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Analyzing Mental Health Curriculums: Recommendations for the Implementation of a Mental Health Curriculum for Middle Grade Students

Lauren A. Bendheim
Colby College

Analyzing Mental Health Curriculums: Recommendations for the Implementation of a Mental Health Curriculum for Middle Grade Students

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Lauren Bendheim

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Abstract

Adolescent mental health has been an increasingly important topic of conversation in education policy as the American Academy of Pediatrics declared a national state of emergency for child and adolescent mental health in 2021. With so much attention surrounding mental health education it is important to bring together multiple voices in order to understand how to teach students about mental health in the most effective way.

In this two phase study I work to understand the landscape of what mental health education looks like in the United States through interviews with policymakers, curriculum developers, and classroom instructors as well as literature research. Additionally, I investigated what mental health education looks like in practice and how it is experienced by middle school students through classroom observation, student surveys, and curriculum analysis.

In my research I found a disconnect between policymakers implementing new mandates and funding towards mental health education, and then instructors struggling to find the money, implement the curriculum, and teach mental health using a shared language due to lack of staff education and support and school overwhelm. I found that middle school students specifically are in need of mental health education due to their developmental age, schools being in crisis, and the COVID-19 pandemic's effect on schools. Additionally, teachers and curriculum developers have different ways of teaching new policies which span deficit and asset-based approaches. Student surveys revealed that students are extremely curious about how to help peers struggling with mental health as well as ways to improve their own mental health, but at the same time many do not feel comfortable reaching out for help about mental health issues. These findings implicate the importance of having a shared common language around mental health and how to teach it as well as communication between policymakers and classroom instructors regarding what type of reform can be implemented successfully during this time.

Introduction

What does the word “mental health” mean to you? Everyone has different definitions of mental health from defining it by disorder and illness to connecting it to emotion regulation and self care. Historically, there has been a large stigma attached to mental health and having mental illness, and language surrounding it has been conceptualized in asset and deficit-based approaches throughout curriculum and society. This language has the ability to reduce or reproduce stigma around mental health, especially when discussed in the classroom with students. Due to varying understandings of mental health, teaching mental health in school takes on different approaches. From social emotional learning to mental health literacy, schools across the nation are working towards mitigating the increasing rise in mental illness in kids. In October 2021, the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children’s Hospital Association declared a national state of emergency for child and adolescent mental health (American Academy of Pediatrics, 2021). Schools acknowledge this state of emergency and are scrambling to build curriculum and supports for students desperately in need. With so much attention surrounding mental health education in education policy and in the classroom, it is important to bring together all different voices working in and around this important issue in order to understand how to teach students about mental health in the most effective way possible.

In a two phase study I answer the questions: How is mental health education conceptualized and implemented in middle schools today? And is there a gap between the two? I used phase one of my study to understand the landscape of what mental health education looks like in the United States today through interviews with policymakers, curriculum developers, and classroom instructors as well as research of journal articles, policy reports, and news reports.

Phase two of my study investigated what mental health education looks like in practice in the classroom and how it is experienced by middle school students themselves. I surveyed middle school students, observed a mental health education class, and analyzed three different mental health curriculums.

My paper will first give a literature review of important research already done in the field of mental health education and provide a theoretical framework focusing on the intersection between policy interpretation and the role of stigma and asset and deficit language in education curriculum. Next, I will describe the methods of how I conducted my research, my study sample, and how I analyzed my data. I will then lay out my findings in four different sections where I discuss: the current landscape of mental health instruction in the classroom, ideal curriculum for students and instructors, why mental health education is needed right now, and lastly a story of disconnect between policy and the classroom. I close with a discussion about implications for policymakers and classroom instructors regarding how to best use this knowledge to create more meaningful and effective mental health education for middle schoolers, as well as direction for future research on this topic that is becoming increasingly important for society to understand.

Literature Review

Mental health in young people is a significant topic of discussion among health professionals and researchers around the world. In the United States in 2020, there was a 24% increase in emergency room visits for mental health reasons for kids aged five through 11 and more than a 30% increase for kids between ages 12 and 17 (Hopeful Futures Campaign, 2022). A lot of research has been done about the importance of addressing the continued increase in mental health issues amongst young people within the school system. According to the Hopeful Futures Campaign, of students receiving mental health services, roughly 30% find that support in schools, making our education system the most accessed mental health delivery system by children and adolescents. Mental health issues affect multiple aspects of the lives of students. For example, the reality for many large urban schools is that well over 50% of their students present with significant learning, behavior, and emotional problems (Adelman & Taylor, 2003).

Due to this increase in mental health issues among young people, schools have built systems to address the increasing needs of students. Research shows that most state education departments, about 32 states as of 2019, are using the Multi-Tier Systems of Support (MTSS) framework to address behavioral and emotional problems, including mental health, in school (Bailey, 2019). This framework was created to proactively respond to and identify students with behavioral and emotional challenges and struggles that interfere with their ability to learn. It consists of three tiers, the first being universal/primary which addresses the entire school population and is the foundation of the system. Tier one work in schools is focused on preventative approaches to mental health such as social emotional learning for all students and school-wide educational curriculums. Tier two is small groups of students which consists of slightly more intervention work and supports delivered in small group settings. The last tier focuses on individual students

which gives students who didn't respond to tier one and two extra individualized support and may include outside school agencies. Tier three is very intervention focused and identifies students who need the most immediate mental health support. Due to the high numbers of hospitalized students and acute cases of mental illness in schools during the COVID crisis, many schools are focused on tier three support and making sure students that need immediate help receive it (Associated Press, 2022). Although this work is extremely important, research has shown the value of whole school, preventative mental health measures as well.

In my research I will focus on the way schools conceptualize tier one, whole school, preventative, mental health work. I chose to focus on tier one because it impacts all students, no matter if they struggle with mental illness at that point in their life or not. It is also at the base of a functional school-wide approach to mental health. Preventative work is key to addressing the entire epidemic of mental illness today as investing in mental health promotion, prevention and early intervention results in cost savings by reducing or eliminating the need for more intensive services in the future. Additionally, preventive and promotion efforts decrease stigma about mental health and illness at a school-wide level and promote well-being for all students and staff (Mclean Hospital, 2021). Tier one implementation in schools leads to the ability to identify mental health conditions earlier and this has been shown to change treatment outcomes as the earlier you treat, the greater the impact can be (Mclean, 2021). I have identified three main ways schools approach tier one support. First is the trauma-informed approach. Second is school based mental health centers, and third is mental health education in the form of social emotional learning and mental health literacy.

Trauma-Informed Approach

Trauma-informed schooling is a school wide approach to addressing the high rate of students who are impacted by traumatic events, while also helping prevent mental health issues for these students. More than half of all young people have reported exposure to violence or abuse, and by the age of 16, more than two thirds will have experienced a potentially traumatic event or adverse childhood experiences (ACEs) (Crisis prevention institute). Having experienced four ACEs doubles your risk of heart disease and cancer, increases your odds of becoming an alcoholic by 700%, and increases risk of attempted suicide by 1200% (Crisis Prevention Institute, 2021). Due to the high number of young people who have experienced trauma, schools have adopted trauma-informed approaches to teaching. This approach consists of creating a safe and supportive environment, supporting and teaching emotional and behavioral regulation, and building relationships and connectedness between students and teachers (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). SAMHSA describes how this is put into practice when they write:

> A program, organization or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist retraumatization. (SAMHSA, 2014)

With these systems in place, students affected by trauma are able to improve their academic performance and mental health. For example, trauma-informed implementation has been associated with significant decreases in depressive symptoms (Ooi et al., 2016),

and in post-traumatic stress disorder symptoms (Qouta et al., 2012), and increases in a metric assessing children's feelings of hope with medium to large effect sizes (Berger and Gelkopf, 2009). This school-wide trauma-informed approach is able to provide tier one universal support by creating a supportive and knowledgeable school environment for all students who may or may not have experienced adverse childhood experiences.

School Based Mental Health Centers

School based mental health centers (SBHCs) are another system put in place in schools to provide universal support to all students and serve as preventative and intervention measures for students experiencing mental illness. SBHCs are centers that provide medical, mental/emotional, dental, and vision care directly in schools. They have physicians and mental health specialists on staff to diagnose, treat, and support children and their families with health-related issues. SBHCs most often provide services to address suicidal ideation, depression, anger management, family and peer relationships, and academic difficulties (Bains & Diallo, 2018). Some studies have shown that, nationally, most children and adolescents who receive mental health services access them in school (Roanes & Hoagwood, 2018). Due to their location in schools, they can reach many more middle school aged students than most health providers. These centers are important for minority youth especially, because these students are less likely to receive needed mental health care, and even when they do receive care, there is great variation in the quality of care they receive compared to their peers (Fortuna et. al, 2010). There are serious consequences when mental health disorders are left untreated, including greater risk for poor academic outcomes, suicide, substance use, and unemployment in

adulthood. SBHCs help bridge the gap between students and care providers that may not be able to get the help they need otherwise.

One 1998 study found that adolescents who had access to SBHCs were ten times more likely to make a mental health or substance abuse visit than those without access to an SBHC (Kaplan et. al, 1998). With an emphasis on prevention, early intervention and risk reduction, school based health centers provide services such as depression and suicide screenings, learning disability screenings, dental, vision, and hearing screenings, health education and promotion, access to therapy and more. These centers are a way to provide universal health and wellness support to all students and prevent mental illness.

Mental Health Education

A third way schools provide tier one support in schools is through mental health education, which I will be focusing on in my research. I chose to focus on mental health education because it is an increasingly prevalent topic within current education legislation, with New York and Virginia being the first two states to require mental health education in schools in 2018 (Leonard, 2019). Since then, many states have followed suit and educators and legislators alike have begun to acknowledge the urgent need for a focus on early mental health intervention in schools. Mental health education has become even more of a popular topic of discussion after the Coronavirus pandemic began to affect the mental health of children and teens across the globe as well. Many states are now mandating mental health education in schools and the landscape of mental health curriculum and implementation is drastically changing and becoming an important topic of research.

Social-Emotional Learning

One of the most cited forms of mental health education being implemented in schools today is social emotional learning (SEL). The goal of SEL according to the Collaborative for Academic, Social, and Emotional Learning (CASEL) is for students to “acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions" (CASEL, 2021). This is implemented through hundreds of different SEL online programs, specific state-run curricula, and teacher adapted programs. Examples of popular SEL programs are Second Step, Too Good for Violence and Open Circle, among the other 86 evidence-based programs listed on the CASEL website. Although these evidence based SEL curricula span early education to high school audiences, 62 of them are only for early education and elementary, and only 7 of these curricula are specifically for middle school students.

There has been a lot of in depth research on the benefits of teaching SEL in schools. A 2011 meta-analysis by Durlak et al. studied 213 schools who had implemented SEL. This study involved 270,034 kindergarten through high school students and found significant benefits compared to control groups. They specifically found that SEL participants demonstrated “significantly improved social and emotional skills, attitudes, behavior, and academic performance that reflected an 11-percentile-point gain in academic achievement” (Durlak, 2011, p. 406). They also found that SEL students had lower levels of emotional distress. Emotional distress in this study consisted of measures of internalized mental health issues. These included reports of depression, anxiety, stress, or social withdrawal, on measures such as the Children’s Manifest Anxiety Scale. The study also states the importance of SEL, when they write “schools

have an important role to play in raising healthy children by fostering not only their cognitive development but also their social and emotional development" (Durlak, 2011, p. 406). These findings show the significance of SEL on the mental health of students and on academic achievement and success in school. There has been proven to be a connection between emotional distress and student success, further showing the importance of SEL. A study in Chile of more than 11,000 students found that mental health in first grade, as assessed with brief standardized screening by teacher and parent, was one of the strongest predictors of performance on national achievement tests of language, mathematics, and science three years later (Murphy et. al, 2015). The above studies show the strong connection between mental health and academic success and the importance of teaching students ways to take care of their mental health in school, which SEL has been proven to do.

Mental Health Literacy

Another way schools conceptualize mental health education is through mental health literacy lessons. When researching mental health literacy curricula most of the research studies and articles were about mental health curricula implemented in high schools, with little information on this curricula for middle school students or younger. There is a trend of implementing mental health literacy curricula into majority high school classrooms, leaving an important gap for middle school students and younger (mentalhealthliteracy.org, 2022). Some schools use health class as a time to teach about the signs and symptoms of different mental health disorders and illnesses. There has been significant research about the benefits of teaching the vocabulary surrounding different mental illnesses in reducing stigma and early intervention and prevention. Mental health literacy is a concept that stemmed from health literacy. Health literacy is the idea that low functional literacy about health issues was associated with numerous

poor health outcomes (Dewalt et. al, 2004). Currently, health literacy, according to the World Health Organization (2013), is comprised of the competencies needed by people to help obtain and maintain health and identify illness; understanding how and where to access and how to evaluate health information and health care; understanding how to properly apply prescribed treatments; and, obtaining and applying skills related to social capital, such as understanding rights related to health and health care and understanding how to advocate for health improvements. The concept of mental health literacy came after this to specify the need for public knowledge about mental disorders.

Anthony Jorm (2013) who coined the term "mental health literacy" found that there is evidence from surveys in several countries for deficiencies in (a) the public's 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 affected by mental health problems (Jorm, 2013). Jorm argues the importance of teaching these skills to children because there is a large time gap between the onset of mental disorders and the receival of treatment. Thompson, Issakidis, & Hunt (2008) found in a clinical study in the United States that there was an average delay of 8.2 years for clinical patients between the onset of anxiety and mood disorders and it when they received treatment. Within these 8.2 years, it took an average of 6.9 years to recognize that a disorder was present but only an average of 1.3 years between recognition and help seeking (Issakidis & Hunt, 2008) These findings are important because it highlights the impact of being able to recognize a disorder and therefore being more likely to get help sooner. One of the reasons Jorm cites as why people are not seeking help and receiving treatment is due to not being able to recognize their symptoms as a mental disorder. He cites one of the reasons for not

being able to recognize symptoms as due to the early age of onset of many disorders. He writes "A factor that contributes to delayed recognition of mental disorders is that they often have first onset during adolescence or early adulthood. For example, in the United States, the median age of onset for anxiety disorders has been reported as 11 years" (Jorm, 2013). At this point in a child's life, Jorm argues, children's knowledge surrounding mental health disorders is underdeveloped. However, if an adolescent can recognize that they are experiencing a mental health disorder, they are more likely to get help. A 2007 study of 1,207 people aged 12-25 about correctly labeling mental disorders found that "As recognition improves, there are benefits for the young person if he or she develops a mental disorder. Young people who recognize a disorder in a scenario tend to have better help-seeking and treatment preferences (Wright et al, 2007)." This is important because it shows that if young people specifically are educated about mental disorders, they will be able to get help sooner. Additionally, an Australian study of youth with mental disorders attending general practitioners, found that the general practitioners were more likely to detect the disorder if the young person conceptualized their problem as a mental disorder (Haller et. al, 2009).

There is also an important gap in knowledge about suicide that is addressed through teaching mental health literacy. Surveys conducted in the United States by Jorm et. al found that young people and parents were less likely to believe it would be helpful to ask a young person with a mental disorder about suicidal feelings and more likely to believe it would be harmful (Jorm et al., 2008, p. 6). Additionally, when asked what they would do if a friend or someone they knew was experiencing depression, only 58% suggested professional help, and only 38% asked about suicidal feelings. Some reported doing potentially unhelpful things like talking to the person firmly about getting his or her act together (45%) and suggesting use of alcohol to forget

his or her troubles (6%) (Jorm et al., 2008). These surveys show the lack of knowledge young people and parents had regarding how to help someone who is suicidal or experiencing depression. Therefore, these surveys reflect a need for teaching how to help someone who is suicidal or experiencing depression which could be done in school through mental health literacy.

Studies have also been done to prove the benefits of teaching mental health literacy in the classroom. Ojio et. al (2015) conducted a study of 118 grade-9 students in Japan who participated in two 50-minute mental health literacy sessions given by a schoolteacher. The researchers found that knowledge of mental health/illnesses and desirable behavior for help-seeking were significantly improved both immediately after as well as 3 months after the program. They also found that proportions of the correct diagnoses of vignette cases of major depression and schizophrenia were significantly elevated from 38.3% and 19.1% (pre-test) to 94.7% and 93.6% (post-test), and 91.5% and 86.2% in the 3-month follow up (Yasutaka et. al, 2015). These results show the ability of the classroom environment to build mental health literacy in students and contribute to increases in help seeking behavior and diagnosing of mental health disorders.

Another study performed by Luisa Campos and colleagues in Portugal (2018) measured the effectiveness of a school based mental health literacy promotion program. They researched a sample of 543 students (22 classes), aged between 12 and 14 who participated in two 90-minute mental health literacy promotion classes taught by a psychologist. They were given a mental health literacy questionnaire 3 times throughout the process; before, during, and 6 months after the program. The questionnaire measured: knowledge/stereotypes about mental health issues, including general characteristics of mental health problems, prevalence, signs and symptoms,

and risk factors for mental disorders, first aid skills and help seeking, and self-help strategies. In their results they found that the students who participated in the program had, on average, significantly higher values in the global score and in all dimensions of the mental health literacy questionnaire compared to the control group, considering the evolution throughout the three evaluation times (pre, post, and follow-up). They found that these students were more likely to seek appropriate help for mental health problems, as well as to help others who present with them compared to the control group. They also found that the students who participated in the program had a more positive view of the use of self-help strategies in young people and the general population, increasing the chance that they will show an interest in learning new forms of self-help as a way of coping with adversity arising from mental health problems like anxiety (Campos et. al, 2018).

Mental Health in Middle School

Research shows that middle school students specifically need the implementation of a mental health curriculum such as SEL or mental health literacy, which is the focus of my research. Middle school students in the United States are between grades 6 and 8 and are around 10-14 years old. Worldwide, depression is the fifteenth leading cause of illness and disability for those aged 10-14 years old, and anxiety is the ninth leading cause for those aged 10-14 years old (Office of Adolescent Health, 2019). Also, there are approximately one in five youth who have experienced mental illness before the age of 25 (Walsh, 2019). According to Burnett-Zeigler & Lyons (2011), youth are most likely to enter the mental health services system between the ages of 9 and 13, and the majority of these youth first receive services in a school setting. Results from one study designed to investigate whether adults with mental health disorders had a childhood psychiatric history found that over half of all adults with a mental health problem had

been diagnosed in childhood, with less than half of them having received the appropriate treatment at the time of diagnosis (Kim-Cohen, 2003). It is widely acknowledged that early diagnosis and treatment results in improved outcomes for the child and their family (Honeyman, 2007). Without treatment or intervention, the overwhelming buildup of pressure for some in trying to cope with a mental health problem can result in suicide (Honeyman, 2007). Based on this research, early intervention is extremely important to preventing more serious mental health problems for youth in their future. The school system is the ideal place to implement this intervention as it is the place young people spend the most time in an institutionalized setting. The school environment is often a place of protection and security for students struggling with mental health disorders.

A report from The Center for Mental Health by Lorraine Kahn (2016) researched the specific age of youth aged 11-15 and mental health and found significant evidence as to why this age group is important to focus on in mental health intervention in school. Kahn writes "it is a period of significant neurodevelopmental change for most children, characterized by the second most dramatic period of structural change in brain architecture after infancy (e.g., rapid pruning as well as significant change in the volume of gray matter)." She argues that this contributes to an increased likelihood of sensation-seeking and risk taking, decreasing sensitivity to social cues, decreasing consequential thinking, and having high influence from peers at this age. Due to this lack of awareness in their brain development, many young people in this age group aren't aware when their mental health is deteriorating (Gulliver, et al., 2010). This age group is also highly self-reliant when coping with mental health difficulties (Rickwood, et al., 2007) and are more likely to use informal sources of support such as friends or family. Due to the high influence from peers to "fit in," young people in this age group experience stigma, shame and

embarrassment about mental health difficulties strongly (Gulliver, et al., 2010). Additionally, during ages 11-15 they are more susceptible to negative environmental perceptions of mental health in their family, in their peer group, in the media or in their school environment, becoming more secretive and backing away from seeking help (Kranke, et al., 2010).

All of this research points to the necessity of teaching about mental health during the middle school time period of a young person's life, as they are highly influenced by stigma in the media and from their families and peers, and their brains in this developmental stage may not be able to recognize signs of mental illness on their own. Additionally, students at ages 10-14 are already experiencing serious mental health challenges and school is a way to reach millions of young people in an institutionalized way. Intervening at this age could help children experiencing mental health issues get help sooner and in turn it could prevent young people from experiencing more severe mental illness in the future. In conclusion, there are many studies that show that tier one support, whether it be the trauma-informed approach, SBHCs, or mental health education, is proven to help mitigate mental illness and help students succeed in school and life. Studies also show that mental health education is necessary specifically for middle school aged students. Therefore, there needs to be a comprehensive mental health education curriculum created for and implemented in middle schools, for middle school students specifically. Resources on the CASEL website and a primary informational page on mental health literacy (mentalhealthliteracy.org) show that many mental health education curricula are taught as social emotional learning for elementary aged students or mental health literacy taught to high school students, and the middle school age is being missed or taught in a way that is above or below their developmental level.

The prior research reviewed above points to the importance of mental health education in middle school but despite this clear importance, there is a gap in research on how to best teach middle schoolers about mental health in an age-appropriate way, leading to many schools and programs missing this important age group. Although the landscape of mental health curricula is changing with legislation supporting mental health education in schools, middle schoolers, which are arguably at the most important developmental age to need mental health education, are being missed by research and curricula. My research will study in depth what middle school mental health curriculum looks like in schools that are doing it, what is missing in middle school mental health curriculums specifically and why, and how teachers, policy makers and department of education administrators, and curriculum developers conceptualize what mental health curriculum looks like for middle schoolers across the country today.

Theoretical Framework

Based on my literature review, it was important to include multiple different perspectives from policymakers to practitioners due to there being multiple different interpretations of the terms "mental health" and "mental health education." This approach was informed by prior research showing that a disconnect between policy and implementation can stem from different understandings of the same words (Hill, 2001). In "Policy Is Not Enough: Language and the Interpretation of State Standards," Heather Hill, professor at Harvard Graduate School of Education, argues that language can be an important barrier between policy and classroom implementation. Through a case study of a school reforming their math curriculum, she found that the words such as "explore," "construct," and "understand" were interpreted by policymakers differently than classroom teachers, affecting the implementation of reform. Hill argues "Standards exist at a level above actual classroom practice and thus are limited in the

picture they can paint of subject matter and instruction, leaving locals a tremendous interpretive task." She notes that because language has no inherent meaning, but meaning is ascribed to words by actions or ideas from different communities, one word can have varying definitions from one community of people to another. This is also the case for the term mental health education, which is increasingly used in policy to be implemented across hundreds of different school systems from urban to rural. In her case study, Hill finds that during the process of interpretation of policy at the classroom level, teachers' understanding of the policy differs by a great distance from what the state meant to convey. Language is not enough to implement policy successfully, she argues, it needs to be accompanied by professional development and on the ground support and visuals for teachers.

This theory is useful for my study which consists of researching the policy and classroom interpretation of the broad terms "mental health" and "mental health education" which can be conceptualized in many different ways. Policymakers, classroom teachers and counselors, curriculum developers, and students themselves likely have varying understandings of what mental health education means to them. Knowing the importance of language in successful implementation and reform of curriculum, part of my study is simply investigating how these different communities conceptualized these terms. With this theoretical framework in mind, it was important to pay attention to these definitions and how this affects how mental health education can be implemented best in classrooms from policy. Based on Hill's theory, in order to study this concept of mental health education it is important to first build a common language and understanding of these words between all participants, which I work to build in this paper.

Additionally, mental health and mental illness and even adolescence can be highly stigmatized or disparaged topics. Researchers in education and human development have often

noted the presence of both deficit- and asset-oriented language in the ways youth and their needs are discussed. For example, Richard Lener's work points out the danger of using deficit centered language when raising teenagers, further pointing to the importance of paying attention to asset and deficit language in mental health education curriculum for middle schoolers. Lerner (2007) argues that parents and other adults in children's lives have a pattern of viewing teenagers as "deficit," and "as if something's wrong with or missing from them" and this language has a detrimental effect on adolescents' lives. When adults view teenagers as deficient, they may ultimately come to believe that it is inevitable that they will experience or become troubled teens themselves (Lener, 2007). He writes "Ultimately, they may come to believe that it is inevitable that they will become involved in problematic or dangerous behavior." And "they may incorporate the sense of actually being 'at risk' as living only a step away from getting in trouble or creating problems for others." (Lerner, p 29). On the opposite side of this is a strengths based approach, which uses reinforcing language to highlight strengths of an adolescent.

Historically, mental health and learning in adolescence has been prone to deficit-based language and approaches (Silbereisen & Lerner, 2007, Benson et al., 1998, Behavior Health Executive, 2015). Larson (2000) argues that developmental psychology has a much stronger tradition of understanding and treating psychopathology than for understanding and promoting pathways to developmental success. Therefore, there was a strong focus on illness and disorder rather than prevention and protective factors against mental illness. Additionally, Silbereisen and Lerner bring up that "the health and well-being of children and adolescents require as much attention to promoting developmental strengths as to directly combating risks, environmental threats, and social dysfunctions that obstruct human development." (Silbereisen & Lerner, 2007, p. 128) They continue saying that although these two approaches are both present in education,

they should be in balance and that in the past they have been out of balance with a focus on the latter. Children are being taught about threats, risks to their lives, and seeing mental health as a problem, at a much larger scale than they are being taught about how to build resilience and foster mental well-being. The concept of focusing on strengths in the classroom is known as an "asset-based" framework. The Psychiatry and Behavioral Health Learning Network defines the asset-based framework of health as "the purpose of care is not only to reduce disease, but also to "recover" and enhance a person's strengths" and "shifting the fulcrum from a solitary focus on disease care to one that also includes disease prevention and positive health promotion" (2015). This type of positive framework is very important for kids during this time in their development as they are experiencing key changes in autonomy, meaning-making, and identity formation (Silbereisen & Lener, 2007).

With a topic such as mental illness and mental health, students already have negative stigma attached to these terms and there are many ways to discuss this topic with middle schoolers that could similarly make students feel as though they will inevitably experience mental illness or become involved in negative aspects of mental health if using a deficit-based framework. It is important to note that negative language isn't necessarily the same thing as using a deficit-oriented approach to mental health education. Some necessary aspects of mental health education, and especially mental health literacy, is naming the negative experiences that come with experiencing mental illness. These descriptions of negative aspects of mental illness are a part of the necessary balance of providing definitions and clarification surrounding mental illness as well as providing coping mechanisms, protective factors, and treatment options (Kutcher et. al, 2016). Based on this framework, it is especially important in my research to pay

attention to deficit and asset language surrounding the highly stigmatized topic of mental health and mental illness in mental health education taught to adolescents.

Methods

This research was conducted as an exploratory study to gain an in-depth understanding of the topic of mental health education for middle schoolers. The research consisted of interviews, classroom observation, and student surveys. Qualitative methods were used to interpret data and understand how mental health education is conceptualized by schools and curriculum developers and experienced by middle schoolers themselves. This study was split into two phases. First was a broad exploration of how mental health education is conceptualized by lawmakers, curriculum developers, and instructors through zoom interviews. This phase also was an investigation into what the landscape of mental health education curriculum looks like in the United States today through research of online journal articles, news articles, and policy reports. The second phase of the study was an analysis of what curriculum looks like in the classroom and how it is experienced by middle school students themselves. These two phases provided both a big picture perspective of the policy and curriculum development landscape and an on the ground perspective of classroom implementation.

Study Sample

For Phase I of the study, participants were identified to participate in interviews through internet searches and word of mouth connections to different curriculum and educators participating in mental health education work nationally. They were chosen through purposive sampling to represent three populations: state administrators, curriculum developers, and school counselors and instructors. They were also chosen to represent different areas of the United States in order to get different perspectives of mental health education from different states. I identified specific states of interest to reach out to based on research about recently passed

mental health education policy and laws in those states. I identified the specific curriculum developers to interview based off of curriculums I heard of through other educators as well as the curricula that state departments were using. A recruitment email was sent out to participants describing the study and asking if they would be willing to answer questions about a thesis paper about mental health education in middle schools.

Phase II of the study was classroom observation and student surveys, and participants were chosen through convenience sampling based on availability and accessibility. The middle school I observed is a small private K-8 school in Rhode Island that consists of around 60 students per grade, with 65 students in the 7th grade, and about 15 students per health class.

Table 1

List of Participants in Phase 1

Role	Pseudonym	Position
State/policy	Becca	Maine Department of Education Employee
	Faith	Oregon Department of Education Employee
	Hannah	California Department of Education Employee
Developers	Jordan	Restore[1] Curriculum Developer
	Danielle	Monument Curriculum Developer
	Josie	Sage Curriculum Developer
Instructors	Kate	Rollings Middle School Counselor
	Tina	Weebly Elementary Counselor
	Anna	Candor Middle School Teacher

[1] All curricula and school names are pseudonyms.

Data collection

Phase I

For phase I, in order to identify relevant experts and practitioners in the field of mental health education, I reviewed department of education web pages for different states, Education Week magazine, google scholar, ERIC database, the Collaborative for Academic, Social, and Emotional Learning website. After this overview of the field through the internet, I began interviews with experts in the mental health curriculum field who were teachers and counselors, curriculum developers, and policymakers or members of state departments of education who were participating in the mental health curriculum field. The interviews were about 45 minutes long and were on the Zoom platform. There were 10 questions asked with the purpose of gaining insight into what the landscape of mental health education looks like in different contexts and how mental health education was conceptualized for different people. The interview questions were designed to find out about participants' roles, their goals, what was important to teach middle schoolers about mental health, what an ideal curriculum would look like for them, and what barriers they face to implementing that. Additionally, the interviews explored questions regarding the connection between the policy side of curriculum and what it looked like on the ground, implemented in classrooms. At the end of the interviews, I asked if the participants would be willing to share their curriculum materials with me for my research. A total of nine interviews were conducted (see Table 1). All interviews were audio-recorded and transcribed through a transcription service.

Phase II

This phase of the study was conducted in order to see mental health curriculum in practice and gain insight into the middle school student experience of the curriculum. A pre and post survey was prepared for students who participated in their school's health class on mental health. The survey questions were created to gain an understanding of what students wanted to learn about mental health, what they had learned already in school about mental health, and what questions they had about mental health. The survey also measured learning outcomes of certain topics shown to be important for young people to know in order to be emotionally healthy, such as knowing the difference between stress and anxiety, feeling comfortable reaching out for help for mental health related problems, and having self care and self soothing tools. They also were designed to see what students knew and did not know about mental health before ever taking a class or participating in a curriculum on mental health and then after participating in the curriculum/class. The surveys were created on google forms and administered by their health teacher the class before and the class after the mental health class on laptops. The questions were formatted as a combination of multiple choice and short answer questions. This provided space for students to voice their opinions as well as to be able to receive outcome data regarding progress of what was learned in the class based on pre and post results. These surveys were paired with classroom observation which focused on student involvement and participation, curriculum delivery and content, and interactions between teacher, student, and school psychologist.

The observation consisted of a one hour long class with 7th and 8th grade students in mixed grade sections of about 15 students. The health teacher co-taught the class with the help of the school psychologist. Parents in the 7th and 8th grade were sent consent forms for their child

to take the survey and/or be observed in class. Students were given assent forms to participate in the study. The class I observed was called a "mental health" class that is taught once a year in this middle school's health curriculum. The teacher used a powerpoint presentation and began the class with breathing exercises. She then defined mental health, discussed statistics of suicide, common mental health diagnoses for middle schoolers, the impact of covid and mental health, what causes mental illness, stress vs. anxiety, common middle school stressors, LGBTQ+ and mental illness, how to ask for help, and self soothing tips. She also gave out scenarios about mental health to pairs of students and they brainstormed how to problem solve and shared with the class. At the end of the class, they did an activity called "my emotional cup" which had them write about what fills their cup and what to do if their "cup" is empty. I received 63 results from the pre survey and 56 results from the post survey.

Data Analysis

Phase I

To begin my analysis of the interviews, I used the transcription service Trint to transcribe the interview recordings. I then coded the interviews through the dedoose platform. I began with topic coding by coding specific topics that I asked questions about in the interviews such as ideal curriculum, when to start talking about mental health, school's role in mitigating mental illness, and more. Next, I narrowed down these codes by doing thematic coding of themes that arose from the interview answers such as funding, adolescence, schools in crisis, and state improvements. I then did coding by cutting across topics in multiple rounds increasingly getting more specific. This included splitting up my bigger codes such as "funding" and "schools in crisis" into smaller subject topic codes within as well as combining codes surrounding

curriculum such as content, delivery, mandates, goals etc. and state current improvements. After this I did analytic memoing to build a cohesive story from the codes.

During phase I, I also was granted access to modules of three curriculums, one SEL focused, one Mental Health Literacy focused, and one whole school approach focused. To gain a better understanding of the content and delivery of mental health curriculum for middle schoolers, I went through three modules for students of each curriculum myself, which included watching 62 short videos and taking 18 mini lessons which was roughly 20 hours total of curriculum watching and 77 pages of notes. In my notes I recorded the content being taught as well as noting images used, activities given, quiz questions and answers, tone of voice, interactive aspects and wording. I specifically paid attention to the ways in which images and language related to asset and deficit frameworks within each curriculum. I then coded these notes into content and delivery and noted important examples of asset and deficit language and imagery. I then coded across the three curriculums to find contrasts and similarities between the approaches to teaching similar topics of mental health education to middle schoolers.

Phase II

For phase II of the study, I took notes during my classroom observation on specific areas such as content of the curriculum, delivery of the curriculum by the teacher and school psychologist, student participation in the class, types of questions asked and how the teacher responded, and body language of students and teacher. I then coded these observations into content and delivery and then into deficit and asset imagery and language.

To analyze survey data, I began by calculating the results from multiple choice statement questions that measured learning outcomes pre and post mental health class. I compared the number of students who strongly agree/agree in the pre survey to the number of students who

strongly agree/agree with the same statement in the post survey to see the change in students agreeing with the statements after the class. I then coded the short answer questions using thematic coding, noticing emerging themes that came up across student answers as well as noticing themes of asset and deficit language.

Positionality

Any qualitative study is influenced by its researchers and their experiences, biases, and subjectivity (Lincoln, 1995; Peshkin, 1988), therefore, I acknowledge that as a white woman attending a liberal arts college, this affected the research of the study. I inherently had bias because I am passionate about the need for mental health education in schools based on my experience of wishing I had learned about mental health in middle school. Nevertheless, I came to the study without any specific image of what mental health education should look like in schools and dedicated the research to understanding the full range of what this could look like in schools with an open mind.

Findings

In my findings I will bring together the voices of policymakers, curriculum developers, and classroom instructors to reveal four different takeaways: first, what the current landscape of mental health education instruction looks like in the classroom. Second, the ideal curriculum for schools and students. Third, why mental health education is needed right now, and lastly, a story of disconnect between policy and the classroom. It is important to put all of these different voices in conversation with each other in order to see the different ways mental health education is conceptualized across fields especially in instances where stigma could be reproduced or reduced in the classroom setting through asset and deficit-based approaches. In my findings I purposefully look across multiple sources and perspectives in order to address these different understandings of mental health education.

Current Landscape of Mental Health Education Instruction in the Classroom

From the interviews, survey results, classroom observation, and curriculum analysis I was able to find that there are common topics taught to middle school students at this age through mental health education curriculum as well as certain ways these topics are being taught that fit into the categories of deficit and asset language.

Across these sources I found that there was a theme of beginning conversations around mental health for middle schoolers with brain neuroscience. Most interviewee participants, curriculum, and my classroom observation covered the topic of fight, flight, or freeze and our brain's response to danger. In this section most curriculum talked about the role of the amygdala, prefrontal cortex, and limbic system and how those areas of our brain affect emotions. I found that another theme among the curriculums I had access to at the middle school age included a

section or multiple sections on emotion regulation, discussing how to handle extreme emotions and how to calm your body using mindfulness exercises. A third component that was similar across the curriculum was social wellness and discussing healthy relationships and friendships, including bullying and some including suicide awareness. Some curricula discussed terminology such as anxiety, depression, and eating disorders explicitly, while others focused more on learning the best ways to deal with overwhelming emotions, not necessarily naming disorders, and some curriculum did a bit of both. Because all of the curricula took different approaches to mental health education, it was expected that the topics they covered would vary in content. Despite these differences, my focus was on how students were being taught and learning this curriculum through paying attention to implicit messaging.

Curriculum Analysis

What is important from my curriculum analysis is that across curricula and topics, some instruction was more deficit oriented or potentially stigmatizing while other was strengths-based or asset oriented. This was especially present in areas such as emotion regulation and teaching about anxiety and depression. An example of this is one curriculum teaches about emotion regulation using the catchphrase "DON'T FLIP YOUR LID." They define this phrase saying, "flipping your lid means losing control of your emotions during stressful situations." This lesson is accompanied by a comic strip of a girl playing basketball who does not get passed to and therefore she begins to "flip her lid" and steam is shown coming out of her ears and her face gets extremely red. The curriculum notes that a way to solve this is "to stop and think before you lose it." Throughout this module, the curriculum repeatedly reminds the students to remember to not "flip their lid." This language as well as the images that accompany them show students that emotion is something to fear losing control over and that intense emotions should be something

to avoid at all costs or you may "lose it." This may make students construct a stigmatized or negative association to feeling and expressing their emotions in front of others or seeing a peer experience intense emotion.

By contrast, another curriculum teaches emotion regulation using asset-based instruction. This curriculum emphasizes that "When we know our triggers, we can find ways to be proactive to prevent ourselves from overreacting." This lesson then goes on to teach the concept of resilience explaining that "we will face a lot of challenges and resilience is how we respond to those challenges." It invites students to reflect on the strengths they bring to certain challenges in their lives and what strategies they have used before that can help them in stressful situations. Another curriculum uses an asset-based approach when they teach about emotion regulation using the concept of an "emotion scientist vs. an emotion judge." In this curriculum they ask students to interpret different scenarios while practicing being observant of emotions instead of judging the emotion as "good or bad." They then ask students to reflect on how being an "emotion scientist" could help decrease misunderstandings and help improve our relationships with others. Additionally, they ask students to answer, "what is the value of being able to express our emotions?" This example shows very different ways to teach emotion regulation to middle school students, one way portraying strong emotion as something students need to control and avoid while others portray emotion as areas of our life, we have the tools to handle by recognizing our strengths and not judging our emotions. Figure 1 below shows, on the left side, examples of images used in deficit-oriented instruction about emotion regulation. The right side shows images used from a different curriculum that teaches emotion regulation through more asset-based instruction. It is clear in these images that the left side focuses on students being out

of control and extremely emotional while the other side shows calm imagery focusing on displaying coping mechanisms and happy and loved people.

Another area of curriculum where asset and deficit approaches to teaching were present in my analysis was in modules about depression, anxiety and disorder in general. One curriculum introduces depression to students describing that "sometimes negative, overwhelming feelings can take hold on your life for weeks at a time." It also teaches the difference between sadness and depression saying, "there is nothing worse than starting out your day only to have it ruined by finding out your best friend is talking about you behind your back." It then lists many signs and symptoms of depression such as "In depression, things just start to pile up. You eventually have a hard time concentrating and interacting with others. You will not know why you are struggling with simple tasks. You will be exhausted all of the time. You may ache all of the time, without ever knowing why you are aching." This description of depression is then followed by repeated messaging about the seriousness of needing to get help if you experience those signs. In all capital letters it reads "DO NOT SUFFER ALONE" and "you cannot diagnose depression in yourself or anyone you may care about. This is really serious and you should not suffer alone." When describing how to help a friend it tells students "Symptoms that go unchecked can literally end your friend's life." This approach to teaching about depression emphasizes the difficult and scary aspects of depression and the urgency in getting help with the risk of losing you or a friend's life.

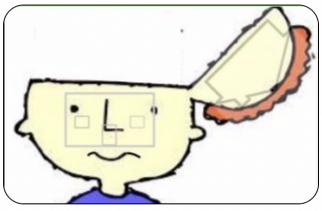
Another curriculum uses an asset-based approach to teaching middle school students about depression and other disorders. This curriculum introduces disorders such as anxiety and depression by saying, "Mental health exists on a continuum and where we fall on a continuum depends on genetic and environmental factors." It mentions that there has been a stigma around

talking about mental health but that recently we are seeing an increase in people's willingness to talk about mental health which is reducing the stigma. This curriculum also lists signs and symptoms of depression, but alongside these symptoms are also protective factors against mental health disorders. Such as having good coping skills, optimism, support from friends and family, and emotional self-regulation. It asks students to reflect on how "you might help yourself, your friends, and your family develop some of the protective factors using the information learned in this course." Along with protective factors, it also spends a majority of the module discussing coping tools or strategies such as getting outside in nature, sleep, and mindfulness. Part of the curriculum asks students to make a plan for themselves to proactively help themselves foster mental health. When discussing getting help it tells students "Strong people seek help early and often" and "you have way more power when you understand your brain better and have strategies in place" and "being willing to get help, that's a sign of strength and power." This shows how teaching concepts such as disorder does not have to be taught using fear tactics or in scary ways. It can be taught with a focus on fostering positive mental health, while still educating students on important signs and symptoms of disorders.

Figure 1

Images Used in Sample Curriculums Representing Asset and Deficit Perspectives

Your Brain, Body, and Strong Emotions



Classroom Observation

In my classroom observation, I also observed that there was a mix of asset-based and deficit-based teaching styles. The instructor began the class with helping students define mental health. She stated, “People think mental health is bad. It can also be good stuff. Everyone has mental health on different levels. We are trying to make sure our brain operates at a nice level.” This is a very asset-based definition that emphasizes mental health as something that can be

positive in one's life. She also acknowledged the stigma surrounding mental health when she noted that many people assume it is a bad thing. Another asset-based approach she used was an activity where students thought about what specific things fill their "emotional cup" which included self-care and self-soothing tools. Some ways that the class included deficit-based instruction was when discussing disorder. The instructor focused on the ways disorder can affect your life negatively and emphasized "if you remember nothing else from today, remember that if someone tells you they want to kill themselves, do not keep it a secret, tell a trusted adult." Instead of emphasizing the positive reasons to talk to an adult about mental health, this was discussed in a deficit perspective, only discussing talking to an adult when something bad was happening.

Survey Analysis

Analysis of the survey results from this class of 7th and 8th graders that I observed shows three important findings: the students defined mental health in a very asset-based way even before the class, the things students remembered that they learned from the class were mostly deficit-based, and that a large number of students do not feel comfortable reaching out for help for mental health related problems before and after the class. In the pre-survey, I asked students: "How do you define mental health?" In the responses, most students used asset-based language to talk about mental health. Some of these words included: "emotional well-being" "healthy mindset" "having happiness and motivation" "how happy you are" "the health of your mind and feelings." Thirteen respondents mentioned the word "emotional well-being" when defining mental health, while only one student mentioned disorder in their definition. One student wrote that to them, mental health is "What keeps you alive and makes you, you." These results show

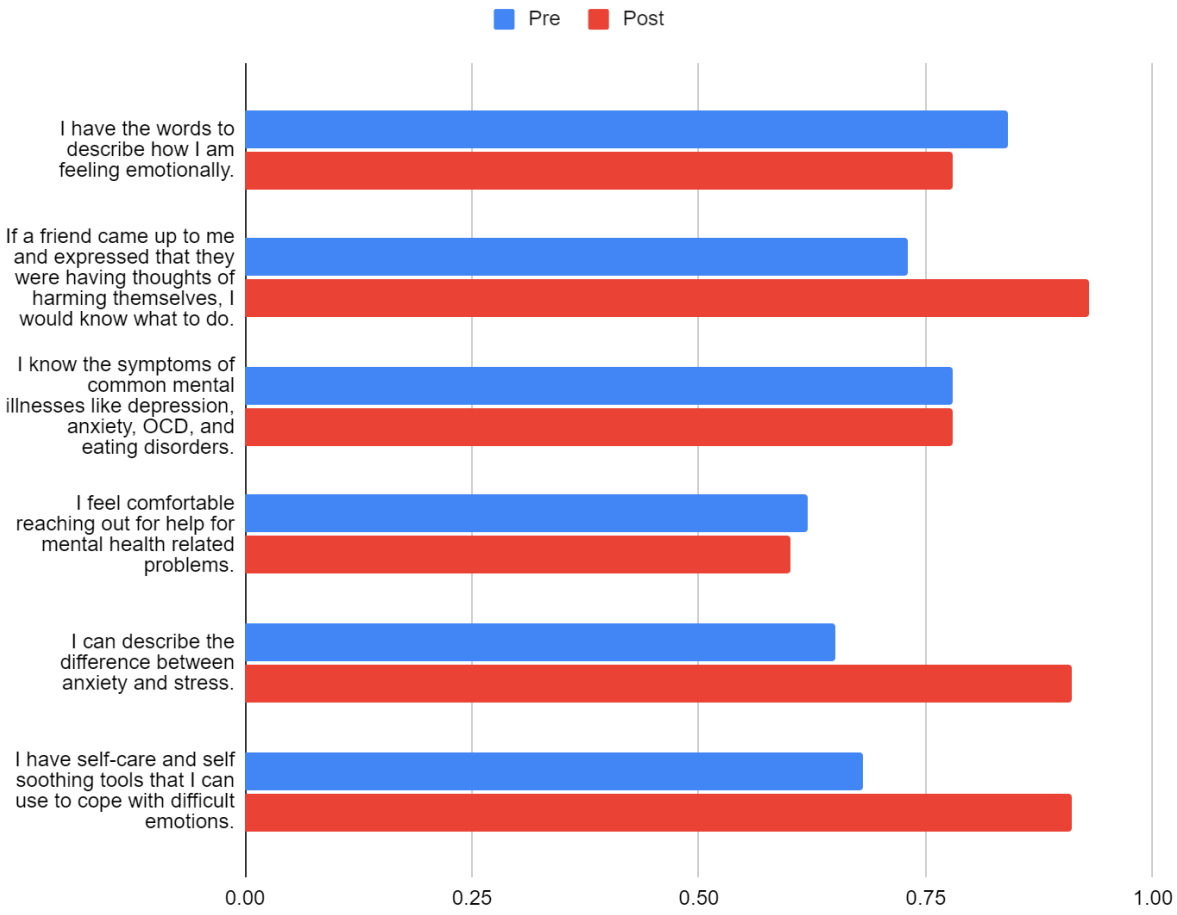
that these students generally have a positive conception of the term mental health, despite how highly stigmatized it historically has been in society.

These results stand in contrast to the deficit-oriented answers to the post-survey question: "What is one thing you learned about mental health from class that you didn't know before?" In these results, many students said that the thing they learned is how bad mental health is in our country and that a lot more people than they thought suffered from mental illness. Examples of these answers are: "that it is a huge problem" "adhd and depression" "high percent of mental illness in teens" "more people than I thought have depression" "a lot more people have mental health issues than I thought" and "the amount of young people that commit suicide." There were also some asset-based answers, although very few. These answers were about learning "grounding exercises" "how to help a friend" and "self-soothing and self-care strategies." Because many of the answers were deficit-oriented, it shows that a lot of the main takeaways from the class were from the parts of the class that focused on deficit aspects of mental health.

Lastly, the data from the surveys showed that overall, many students do not feel comfortable reaching out for help for mental health related issues. On a scale from strongly agree to strongly disagree, about 40% of students disagreed/strongly disagreed that they felt comfortable reaching out for help for mental health related problems. Figure 2 below shows the number of students that strongly agreed/agreed to the statements given in the pre and post survey. Statement 4 was: "I feel comfortable reaching out for help for mental health related problems." This number stayed consistent in the post survey as well. This is a large number of students who expressed a sentiment of not feeling safe and comfortable reaching out for help, despite learning in their class the importance of reaching out for help, which is a major concern when so many students are struggling with mental illness.

Figure 2

Pre- and Post-survey Comparison for Students Who Strongly Agreed or Agreed with Statements About Subjects Learned in Class to Measure Learning Outcomes



Ideal Curriculum for Schools and Students

Professional Perspectives on Ideal Curriculum

Interviewees were asked the question: "What would an ideal middle school mental health curriculum look like in your state/school if you had all the time and resources you wanted?" In

their responses, instead of pointing to specific subjects being taught or naming specific curriculum, there was an overwhelming theme of the concept of a "whole school approach" to mental health education that was ideal for administrators, curriculum developers, and teachers/counselors. This concept of the whole school approach looked different for different people I interviewed, but many expressed that having a time slot for mental health education once a week/month/year was not enough. An important aspect of an ideal curriculum for all of the interviewees was to start talking about mental health as early as possible with students, in developmentally appropriate ways.

When asked about her comprehensive curriculum, Faith, a representative from the Oregon Department of Education expressed, "I think my ideal world, if I could wish for this, would be for all educators, all teachers, whether you're teaching science, math, English, to weave SEL into your work." This quote sums up what all the other interviewees expressed: that they want the mental health curriculum to span all classes at school and be built into the structure of the school day.

For Danielle, creator of the Monument mental health literacy curriculum, this whole school approach means having everyone involved in the school speak the same language. She says, "What we think is important, and we were very intentional about having programs for parents, teachers and students because it's important that everybody have that and health care workers, everybody, have the same language within a community." If everyone has the same language around emotions and mental health, then a mental health curriculum can be implemented and used in all different classes throughout the day and at home. Danielle talks about a strategy that can be used across multiple subjects throughout the school day called the Four S's which are ways to be resilient in the face of challenges based on Self (who am I, what

do I stand for, what are my strengths and weaknesses), Situation (how can I bring this challenge into perspective), Supports (who and what do I do to get help), and Strategies (what are the things I do to handle this challenge). Danielle explains how this might look in the classroom when she says,

> You talk about them throughout the year, you introduce the concept of the four S's and then talk about it in every single class. So if somebody is struggling with a math problem, you say, Oh, you know, is your strategy working? It's not. So you got another strategy here. What else could we try? Is there support that can help you use that language throughout the year? So it's introducing the concept in very short, very small bursts.

This way of teaching a mental health curriculum provides ongoing education and support for students throughout the school day and provides a framework for discussing mental health in different situations such as trying to solve math problems.

Josie, an employee of Sage Curriculum, expresses a similar want for a comprehensive curriculum and also names the idea of having a common language. She says “we really feel that Sage Curriculum is not something or really SEL in general is not something that is effective if it's only from 11 to 11:45 on Thursdays. That's not effective. So, we really encourage embedding Sage Curriculum kind of everywhere in the student's day and in their lives.” For Josie when this is implemented into the classroom it looks like, “any teacher of any subject can talk to kids about test anxiety. And you don't have to be the Sage Curriculum teacher…that teacher is really embedding Sage Curriculum into everything that they're doing. And they're embedding that into what they're doing for literacy, but also for numeracy and for social studies. And right, they're weaving it all in.” Similarly, to Danielle, this curriculum spans the school day and can be used in all classes because of this shared language. She continues to express that ideally “we also want to think about family engagement because some of this work really involves really building a common language among the school community.” Family engagement could then spread this

curriculum after school as well. This common language she talks about is something that could help create the ultimate vision of her ideal curriculum which she says would look like “that they [teachers, administrators, staff] can just embed this in the lifeblood of what they're doing at their school. That's the kind of thing where you just walk in, and you can feel it. You can just tell that emotions matter here, and it's OK to have feelings and the support and the relationships and the warmth that are there.” This ideal outcome of a comprehensive curriculum comes from the whole school approach.

Becca also expresses her own version of what a comprehensive curriculum would look like in Maine which also involves a whole school approach. She says,

> And knowing that it's not just like one initiative, but it really needs to be something that leadership believes in, something that, you know, the entire school culture sort of becomes framed around, you know, any one teacher can kind of create a bastion of safety within their classroom. But if students don't have that throughout the building, you know, it's really hard to have that success sort of permeate.

For Becca, what would create success of a mental health curriculum in school would be to have a whole school culture of safety and something all staff believe in. She goes on to say that “This is really what school is for so that that has its own kind of safety and security and allows kids to make mistakes and grow from them and stay connected to a community like those are all the core pieces.” Instead of naming specific things that she thinks middle schoolers should learn about mental health, to Becca, “It's less about what is being taught and more about how kids are being engaged.” and in addition to this, she notes that “having extra support there that are scaffolded. So, students that need more support that have more barriers in their lives get those supports early and consistently so.” A school culture of safety and support in addition to scaffolded support for students who need more help is what a comprehensive middle school mental health curriculum would look like for Becca in Maine schools.

Hannah, a representative from the California Department of Education, also emphasizes school culture as the biggest goal for the mental health curriculum in California schools. When asked the question about a comprehensive curriculum in California middle schools Hannah emphasizes "a culture of wellness" where she states "I think SEL should not be a curriculum. I think it should be a mindset. Right." She continues to describe how that would look when she says "How do you really do that? You can't really do it through a class. I think it has to be really integrated within the whole school system that, um, that aligns with the values of the school." This quote emphasizes once again that it is important to not just train students in a one-time training but really provide a space that fosters mental wellness and support.

Other aspects of a comprehensive curriculum that were expressed in multiple interviews was increased staffing for mental health related services in order to increase how many students could see counselors and school psychologists. For Kate, a classroom teacher in a Maine public school, she says "I think there needs to be a middle school counselor for each grade. That would be amazing." Tina also expressed the need for more staff when asked this question when she said she would want "maybe like quarterly check-ins individually with students. That would mean a lot of manpower. Yeah, that's a lot of manpower, but I do think it would be helpful." Due to the fact that schools are extremely short staffed and overwhelmed right now, having more counselors would be extremely beneficial for schools to be able to implement a comprehensive curriculum.

Within this comprehensive curriculum, many of the interviewees expressed that it is important to explicitly discuss mental illness in school to reduce stigma. When talking about explicitly teaching about mental illness at school, Faith says, "there's parents in the district who are like, oh my gosh don't be talking. Just don't get those thoughts in my child's head, my child's seven. But we have kids younger and younger, 10 and 11 that are thinking about killing

themselves. So, I mean, you know, or they're depressed or they're anxious or they're being bullied. You know, they have nobody to talk to. So, this is why, you know, when we talk about reducing the stigma, a lot of it is just talking about it. Yeah, just talking about it normalizes it." This quote describes how there is resistance out there for explicitly talking to young kids about mental illness, but for someone like Faith in the Oregon Department of Education, she sees that this topic is extremely important to discuss in school in order to reduce stigma. Tina, a counselor at a Maine public school, agrees with this when she describes the necessity of talking about depression to her students. She says "lots of kids will want to say the word depressed as meaning really, really sad. And that's what they think. And so, I do have to have this conversation about depression every year because they keep using it the wrong way…so they do need to know that. So that would be like an example of mental illness that's discussed early on." According to Tina, having these conversations about serious mental illness like depression is necessary because kids at the middle school level are already using those words, and many are using them incorrectly.

Another important aspect of a comprehensive curriculum according to my interviews, was beginning conversations around mental health at an early age. When asked what the appropriate age to begin discussing concepts of mental health in school, all of the interview participants expressed that the younger the better. The counselor at a school in New York, Anna says, "honestly I think that in the lower school, our lower schools K through three, um, we've been having conversations about this. I think that starting young is amazing because I think that it also takes away that stigma." She says in order to take away this stigma, "I think that starts by having these conversations when you're younger and obviously in kindergarten, we're not going to be like, are you depressed? Do you have mental illness? But I think that. Um, age-appropriate ways to start introducing it even from kindergarten." For Anna, a way to discuss this with

younger kids may be “kind of adding in with language appropriate for younger kids, like, how are you feeling up here? You know, are you feeling sad? Is something on your mind? And so I personally think starting younger is better.” According to Anna, having these conversations at a young age really helps take away stigma and it can be done in scaffolded ways.

Curriculum developer Jordan agrees with Anna when she says, “I think it's probably never too early to talk about health and wellness and like self-care, you know, like things that you can do to improve your mood or to to feel better.” She also says that this can also be applied to emotional literacy, she says “I think like when you're looking at sort of education around mental illness, it's like recognizing the signs, you know, like thinking about what should you be worried about a friend or should you be getting an adult involved, that can start really young.”

Teachers in the classroom like Kate also agree with teaching mental health early. Kate says “I don't think that you can be too early. Like. Even early childhood care centers would talk about feeling words. I think that recognizing and managing yourself is a really important skill from day one.” Josie also agrees when she says we should start talking to kids about mental health “Day one” she elaborates “I mean, pre-K, right, like I want to be clear that sometimes people hear you say that and they're like, That's so inappropriate. You shouldn't be like telling five-year-olds about, it's like you can do it in developmentally appropriate ways. Right?” This shows a theme throughout the interviews that counselors, curriculum developers, and policymakers all agree that mental health education should start as early as possible in order to reduce stigma albeit in developmentally appropriate ways.

Student Perspectives on Ideal Curriculum

In asking middle school students the questions: “What questions do you have about mental illness and mental health that you would want to learn about at school?” And “What are

some things you are hoping to get out of this mental health class?" I found three prevalent themes in the answers; wanting to know what to do if a friend or someone they know is struggling with mental illness, coping strategies and how to improve their own mental health., and signs, symptoms, and statistics around mental illness. The student perspective is also able to inform the question of what do schools want to be doing in regards to teaching mental health curriculum. Along with the whole school approach, explicitly talking about mental health, and starting to teach mental health early, middle school students themselves also want to learn about very specific and important things in the classroom.

Many students expressed in the survey that they felt as though it was very important to them to learn more about how to help a friend or someone close to them who may be struggling with mental illness or have thoughts of harming themselves. Some of the quotes about wanting to know how to help someone struggling with mental illness were very powerful. One student said, "I want to know how I can stop them from killing themselves because you only have one life." Another student said "I think that it'll be important to know about what I should do if someone tells me that they'll harm themselves, because if I was put into that situation, I wouldn't know what to do. I also want to know about symptoms so that I can know if people might be going through a tough time, and so I can help them. "Another response said, "I hope I can learn how to help people with mental health challenges because that's something that's definitely outside my area of expertise." Many other responses (15) included the desire to learn about how to help friends who are going through a hard time, how to make friends feel safe, and general ways to support friends with mental illness. These responses show that so many students know or anticipate knowing people who are struggling, and they are worried that they will not be able to adequately support them. These middle school students are acknowledging that mental illness is

something they expect to be exposed to and are desperately seeking advice on how to help their peers.

Student responses also showed a desire to learn how to improve their own mental health. Some of the responses in this theme were, “I want to learn to control the social anxiety that prevents me from having friends” and “Learn how to be happier and deal with myself” and “to learn more about managing my mental health.” In addition, many responses named wanting to learn coping strategies. They said, “I just want to learn coping mechanisms to help with depression” and “How to cope with all the stress of homework while not skipping pieces of homework (I struggle with a lot of anxiety, it can be really stressful to complete homework).” These quotes are showing that many students are aware of their own mental health struggles, they understand the importance of improving their own mental health, and they are wanting to learn coping strategies in school to help with this.

Additionally, students expressed an interest in learning about specific signs, symptoms, and statistics about mental health and mental illness, otherwise known as mental health literacy. Some examples of these responses are:

> What are symptoms of ADHD? How do you know if you have ADHD?
> What is the line of clinical depression?
> I am hoping to learn a lot more like what I can see if they are having depression and what, for say OCD, looks like from another person's standpoint.
> I want to learn the symptoms of common mental illnesses, and to get a better sense of what mental health is as a whole.

These responses show how curious students are about specific aspects of mental illness. The answers to these questions are important to know in a world where middle school students are increasingly becoming affected by symptoms of mental illness earlier and earlier in life and knowing signs and symptoms can help students get help earlier.

With input from teachers, curriculum developers, policy makers, and students themselves, a lot can be learned about what schools want to be doing and what students want to learn. According to my interviews, teachers, curriculum developers, and policymakers would ideally have mental health curricula embedded into the culture of the school instead of a 45-minute class once a week. This would look like a culture of wellness where teachers could bring mental wellness and emotion regulation into any class. Additionally, schools would start talking about mental health with children starting as young as pre-K and once it is developmentally appropriate, explicitly talk about mental illness in order to combat stigma. Students themselves are extremely curious about mental health and mental illness and have a lot of questions they want answers to in school. They want to know how to help friends who are struggling with mental illness or having thoughts of hurting themselves. They want to know how to improve their own mental health and well-being through coping strategies, and they want to know mental health literacy, or signs, symptoms, and statistics, about mental health.

Why Mental Health Education is Needed Right Now

Throughout my interviews with policymakers, classroom instructors, and curriculum developers I found that schools need mental health education for middle schoolers right now due to three compounding reasons: developmental age, schools being in crisis, and the COVID-19 pandemic's effect on schools. The interviews pointed to that middle school aged children are in a developmental age where they are inherently at risk for mental health issues and suicidal ideation. Interview participants continually brought up that mental health issues are affecting kids younger and younger, global stress and increased violence in the world is affecting students right now and the COVID-19 pandemic has increased isolation, social media usage and the need

for more support for kids. These narratives show an example of deficit-based language used to describe mental health for adolescent students. The increasing list of issues participants discussed that adolescent students are facing in today's world could make it feel as though middle schoolers are in a place of inevitable danger for developing or experiencing mental illness. Due to this deficit language surrounding the state of mental health for middle schoolers that emerged from the interviews, it is even more important to provide curriculum to these students that combats stigma and educates students with correct information about mental health.

Policymakers, curriculum developers, and classroom instructors noted the importance of mental health education for the middle school age in their specific developmental age. While talking to curriculum developers, I learned that middle school itself is a relatively new societal construct intentionally set aside to prepare students for the stressors and changes in high school. Josie, speaks about the importance of the middle school time period for adolescents when she says:

> [M]iddle school is like a relatively new construction of the early adolescent experience where we have sort of been intentional about saying, like, let's set aside a time that's in the middle where you know, you're maybe not necessarily ready for the sort of full responsibility of your high school experience.

This time is set aside specifically for kids in grades 6-8 because, Julia adds, during this time in their lives "adolescents have a proclivity to basically this undue sense of permanence." Meaning that they feel as though whatever feeling they are feeling seems like it is always going to feel that way. Because of these intense feelings, kids at the middle school age need extra support and education to learn that they actually aren't always going to feel that way and their feelings are normal and valid.

Additionally, Tina as a middle school counselor notes that at the middle school age, boys and girls are developing at different rates. She says, "there's like eighth graders here and you

know, some of them have a beard, right?" and because of this, "we have got to be super careful about making sure that we talk to kids about the seriousness of stuff, and some kids have some serious mental health issues." Danielle also supports these claims when she discusses the inherent risk of mental illness in middle school students. She says:

> Just like being over 65 is a risk factor for the physical health issues with COVID, being an adolescent by just virtue of brain development puts them at risk for mental health issues.

Danielle notes the reasons that kids at this age are at risk are "because of the neurochemical need, because of brain development, because of the sense of autonomy." All of these specific needs of the adolescent brain put kids at risk for developing mental illness, she argues. Although middle school students are at risk, they also are in a developmental age where they are becoming mature enough to think more complexly and as Danielle explains "move out of some of that black and white thinking that you might see in younger kids." Due to this development, middle schoolers she explains "are able to kind of grapple with more of that complexity of sort of the human emotional experience and have classroom discussions with each other or like, you know, challenge each other on their perspective." The specific developmental age middle school students are in where they are at risk for developing mental illness and at the same time have begun to be able to participate in complex thinking about their emotional experiences, makes middle school the perfect age to teach mental health education.

Unfortunately, teachers and state department employees voice that many social, emotional learning curricula that are taught to middle schoolers are not age appropriate. Becca, Maine department of education employee, notes this struggle when she says, "most social emotional programs were designed for elementary school, and they tried to extend them into middle school, and it doesn't always feel genuine or age appropriate." Middle schoolers are at an

age where they need mental health education desperately, though many curricula are geared towards either younger kids or high school students, leaving a gap for middle schoolers needing age-appropriate mental health education.

Another reason schools need mental health education for middle schoolers right now is because kids are in a mental health crisis. Interviewees from California, New York, Connecticut, Oregon, and Maine all mentioned seeing a worsening in mental health in middle school students in their states. Hannah in California says, “I've just noticed a skyrocketing of, just anxiety of general worry and even things like being nervous when there's a fire drill or a lockdown practice in school, the subway, just an intensity and fears of what could happen.” A Maine teacher also mentioned this when she said, “I’ve noticed an uptick in that general worry of what could happen.” This increase in students struggling can be seen in Maine as well, the Maine counselor Tina, who conducts the Maine Youth Integrated Health Survey each year at her school says “our numbers for kids thinking about having thoughts of suicide or self-harm have just steadily increased over the last eight years. They just keep going up and up and up for kids.” This shows that statistically, kids are continuing to struggle more and more every year with mental illness, anxiety, depression, and suicide and this increases the need for mental health education.

The heightened emotions of the adolescent brain are being challenged even more in today’s world due to the political, environmental, and global unrest. Curriculum developer Jordan expresses this when she states, “the world has become a scarier place.” She refers to the pandemic, the political situation, more “extremism and discord,” and more shootings. This type of global stress, she notes, “has an impact on mental health when it's in an ongoing way.” This impact can be seen through a decrease in mental health of people around the world, not just students. Josie from Sage curriculum states that “the data is very clear that mental health is

decreasing in our country, it's worsening. It's up among undergraduates, like it's just it's up everywhere."

In addition to the already decreasing mental health of middle school aged students, interview participants expressed that the COVID-19 pandemic only exacerbated the need for mental health education in middle schools. In regard to mental health in a rural Maine school, Tina said, "the pandemic just kind of made things really worse." She described that at their school kids have always struggled with "poverty and not enough food to eat and always with domestic violence" but that the pandemic has "just kind of exacerbated things" making it so that "it's really important that we support kids' mental health."

Remote learning due to COVID-19 was expressed in the interviews as having a significant effect on the ability for students to build meaningful connections with peers and trusted adults which are important protective factors against mental illness. One teacher from Maine reflected on this when she said "contact has been different, you know, like last year they were in pods before that, like people couldn't even see each other except at recess. And these are their formative years of figuring out how to deal with relationships." This has led to, as a Maine school counselor reflected on "they've [the students] gotten really good and being like super savvy on the computer, but not being able to talk like peer-to-peer problem solve, things like that." Hannah from California says that she has seen this manifesting in the way the "friend drama has been to another level because they're not used to figuring out how to navigate and handle relationships because they've been so used to being limited in the people they see or being over zoom." Students are also not as involved in their communities because of the pandemic as curriculum developer Jordan states "We're staying at home and we're watching things on Netflix instead of going out to the movies and being around other people or we're ordering instead of

eating out. So, there's just less integration with the community." Less socialization in the developmental age of middle schoolers, who are in formative years of socialization and relationship building, can be extremely detrimental to the mental health of these students, showing a need for increased mental health education in schools for this age group.

The pandemic has exacerbated mental illness, friendship issues, and drama for middle school students who are already in a vulnerable age. Faith describes how in Oregon, "we're in kind of like huge crisis mode" where teachers and school staff are seeing behaviors they'd never seen before. An example she gives is "we have like kids that are drinking bleach undiluted from their thermo flask to commit suicide…saying that they're going to kill themselves" She emphasizes, "everything is really bad." This is just one example of how intensely kids are struggling right now in terms of mental health from across the country. In the context of developmental age, a mental health crisis, and a global pandemic, tier one mental health education is desperately needed in school systems right now.

A Story of Disconnect Between Policy and the Classroom

The desperate need for mental health support for adolescent students in schools right now has created a nationwide policy push for this support, while at the same time schools actually have less implementation capacity due to overwhelm and understaffing. The interviews showed a disconnect between these current state legislation decisions supporting mental health education and classroom implementation of this curriculum. Interviews with policymakers and state department of education representatives showed that states right now are recognizing the need for mental health support for students and therefore passing laws and allocating funds to encourage mental health education in schools. Interviews with instructors at the school level, on the other hand, expressed that they are extremely overwhelmed and understaffed and cannot

implement new curricula/supports well right now. Additionally, participants shared many concerns about teachers not having the emotional regulation and social emotional learning themselves that they are being expected to teach students by the state legislature creating a disconnect between state legislature and classroom implementation.

Across the country, states are passing groundbreaking legislation mandating mental health education, social emotional learning, mental health literacy, mental health days and more, showing a national awareness of the need for mental health education. When interviewing representatives from state departments about mental health education in their state, they were all extremely optimistic about the current improvements going into place as well as the awareness of their team regarding how important mental health education is for middle schoolers. New York is a state that has increasingly been addressing mental health concerns of students in their education department. Danielle, the curriculum developer hired by New York State to help provide mental health literacy resources for their students discussed these efforts. She proudly stated, “New York state became the first state to require mental health literacy from k-12, Virginia did it at the same time, but they only required it in 9th grade.” She also noted that Michigan was another state that was leading the charge legislatively in mental health literacy curriculum. She said “Michigan, believe it or not, is the state that is, I think, the furthest along on mental health literacy right now legislatively. They are requiring in schools every year, around 50 hours.” She describes how in Michigan they have created an online hub for mental health literacy resources as well for parents, educators and health workers to access.

Maine state administrators conveyed a similar enthusiasm about passing legislation to create a more holistic approach to mental health education by hiring more mental health related staff for the department and creating a free curriculum. State administrators share similar

enthusiasm about mental health legislation being passed such as new staff and curriculum being put in place. The Maine Department of Education is also very focused on improving mental health education for middle schoolers. When interviewing Becca, the mental health and school counselor specialist in the Maine Department of Education, she was extremely excited to share an increasing focus on mental health in Maine schools. She shared that now in the Maine Department of Education they have a "social emotional learning specialist, a family engagement and cultural response specialist and restorative practices specialist. So, there is a bunch of us that are really trying to provide a more holistic approach to mental health in schools." In the schools, Becca describes that "each district is charged with coming up with a comprehensive school counseling program, and the school counselor helps design that." Additionally, Becca's role as a mental health and school counselor specialist was a new position that the commissioner created in fall of 2019. Becca said, "understanding that there's never been a mental health position in the department before. So, it was a new thing and the commissioner understands the importance and I think the ever-increasing role of mental health support in schools." One way Maine has addressed this importance is through the creation of a free SEL program that all schools are able to access. Becca describes that "the commissioner really asked us to create free and readily accessible programming that has sustainability associated with it, to really make it worthwhile and to have it be Maine made or unique to Maine. Which is really important because while national best practices are great to follow, Maine has its own unique strengths of barriers that we really want to highlight." This program is something the Maine department is really proud of and has spent a lot of time and money on creating.

California and Oregon are two more states that I interviewed representatives from who have been doing groundbreaking work in mental health education. In Oregon I interviewed the

School-Based Mental Health Program and Policy Coordinator for the Department of Education who stated that in Oregon “there was legislation passed this past year that said that ODE has to create social, emotional learning standards that every state or every school and district will have to use.” She also mentioned that there is another proposal being sent to legislation that will work to get funding for the whole state to get community care coordinators in every school.

In California, the SB224 bill was recently passed, which mandates that students in grades 1 through 12 will receive mental health education from a qualified instructor at least one time during elementary school, one time during middle school, and one time during high school. When asked about this bill, Hannah, stated that actually, what this bill really means in schools is “there really isn't, um, a requirement that middle school students receive mental health trainings. Um, the bills that passed are simply saying that if the district has a health class, then they are required to teach some of those topics, right. Like, you know, risk factors sometimes, and, and saying all those things and the bill just got passed.” She expressed that even though this bill did pass, there still “isn't a requirement that middle school students receive mental health training.”

Through my interviews I also found that the country as a whole has been pushing for increased mental health education in schools through specific funding to support students’ mental health. Danielle discussed how the federal secretary of education, Secretary Miguel Cardona, recently released a 103 page document which, she describes “basically says that we should be teaching mental health literacy from pre-K through 12” and this document also lays out how schools can use money from The American Rescue Plan, which Danielle refers to as “the ESSER funding to help schools rebound from the pandemic so mental health literacy can be paid for with one hundred and twenty six billion dollars.” In her interview Danielle states that because of this funding, “schools have more money than they have any idea what to do with.

They have in most districts; they have the ability to double to triple their budgets. She firmly states that “as of the beginning of this school year, there is not a school district that doesn't have a ton of funding that's supposed to be going towards mental health literacy.”

A disconnect between legislation and classroom implementation begins to appear when Danielle discusses how instructors and schools have difficulty being able to actually use the funding that states are passing in legislation. Danielle says “A lot of them don't know how to get it” referencing money dedicated to mental health support in schools. Danielle says that there is tons of money out there for schools to use to support mental health education, state legislation is passing many different bills mandating mental health education and supporting the creation of new curriculum, but classroom teachers and counselors seem to be telling a different story.

When discussing mental health education implementation with teachers and counselors, they all described the harsh reality of working in the school system right now, naming staff shortages, overwhelm, and lack of resources as common issues they face. When interviewing Maine counselor Tina, she described how at her school she had been using a certain curriculum and then all of a sudden, her funding for it got cut off. She said “this is a little bit of a sore spot right now. Curriculums cost a lot of money. Yeah. And so, if you don't purchase the curriculum well, not to be negative about it, but here's the thing, like, I don't have time to do anything, I don't have planning time. I don't eat my lunch alone, I eat lunch with kids or I eat lunch talking to parents like I have absolutely zero planning time” She continued to say that because of this cut in funding, she wasn’t sure how she was going to have the time to prepare lessons for the kids about mental health. Expressing that before her funding was cut, she could, “just put it on my computer, zoom down the hall, I could go into the classroom, pull up the video like the whole lesson and teach you a lesson, then zoom out and leave without having to worry.” Because of

this cut, she explains “I have to like, you know, print out the papers and make sure the kids have all the scissors and cut out the pictures. And those kinds of curriculums are a lot of work.” Because she expressed before that she does not have planning time, the cut in funding was a huge hindrance to her ability to teach her classes well. Throughout the district as a whole, this cut in funding has affected their mental health curriculum. She says “So in our district and I think a lot of school counselors do use Second Step, but since Second Step got so expensive. And since we all used it, Well, we’ve actually had to go into other things like what would be something else.” Unfortunately, in this school district they had to change what had been working for them to teach mental health due to cuts in funding.

Although there is a free resource in Maine for teaching SEL in the classroom that the state department implemented, Tina did not mention this as a resource she would use. Additionally, Kate discussed the Ramp curriculum saying that “it's a great first step in my opinion. That being said. Some of the example lessons are…they're just kind of like hard to put put in place.” and that “if you come from a district that can afford a curriculum, I think most counselors would choose the one that they could afford.” This is an example of the way the state legislature is passing laws and building curriculum about mental health education but in these cases, it is not necessarily implemented successfully into the classroom.

In her interview Danielle pointed to the duality of a state mandating an important law but struggling on the implementation side because teachers don’t understand how to implement it correctly or how to fund it. In her interview she described how when New York passed the mandate for teaching mental health literacy in K-12, there was a struggle in communication with teachers. She said “You know, you've got this mandate. And she [a teacher] was like, It's awful. She said literally no teachers feel confident in teaching mental health literacy. Yeah, and there

are no resources." Danielle recognizes that New York is asking a lot of schools and teachers who do not necessarily have the correct training and resources to be able to implement what the mandate asks them to. She states "When it comes to mental health literacy, most administrators will admit that they're completely and utterly lost. And that they want guidance." Despite the fact that they may want support in this, Danielle expresses that "it's so hard to go to school and try and help them understand both how to fund it, and that they need it."

Hannah similarly expressed that California struggles with the duality of legislation being passed and schools not being able to implement it because of overwhelm. Hannah discussed in her interview that on the implementation side she noticed that "it is not the best time to implement new programs, that everyone is really stressed." When trying to implement new curriculum and support for California schools, she had to try a different approach. She explained, "So with the good intent of trying to support them, we also don't want to overload them. And there are a lot of things I can do and knowing that, you can't do it right now. Right?" So instead of requiring schools to implement new curriculum, she says "I think that just the knowledge that a school is overwhelmed. I think it's important to say, well, we can put a lot of training and support out there, but it's up to you [the school] to decide when to take it and how to take it and how much you take it." This approach is necessary for the schools she works with in California because the overwhelm she noticed is so prevalent right now.

Kate adds an important perspective to this duality story by noting the struggle of having enough resources in schools to implement new legislation well. She talked about students beginning 1 on 1 counseling in school or trying to allow students to have telehealth therapy visits while at school. Unfortunately, she said they "don't have the manpower" for this and that "the two systems don't work well together." She continued to describe how this could be solved

saying, “A better way to deal with that would be to allow mental health counselors to come into schools” The problem that comes with implementing this though she says is that “Now that still is like tapping school resources, right, because there's not enough space for that to happen, it would be very difficult.” Ideally, students in need would be able to see the social worker they do have at their school, Kate says “So I guess that's what I think is the perfect answer, but, you know, she's booked up, right? I have her full.” Due to not having space at the school and tapping too many school resources, this Maine teacher struggles to implement new reforms.

A clear disconnect is seen between policymakers and instructors as Kate expresses, she doesn’t have the manpower or money for more mental health support for students, while Becca describes that there currently is a lot of funding for school districts to hire more mental health support and new curriculum. In her interview, Becca described the Student Success Act which “has the bucket of dollars that is attached to that is called the student investment account. And schools can hire their own mental health people. They can use those dollars, to like help improve buildings, buy a curriculum for social, emotional, mental health. The big thing is, and a lot of schools want to hire like mental health providers or like that, bachelors level folks to do skills training just yet, you know, teaching health classes to teach mental health, you know, prevention, promotion and things.” According to this information, the student success act acknowledges and gives money towards exactly what Kate’s school needs. Additionally, it states that there is specific money for schools to use to buy social emotional learning curriculum, which is exactly what Tina expressed she was struggling with at her school. Neither of these teachers mentioned being able to use funding from new legislation to implement new curriculum or hire new staff, in fact they expressed that lack of staff and lack of money for curriculum were some of their biggest struggles in supporting students' mental health.

Discussion and Conclusion

Practitioners, policymakers, and future researchers can use the findings from my study to improve the way they implement comprehensive mental health education for middle schoolers who not only need tier three crisis intervention, but also ongoing tier one preventative support. My research found an important disconnect between policymakers implementing new mandates and funding towards mental health education and support in schools, and then classrooms struggling to find the money, implement the curriculum, and find the time and resources to implement new mandates. I found that at the same time as students are struggling the most and need the most support in regard to mental health, teachers and schools are the most overwhelmed and unable to implement support and curriculum due to the COVID-19 pandemic. Students are extremely curious about how to help friends or peers struggling with mental health as well as ways to improve their own mental health, but at the same time many do not feel comfortable reaching out for help about mental health related issues. Curriculum itself being used in the classroom comes in many different forms that carry important implications regarding teaching students that mental illness is something scary they need to learn how to control or as something they can use their strengths to foster a good relationship with.

From my research, it is essential for policymakers to understand the importance of having a shared common language around mental health, that many schools do not know how to find or use funding available to them, and that staff struggle to implement curriculum that they themselves do not know how to practice. One of my findings mirrors Hill's prior literature on the lack of common language in curriculum reform. My research contributes an important perspective to this literature, where in the case of mental health education within curriculum reform, language matters even more so due to its ability to reduce or reproduce stigma

surrounding mental health. Mental health education was conceptualized in many different ways by schools themselves and policymakers therefore creating varying interpretations of policy recently passed regarding mental health education in schools. Additionally, teachers and curriculum developers use different phrasing and words to teach and implement new mandates and policies which span deficit and asset-based approaches that may have important effects on students' learning. Mental health is a highly stigmatized topic and therefore policymakers need to be cognizant about creating a common language around what mental health and mental health education means and looks like in the classroom. Another way my research builds on prior literature about shared language is my findings regarding the lack of common understanding of policymakers about what teacher implementers have the capacity for in the classroom. When passing policy which mandates a certain number of hours of mental health literacy or mental health education for every grade, it is important for policymakers to understand the extent to which teachers who are implementing this curriculum have the time, resources, and mental health literacy knowledge themselves to actually implement the policy well. Understanding the current disconnect between policy and classroom implementation can inform policymakers on the necessity of supporting schools in this implementation process as well as passing policy that matches the capabilities of schools and their teachers. With a shared understanding between policymakers and implementation instructors of the capacity level of schools and teachers, policymakers can pass policies that have the potential to be implemented more successfully in the classroom.

Classroom teachers and instructors can take away from my research that middle school students want to learn about mental health and mental illness in school, schools should start teaching about mental health in developmentally appropriate ways starting as young as possible,

and the whole school approach to mental health education may be an ideal curriculum. From the student pre and post survey, there were some significant learning outcomes of particular concepts such as a jump from 65% of students to 91% of students who agreed or strongly agreed that they could describe the difference between stress and anxiety after the class. For other statements, such as feeling comfortable reaching out for help about mental health, the numbers did not change from pre to post survey. Additionally, when the survey asked if students had learned anything about mental health in school before in the pre survey, 23% of the students' responses expressed that they had learned about mental health before, but they forgot what they learned, and 30% of students expressed that they hadn't learned anything before. This shows a need for exploring how well students retain the information they are being taught in different formats of classes. Another important finding for teachers and instructors to note in regard to student retention is in the student surveys, most students expressed asset-based ways of conceptualizing the definition of mental health before the class, yet the more negative and fear-based instruction seemed to stick with the students after taking the class. This finding is important for teachers and instructors to take into account when teaching about mental health in order to encourage a balance of instruction regarding symptoms and severity of mental illness as well as ways to foster mental wellness, relationships with trusted adults, and treatment options. The class I observed was a one-time 45-minute class slotted into health class, and most participants expressed that this type of mental health education is not the goal, but rather a whole school approach of integrating mental health education into multiple classes and having ongoing discussions about mental health in school, that may be able to address the deeper-rooted mindsets of middle school students not feeling comfortable reaching out for help for mental health issues.

Limitations & Future Research

Many obstacles arose throughout the execution of the research study due to the COVID pandemic. Due to the stress on schools during the pandemic, the teacher shortage, as well as the omicron surge in the middle of the research, aspects of the study were changed. Two other schools were scheduled to be observed during January which were canceled last minute due to the Omicron surge and immediate school closures. These are unprecedented times and last-minute changes cannot be predicted which can change the research at any time. Although flexibility was required for the sudden changes within the study, valid and important research was still performed within the circumstances. Due to the cancellations of the observations, the sample size was a lot smaller than expected and is therefore not a fully representative sample. I only observed and surveyed one class that was a private, k-8 school, therefore I was not able to see how mental health education is received and taught in the public-school setting or how mental health education affects students over a longer period of classes. Future research is needed with a bigger sample size of more middle school students at different schools to further understand the impact and importance of the mental health curriculum for middle schoolers. Other researchers should examine how mental health education affects student's lives when done through the whole school approach framework in comparison to time slotted classes. Additionally, future research should study the effects on students' mental health of teaching mental health in deficit versus asset-based approaches, which I did not have the capacity to do in a one-year study.

Children's mental health has been declared a state of emergency in the United States right now and legislation and policymakers are currently allocating funds and creating landmark

legislation to combat this issue. If policymakers, curriculum developers, instructors, and students all put their voices together as I did in this paper, a clear story can be seen as to how to build a more meaningful and comprehensive curriculum for students. As a system, we need to do better at listening to the voices of multiple different perspectives and be in conversation with people in different fields in order to fully understand what will work best from policy level down to the classroom.

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