Fortunately, the majority of the four most common mental disorders in children have been the target of preventative interventions. Mendelson, et al. (2012) report that some of these interventions have shown promise in real world settings.

Mental illnesses tend to present more frequently at certain ages than others. Note that some mental illnesses commonly affect children while some are very rare in this demographic. According to the Centers for Disease Control and Prevention (CDC) (2021), the most commonly diagnosed mental illness in children aged two to 17 is attention deficit hyperactivity disorder, or ADHD at 9.4%. ADHD is a mental illness that starts in childhood and consists of difficulties with paying attention and overactivity, to the point that school and other areas of life can be a struggle (Hooley, et al., 2017). About half of children diagnosed with ADHD will continue to meet the criteria for ADHD as adults (Hooley, et al., 2017).

There are many proposed causes of ADHD. Genetic factors seem likely, and though others such as pre and perinatal factors, environmental toxins, dietary factors, and psychosocial adversity are being explored as possible contributing causes, these environmental factors are less understood (Thapar, et al., 2013). Due to this lack of knowledge, crafting effective preventative programs within schools will be a challenge. Further research must occur before large scale interventions take place. However, school districts might consider improving the physical environment of older schools that might have higher levels of lead in drinking water.

The second most frequently diagnosed category of mental illnesses in children is behavioral disorders, the most common of which are oppositional defiant disorder (ODD) and conduct disorder (CDC, 2021; Hooley, et al., 2017). About 7.4% of children aged three to 17 have been diagnosed with a behavioral disorder (CDC, 2021). Symptoms of ODD include frequent anger, argumentativeness, and vindictiveness; most cases are identified by age eight (Hooley, et al., 2017). Children under the age of 18 may be diagnosed with conduct disorder if they are harmful to others, destroy property, lie, steal, and/or break serious rules. Almost all cases of conduct disorder are preceded by ODD (Hooley, et al., 2017).

Researchers have looked to prevent behavior disorders at a number of different socio-ecological levels. Within the family setting, parenting training programs like The Incredible Years and The Positive Parenting Program aim to teach skills and parenting strategies parents of children with behavior issues (Mendelson, et al., 2012). In schools, there have been many interventions to reduce behavior problems such as drug use and violence. These programs include Promoting Alternative Thinking Strategies (PATHS) and the Good Behavior Game (Mendelson, et al., 2012).

The CDC (2021) lists anxiety as the third most diagnosed mental disorder in children aged three to 17, and it affects 7.1% of them. It has the earliest onset of any mental disorder (Hooley, et al., 2017). Furthermore, it has been increasing in children in recent years, increasing from 5.5% of children (diagnosed) in 2007 to 6.4% in 2012 (CDC, et al., 2021). Anxiety disorders exist in many forms, such as phobias, social anxiety, and separation anxiety, as well as generalized anxiety and others (Hooley, et al., 2017).

Also of note, according to the CDC (2021), is depression; 3.2% of children are diagnosed with this condition. Although this may seem like a small percentage, a 2019 survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) determined that

between 2009 and 2019 the number of youth ages 12-17 who experienced a past year major depressive episode nearly doubled. Depression occurs in a variety of mood disorders, including major depression and bipolar disorder. In children depression often presents as irritability, which can cause it to go undiagnosed (Hooley, et al., 2017). Treatment consists of medication and/or Cognitive Behavioral Therapy. Universal prevention programs, such as FRIENDS, have been shown to work in even in preschool aged children (Fisak Jr., et al., 2011).

The statistics above apply to children who have been diagnosed, and for some of these disorders, the number of undiagnosed children remains high. Also, these disorders are often comorbid. When this happens, children can face high levels of disability and suffering. According to the CDC (2021), mental illness begins in early childhood in many cases: one-sixth of children aged two to eight have a mental, behavioral, or developmental disorder. Knowing this can be very useful when determining what mental health education classes schools should introduce and at what age these classes should occur.

Overall, the mental health of children in America is getting worse. From 2007 to 2016, emergency room visits due to self-harm in children increased 329% (Acosta Price, et al., 2022). Between 2014 and 2017 suicide deaths in children went up 30% (Acosta Price, et al., 2022). The COVID-19 pandemic further increased these trends. Between March and October of 2020 emergency room visits for mental health conditions increased 31% in youth aged 12 to 17, while emergency room visits for mental health conditions increased 24% in children aged five to 11 compared to the same period in 2019 (Acosta Price, et al., 2022).

When considering mental health education, it is important to note that disparities exist, both in the rates of mental illness and in access to treatment, for youth of color compared to white youth. Over 25% of American Indian/Native American youth reported attempting suicide in the

last year (Acosta Price, et al., 2022). African American youth aged ten to 19 experienced a rise in suicide rates from 2.55 per 100,000 in 2007 to 4.82 in 2017 (Watson Coleman, et al., 2019). In the five-to-11-year age range, African American children are more likely to take their own lives than white children. In 2012 African American children in this age range had a suicide rate of 2.54 per million compared to 0.77 per million for white children (Bridge, et al., 2018). Additionally, only one-third of Black youth who had a past year major depressive episode received care compared to half of white youth (Acosta Price, et al., 2022). The COVID-19 contributed to worsening mental health for youth of color, as many of them receive mental health services through schools, which were shut down (Acosta Price, et al., 2022).

Another population that faces disproportionate levels of mental illness and suicide is the lesbian, gay, bisexual, and transgender, queer/questioning, intersex, asexual/agender community (LGBTQIA+). LGBTQIA+ youth are four times as likely to commit suicide than straight youth (The Trevor Project, 2022). Some of the issues this population faces are discrimination, rejection and bullying from peers and homelessness. Schools have the opportunity to become affirming and safe spaces, but only half of LQBTQIA+ students say their school is LGBTQIA+ affirming (The Trevor Project, 2022).

Based on this information, it is clear that mental illness in children is present and needs to be addressed through some form of intervention. One of the most obvious places for these interventions to occur is schools. This is because children spend so much of their time in schools and because multiple children can be addressed at one time (such as a class listening to a lesson). Many children in one place are also able to practice skills they have learned or roleplay as a part of the lesson.

Schools have addressed mental illness in some form or another for decades. During the 1960s and 1970s, with nurses becoming increasingly present in schools, mental health programming started to appear. These programs were initially meant to target teenage pregnancy and drug use, but in 1975, when the Education for All Handicapped Children Act became law, special education programs expanded to include children with "emotional problems" (Flaherty, et al., 1996). However, between the time of this act and 1996, a movement pushed reducing special education in schools, because districts were looking to lower costs, and some adults felt that special education was a negative label that stigmatized children (Flaherty, et al., 1996).

In 2005, SAMHSA conducted the first national study concerning mental health services provided in American schools. The administration aimed to learn about which mental health conditions were most commonly experienced in public schools, how and what type of mental health services schools offered, the types and qualifications of providers in schools and whether there were issues financing mental health care in schools (Foster, et al., 2005).

Foster et al. (2005) found that 20% of students received some kind of mental health services, but the disorders depended on age. They found that "behavioral problems" and "poor adjustment" were common in both elementary and middle schools, while middle schools dealt with the most "social, interpersonal, or family problems." Meanwhile, high schools saw a high number of cases of depression and substance use and abuse (Foster, et al., 2005). Their survey identified 11 common mental health services in public schools: assessment, behavior management consultation, case management, referrals, crisis intervention, individual and group counseling, substance abuse counseling, medication, referral for medication management, and family support services (Foster, et al., 2005). They found that about 60% of schools had school-wide curricula concerning mental health issues, but most of these programs consisted only of substance use

prevention programs, although almost every school that responded to the survey had at least one person who could provide mental health services (Foster, et al., 2005). However, an American Civil Liberties Union (ACLU) report from 2019 found that 90% of schools did not meet the professional standards for school counselors. The report also found that while 14 million students in the United States had a police officer in their school, they did not have counselor, nurse, school psychologist, or social worker.

In addition to these interventions and other services, education-based interventions exist. These are often in the form of research studies, because there is no gold standard for teaching mental health topics in schools, meaning people who are concerned with the mental health of children are still learning what to teach and how to teach it. One approach that a Johns Hopkins University study in Pennsylvania schools took was to focus solely on the students' knowledge of depression and increasing the number of students who sought treatment. The study used a program called the Adolescent Depression Awareness Program (ADAP) with all students, not just ones deemed at high risk, at 15 participating schools that researchers matched for many different factors (Beaudry, et al., 2019). After getting parental and student consent, the students were randomly placed into either the intervention group or the control group (Beaudry, et al., 2019).

The researchers used two different scales to help them assess the effectiveness of their intervention (Beaudry, et al., 2019). They used the Child and Adolescent Services Assessment (CASA) to determine the change in the number of students in the intervention and control groups who sought treatment prior to the study and four months after its completion. They also used the Adolescent Knowledge Questionnaire (ADKQ) to measure depression literacy before the intervention, six weeks after the intervention, and four months after the intervention (Beaudry, et al., 2019).

Attrition was high in this study; they started out with 481 students and ended up with 201 (Beaudry, et al., 2019). This might raise some concern about bias, as students who stayed in the study might have traits in common with each other, and students who left the study might have traits in common with each other. It is possible that students with depression might not feel motivated to complete the survey months later. The ADAP program significantly increased depression literacy scores in students in the intervention group compared to the control group ($p = <0.001$). They also found that eight percent of the students in the intervention who had not previously sought treatment did so within four months of the completion of the study (Beaudry, et al., 2019).

Another study, carried out in Canada, aimed to increase students' knowledge of mental health, reduce stigma, and determine if knowledge of mental health predicted reduced stigma (Millin, et al., 2016). The sample consisted of 11th and 12th graders in 30 Ottawa schools randomized into three groups: a control group, a group that learned the curriculum researchers developed, and a group that learned the curriculum and did online learning modules (Millin, et al., 2016). The program's six modules took six hours all together to complete. These modules addressed stigma, understanding mental health and mental illness, information on specific mental illnesses, experiences of mental illness, seeking help/support, and the importance of positive mental health (Millin, et al., 2016). They developed two scales for the study, one that measures mental health knowledge and one that measures attitudes towards mental illness. The researchers trained the teachers on the curriculum, and the majority of the teachers were satisfied with the curriculum (Millin, et al., 2016). The students' average age was 16.5; 308 students participated in intervention groups and 157 in the control group (Millin, et al., 2016). The intervention groups saw a significant increase in mental health knowledge ($p = <0.001$) and positive attitudes towards

mental illness (p<0.01). The results also suggested that increased mental health knowledge predicted better attitudes towards mental illness (Millin, et al., 2016).

Another study, conducted by Wasserman, et al. (2015), is the Saving and Empowering Young Lives in Europe (SEYLE), a suicide prevention program, in which 232 schools throughout Europe participated. The researchers randomly sorted the students into four groups. The control group "intervention" consisted of a set of posters on classroom walls. The first experimental group was the Question, Persuade, and Refer (QPR) group, which involved training teachers to recognize signs of suicide risk and hand out information cards (Wasserman, et al., 2015). The second experimental group was the Youth Aware of Mental Health Programme group (YAM). In this group, students participated in roleplaying, workshops, and lectures that aimed to increase knowledge about mental health and teach skills to help the students cope with difficult life events (Wasserman, et al., 2015). The final experimental group was the Screening by Professionals (Prof Screen) group, in which students who scored high enough on the baseline assessments were given a clinical assessment and referral (Wasserman, et al., 2015). All of the students in each of the four groups were given a baseline assessment, an assessment three months after the study, and at 12 months after the study (Wasserman, et al., 2015). The only intervention group that showed significantly less suicidal ideation and fewer suicide attempts at 12 months compared to the control group was the YAM group (p=0.014 for attempts; p=0.025 for ideation) (Wasserman, et al., 2015). The authors suggest that students need to be personally engaged in the intervention in order for it to work (Wasserman, et al., 2015).

3.0 A Closer Look

This section will provide a closer look at some states that have implemented policy initiatives to promote mental health and prevent and treat mental illness. Those states discussed are New York, Virginia, Florida, and New Jersey, Oregon, Texas, Kansas, Minnesota. There will be a brief summary describing the intervention and arguments others have made for their implementation. Then, for each state there will be a description of what the initiative looks like in each state.

3.1 Mandatory Mental Health Education

Mandatory mental health education is a conduit to teaching social emotional learning skills, such as emotion recognition, mindfulness, relationship building, and in later grades mental health literacy (recognizing mental illness and knowing ho to get help). Mandatory mental health education is a universal intervention, meaning all students, even ones not struggling with mental health issues participate (Weare, et al., 2005). Including all students helps ensure that students who need help but are not identified as such will not be missed. Furthermore, students who do not have indications of any emotional or behavioral problems can still benefit from improved mental health with the introduction of a mental health education program. Perhaps most importantly this universal approach does not perpetuate stigma by separating children with possible mental illness from their peers.

According to this article (Weare, et al., 2005), interdisciplinary cooperation and teamwork is vital to success for a program of this type. One effective way to address needs of different students is to use a pyramid-based system, where at the bottom are all students, who would receive some form of mental health education from teachers or school professionals. The next step up the pyramid is students who are considered at risk or are in need of early intervention. School professionals or community providers can offer additional support to these students. At the top of the pyramid are students who need individualized care, provided by school professionals or community providers (Acosta Price, et al., 2022). Wells, et al. (2003) note that the most effective programs last longer than just one school year and focus on mental health promotion rather than mental illness prevention.

3.1.1 New York

Beginning in 2010 the Mental Health Association in New York State, Inc (MHANYS) began advocating for mandatory mental health education after seeing positive effects of programs in Long Island schools (Acosta Price, et al., 2022). In 2015, the New York State Assembly introduced a bill that would mandate mental health education, Bill No. A03887B, which became law and was made effective for the 2018-2019 school year.

Bill No. A03887B emphasizes the need to specify in law that health has many dimensions, including mental health, and therefore, mental health should be taught about in public schools in grades K-12 (Bill No. A033887B, 2018). The law states that when health classes address mental health, students might be better able to recognize symptoms of mental illness in themselves and others, increasing the likelihood that people seek treatment for their symptoms. Furthermore, the law notes that teaching about mental health reduces stigma surrounding mental health topics,

including mental illness, and decrease isolation and bullying. Legislators intended for mental health education classes to reduce the number of students dropping out as well as suicides in young people (Bill No. A033887B, 2018). Bill No. A033887B does not mandate any specific curriculum, so the school districts were free to develop their own (Bill No. A033887B, 2018).

In 2018, the rate of suicide in the 15-24 age range in New York was 7.8 per 100,000 (CDC, 2020). In 2019, it increased to 9.3 per 100,000, and then in 2020, it decreased to 6.9 per 100,000 (CDC, 2020). Throughout this period, New York's rate of suicide in this age category was substantially better than the overall United States rate (14.2 per 100,000 in 2020) (CDC, 2020). More data are needed in order to determine if the law is making any contribution. However, in 2019 National Public Radio's (NPR) affiliate out of Buffalo/Toronto (WBFO, 2019) reported that quality of mental health education varied immensely. Mental health advocates told the news source that some districts like Niagara Falls City School District have "taken a very enlightened and progressive view towards mental health education, while other advocates in the state heard from students that they were receiving mental health education during one class over the course of a school year" (WBFO, 2019). Advocates suggest that this disparity is a result of the state not setting a statewide curriculum, but they hope that New York will look to successful programs and set a statewide curriculum based on those programs (WBFO, 2019).

3.1.2 Virginia

In Virginia a group of high schoolers advocated for a law that would require mental health education in schools. They approached State Senator Creigh Deeds to sponsor the bill, as Deeds' son was a suicide victim (NPR, 2018). The state mandated mental health education in July of 2018

with Senate Bill No. 953 (Leonard, 2019). This law amends previous legislation on health education to include mental health education in grades nine and ten. The law also states that the Board of Education will review learning standards and that it "… shall consult with mental health experts, including representatives from the Department of Behavioral Health and Developmental Services, NAMI Virginia, Mental Health America of Virginia, the Virginia Association of Community Services Boards, and VOCAL" (Senate Bill Number 953, 2018). The law identifies the 2018-2019 school year as the date the law would go into effect (Senate Bill Number 953, 2018).

In 2018, in Virginia, the suicide rate among 15- to 24-year-old people was 17.7 out of 100,000 (CDC, 2020). In 2019, it had dropped to 14.3 out of 100,000, but by 2020 it was 16.7 out of 100,000 (CDC, 2020). The suicide rate for the 15-24 age range is higher in Virginia than the national average (CDC, 2020). Ultimately, as in New York, it is too early to tell if mental health education is having a real impact in Virginia. Virginia did change its health education standards in 2020 to include, among other things, signs and symptoms of mental illness, the effect of sleep and nutrition and on mental health, stress reduction techniques, and resources (Virginia Department of Education (2020).

3.1.3 Florida

In 2019, after the Marjory Stoneman Douglas High School shooting, Florida signed a law mandating mental health education in public schools (Leonard, 2019). This 54-page law was part of the recommendations of the Marjory Stoneman Douglas High School Public Safety Commission (SB 7030, 2019). It contains many requirements, which are meant to reduce the number of school shootings and mitigate their impact when they do occur (SB 7030, 2019). The law allocates funds to districts for mental health training for teachers and staff, and also for helping

students and their families locate needed mental health services (SB 7030, 2019). The state of Florida now requires that students in grades six through 12 receive at least five hours of mental health education (Florida Department of Education, 2022). In July of 2021, Florida revised some of its health education standards to include information about how using drugs affects mental health and about character building (CPALMS, 2021). It is not clear if additional changes will be made, however.

3.1.4 New Jersey

New Jersey was the fourth and most recent state to introduce mandated mental health education in August of 2019 with a bill entitled A-4446/4592 (Leonard, 2019). The law, which took effect in the 2020-2021 school year, requires health classes to cover age-appropriate mental health related topics (New Jersey Assembly Democrats, 2019). Aims of the law include helping students with mental illness feel less alone, encouraging students to seek help when needed, reducing stigma, and teaching about symptoms of mental illness (New Jersey Assembly Democrats, 2019). Because the law was put into effect in the 2020-2021 school year, no suicide data are available to suggest whether the mental health education law in New Jersey is having success. New Jersey did update its health education standards across the state to include mental health themes such as emotion management in the early grades and developing a plan to help people with emotional distress in high school (New Jersey Department of Education, 2020).

3.2 Excused Absences for Mental Health Reasons

As Hailey Hardcastle (2020), one of the students involved in advocating for the passing of a law excusing mental health related absences in Oregon, points out in her TED talk everyone has mental health. Even students who do not have clinical mental illness can benefit from being allowed to take a day off occasionally for their mental health (Hardcastle, 2020). Furthermore, schools can track absences and reach out to families once students reach a certain number of absences to offer resources. Allowing absences for such a reason would not necessitate increasing the number of days students are permitted to take off per term; it would just broaden the definition of what can be considered ill health. Doing so would be more consistent with the WHO's definition of health (WHO, 1949).

3.2.1 Oregon

In 2019, Oregon became an early adapter of excused absences in schools for mental health reasons after House Bill 2191 was passed (HB 2191, 2019). The bill now allows students to take five sick days in a three-month period; these sick days can be for physical or mental health reasons (Scipioni, 2019). Oregon was not the first state to initiate mental health days in schools, but it is notable as students led the initiative with the goal of reducing stigma (Hardcastle, 2020). They partnered with lobbyists and presented their idea to their state legislature (Acosta Price, et al., 2022). Ultimately, this new policy did not cost the state any money (Acosta Price, et al., 2022). In 2018, the suicide rate in Oregon for the 15 to 24 age group was 22.6 per 100,000 (CDC, 2020). In 2020, it had decreased to 18.5 per 100,000 (CDC, 2020).

3.3 Telemental Health

Telemental health is when a client receives mental health services over the phone or a videoconferencing application (National Institute of Mental Health, 2022). Providing telemental health in schools is one way to provide access to mental health services for youth who might not have it otherwise due to not being able to get to appointments or lack of insurance (Stephan, et al., 2016).

3.3.1 Texas

In 2019 with Senate Bill 11, the Texas state legislature established the Texas Child Mental Health Care Consortium which developed Texas Child Health Access Through Telemedicine (TCHATT) (Meadows Mental Health Policy Institute, 2021). The program consists of providers from medical schools working with students for free via telehealth to overcome crises and then refer them to continuing care (Meadows Mental Health Policy Institute, 2021). By 2022, 2.1 million students had access to the program; not all school districts in the state have access to TCHATT due to limited funding (Wakefield, et al., 2022). TCHATT's accomplishments consist of increasing access to care.

3.4 Grants to Partner with Community Providers

Another way that the state can provide more access to care is by funding grants to bring community providers into schools to provide services.

3.4.1 Kansas

Legislators in Kansas initiated the Mental Health Intervention Team program in 2018. The initial pilot covered nine school districts and allowed these districts to partner with Community Mental Health Centers to provide services to their students (Kansas State Department of Education, 2022). The program constructed a database that keeps track of all the students in the program (Kansas State Department of Education, 2022). The pilot program served 1,700 students and had encouraging outcomes in increasing attendance, improving academic results, and improving behavior (Kansas State Department of Education, 2022). By the 2020-2021 school year the number of participating school districts had increased to 56 (Kansas State Department of Education, 2022). For that school district, 70% of enrolled students improved attendance, 71% improved behavior, and 69% performed better academically (Kansas State Department of Education, 2022).

3.4.2 Minnesota

Minnesota has had school-linked mental health services since 2007 (Acosta Price, et al., 2022). This works similarly to the Mental Health Intervention team in Kansas. Mental health providers from the community come into the schools and provide assessment and treatment for students (Minnesota Department of Human Services, 2018). The program aims to increase access, improve outcomes, and identify mental health issues in children (Minnesota Department of Human Services, 2018). It touts its success at identifying students in need who have never received care before, as 47% of the students new to mental health services had serious emotional disturbances (Minnesota Department of Human Services, 2018).

3.5 Amending Medicaid

As of 2014 states have been able to allow their school districts to bill Medicaid when qualifying students use mental health services in schools (Acosta Price, et al., 2022). Previously, students had to have an Individualized Education Plan (IEP) meaning they had to have a legal disability (Acosta Price, et al., 2022).

3.5.1 Michigan

Michigan amended its plan with Centers for Medicare and Medicaid Services (CMS) in 2018 to take advantage of this policy change (Acosta Price, et al., 2022). As of 2021, Michigan has been able to use this money to increase behavioral staff in schools by 71% (Acosta Price, et al., 2022). Reimbursement increased by $6.17 million dollars (Acosta Price, et al., 2022).

3.6 Pennsylvania

Pennsylvania (PA) does not yet have mandated mental health education in its schools, although on May 27, 2021, House Bill 784 was introduced in the state House of Representatives (PA House Democrats, 2021). As of February 2022, the bill is in committee (Bill Track 50, 2022).

Pennsylvania also does not have a statewide policy that excuses absences for mental health reasons (Acosta Price, et al., 2022). In April of 2021, Senate Bill 506 was introduced, and it is

currently in committee (LegiScan, 2022). It is a bipartisan initiative, as it is sponsored by nine

Democrats and one Republican (LegiScan, 2022). Pennsylvania is not considering initiatives like

those in Texas, Kansas, Minnesota, and Michigan in its legislature at this time (Acosta Price,

2022). Pennsylvania's suicide rate for the 15 to 24 age category is 11.4 per 100,000, which is

lower than the national average of 14.2 per 100,000 (CDC, 2020).

4.0 Discussion

If Pennsylvanians want to implement any of these initiatives in their schools, there are some steps they can take to achieve this. Acosta Price, et al. (2022) suggest looking at the case study of New York state's process for passing its law as inspiration for future policies mandating mental health education (section 5). The first step they recommend taking is becoming familiar with the existing policies surrounding health and education (Acosta Price, et al., 2022). The Pennsylvania Department of Education (2022) states that "Every student…must be provided with planned instruction that is aligned with academic standards in health and physical education" (Pennsylvania Department of Education, 2022). This means that Pennsylvania already has a framework to work with as it already has health education in all of its schools.

The next step is to form a coalition of like-minded stakeholders including mental health groups, educators, and young people, among others (Acosta Price, et al., 2022). Young people have been instrumental for passing previous initiatives into law, and teachers are often one of the most difficult groups of stakeholders to bring on board (Acosta Price, et al., 2022). The coalition will need to find a sponsor in Harrisburg for the bill (Acosta Price, et al., 2022). Logically, the coalition should contact and support Representative Tim Briggs, as he in in the process of sponsoring a mental health education bill. The coalition will need to write policy briefs to support their argument, and they can also use tools like memorandums of support, press releases, and calls to action, as the coalition in New York did (Acosta Price, et al., 2022).

Steps taken in New York state following the passing of the legislation included holding a summit in Albany in order to start new partnerships and generate new ideas, forming the Mental Health Education Advisory Council, consisting of stakeholders who provided insight on curricula

and resources, and obtaining funding for a training center (Acosta Price, et al., 2022). At some point the state of Pennsylvania will have to form a curriculum, at which point it can look to other states to see how they have approached this.

The first initiative to implement would be excused absences for mental health reasons. This is because there is already some bipartisan support for it in the Pennsylvania Senate. There is already infrastructure in place in Pennsylvania so that implementation would cost very little if anything. Because of these two facts, this would probably be the least controversial of the possible initiatives mentioned in this paper. It would provide a litmus test for assessing the Pennsylvania legislature's openness to enacting policy on mental health promotion in schools.

Next, mandatory mental health education should be pursued as a policy initiative. It is already in committee in the Pennsylvania House of Representatives, so there are members of the state legislature who are already interested in it. Also, out of the initiatives mentioned, it has the most potential to promote mental health rather than prevent or treat mental illness. Since it is universal it would affect the highest number of students.

The states that are implementing mandatory mental health education all have something in common: they take an approach of increasing all students' mental health literacy to some degree. Millin, et al. (2016) define mental health literacy as "knowledge and skills addressing biological-psychosocial aspects of mental health to improve understanding of mental health and mental disorders, to reduce stigma, to help with early identification of mental disorders, and to facilitate help-seeking behaviors in youth" (para. 2). This approach reflects the one taken by the successful interventions mentioned in the background section. Those successes show that mental health literacy classes can be effective at achieving the goals that each of the states wants to accomplish.

Goals are important when considering a curriculum. Acosta Price, et al. (2022) note that goals should address well-being, resilience, connection, and inclusion, not safety and discipline. For example, in Florida the mental health education law encourages each school to have an armed police officer or teacher. Although this policy could promote safety, it has led to increased arrests of students of color (Acosta Price, et al., 2022). This could undermine the promotion of mental health.

As per the Beaudry et al. study (2019), it is apparent that knowledge of mental illnesses can lead to more help-seeking behavior, a goal that New York and New Jersey explicitly state they want to meet. These states also cite the need to reduce stigma, which the Milin et al. study (2016) in Canada showed can be accomplished through a direct link with mental health literacy. Another aim expressed by some of the states includes a reduction in suicide rates for young people; and the YAM intervention used in the SEYLE study (Wasserman, et al., 2015) showed that mental health literacy and skills training can achieve this. The four states discussed here have promising interventions that could ultimately save and improve people's lives. If Pennsylvania decides to implement mandatory mental health education, it should consider incorporating mental health literacy into its curriculum.

When states mandate the ratio of students to mental health professionals, access to care increases (Acosta Price, et al., 2022). This is an equity issue as children of color are more likely to use school based mental health services and to rely on those services alone compared to white children (Acosta Price, et al., 2022).

Weare, et al. (2005) argue that adopting a "whole school approach" is an additional way to accomplish mental health promotion in children. In addition to the curriculum this involves consideration of aspects such as "management, ethos, relationships, communication, policies,

physical environment, relations with parents, relations with community, and pedagogic practice" (p. 118). According to Weare, et al. (2005), focusing on the determinants of health is as important as focusing on outcomes. They also tout the need to involve many different parties at different levels (teachers, families, the community, the school, government).

The curriculum development process should include representatives from the student body, who can help inform professionals of needs to be addressed in the program as well as strengths that can be capitalized on (Weare, et al., 2005). Young people have proven to be instrumental in getting legislation passed and informing curricula, especially in Virginia and Oregon (Acosta Price, et al., 2022). Students are not the only stakeholders to involve in developing the curriculum. This is an opportunity for parents and teachers to give feedback (Weare, et al., 2005). Furthermore, as a part of the overarching program, support should be offered to the parents and teachers, possibly in the form of training or classes (Weare, etal., 2005).

Important topics to include in the curriculum itself are skills such as "self-reflection…problem solving, … and relationship skills" (Weare et al., 2005, p.119). If the curriculum developers do decide to opt for a longer-term program, say kindergarten to 12th grade, the lessons will need to be age appropriate (Weare, et al., 2005). One way of doing this is to focus on mental health literacy in the upper grades while focusing on social emotional learning in the lower grades. The Collaborative For Social and Emotional Learning (CASEL) (2022) defines social emotional learning as a process through which people obtain and use "the knowledge, skills, and attitudes to develop healthy identities, manage emotions, achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions" (para. 1). So, in the elementary years the focus is entirely on

mental health promotion, while in middle school and high school curricula include topics like recognizing mental illness, getting help, and preventing suicide.

One skill-based intervention that the World Health Organization recognizes as effective at preventing anxiety and depression and improving resiliency is the FRIENDS program (Barrett, 2019). FRIENDS actually consists of four age-based programs: one for preschool and early elementary, one for late elementary, one for middle school/junior high, and one for high school and older (Barrett, 2019).

The programs are based around the acronym FRIENDS, each letter standing for a different skill (Barrett, 2019). F is the first skill taught, and it focuses on feelings; it teaches how to recognize emotions and show empathy for others. R stands for "relax" and teaches relaxation techniques like beathing exercises and mindfulness. I is "I can try my best" and involves challenging problematic thoughts. E stands for "encourage," and it involves problem solving skills. N involves nurturing relationships by spending time together. D stands for "don't forget" and involves daily practice of the skills. S is "stay happy;" it involves building and talking with support networks (Barrett, 2019). This program needs to be studied more in American schools.

If Pennsylvania choses to have a statewide curriculum, it will need to develop an implementation strategy and a data collection and evaluation strategy. The case of New York state is instructive on how to do this. New York developed an institution called the School Mental Health Resource and Training Center that will provide resources to help schools develop curricula, comply with the mental health education requirements, train teachers, and find local resources that the students can use (Acosta Price, et al., 2022). For evaluation, schools could review lesson plans to make sure that teachers are teaching the material. The state could look to suicide rates to see if there are improvements.

Next, Pennsylvania should implement telemental health and partnerships with community providers. These two initiatives complement each other, and evidence suggests that a combination of both is ideal (Stephan, et al., 2016). Evaluation should focus on the number of children who have access to these programs, as improved access is the primary objective to both of these programs. However, the state could also look at attendance levels, academic performance, and mental health evaluations in students enrolled in these services. Finally, Pennsylvania should implement billing Medicaid for students who do not have an IEP, as this could help fund the telemental health and community partnerships initiatives. Pennsylvania could measure how much money is reimbursed through this initiative in order to evaluate it.

5.0 Conclusion

It is clear that mental illness is common in children, and it often starts at a young age. This means that it is imperative to begin interventions early and sustain them throughout the course of childhood. Studies have shown that mental health education in schools is an effective intervention for increasing help seeking behaviors, decreasing stigma, and lowering suicide rates in youths. States are beginning to focus more on mandating mental health educations in their schools with the hope that they will achieve similar results. Thus far, New York, Virginia, Florida, and New Jersey have taken this step, and Pennsylvania should consider it, too.

Furthermore, there are many additional mental health initiatives in schools that Pennsylvania could utilize. These include excusing absences for mental health reasons, using telemental health, working with community providers, and amending the Medicaid plan to include students who do not have IEPs. States that have pursued these initiatives have seen positive results.

If it decides to introduce mandatory mental health education or any of the other policy changes mentioned, Pennsylvania will have to set clear objectives that can be measured, as well as evaluation strategies for each initiative. When implementing these initiatives, Pennsylvania should involve stakeholders, especially the students themselves.

A limitation of this paper is a lack of data regarding the efficacy of the extant state mandated mental health education programs. As of the spring of 2022, these programs are too new to observe trends. It will be vital to follow statewide trends in New York, Virginia, Florida, and New Jersey in the upcoming years to ascertain whether these programs are helping their intended target. That being said, not all of the states have listed clear goals for these programs,

nor does there seem to be an agreed upon metric that could be used in evaluating the efficacy of the programs themselves.

If the programs do end up being effective, Pennsylvania will need to strongly consider enacting similar legislation if it cares about the wellness of its youth. Mental health is a necessary component of overall health, so it follows that students would have to learn about it as a part of any health curriculum. The CDC asserts that health education should help "youth to develop positive well-being, academic success, and healthy outcomes into adulthood" (CDC, 2021). With the right program in place, mandatory mental health education in combination with other mental health promoting policies can accomplish this.

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