International Social Science Review

Volume 93 | Issue 2 Article 1

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Recommended Citation
Meier, Mary Beth () "An Analysis of Adolescent Mental Health According to the Social Work Competencies Identified in the Council on Social Work Education," *International Social Science Review*: Vol. 93 : Iss. 2 , Article 1.
Available at: https://digitalcommons.northgeorgia.edu/issr/vol93/iss2/1

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Cover Page Footnote
Mary Elizabeth Meier is a graduate student studying for her Master of Social Work at the University of Houston.

This article is available in International Social Science Review: https://digitalcommons.northgeorgia.edu/issr/vol93/iss2/1

An Analysis of Adolescent Mental Health According to the Social Work Competencies Identified in the Council on Social Work Education

Mental health affects all adolescents through normal developmental or chronic life stressors, and yet, the United States fails to address emotional well-being until it manifests into a diagnosable mental health disorder that interferes with daily life activities and later success in adulthood. The alarming rate at which mental health disorders emerge, coupled with low adolescent engagement in mental health services, affirms the obligation by professionals and students in the social science field to analyze adolescent mental health using non-traditional methods. Critical analysis of existing adolescent mental health research by applying the social work competencies identified by the Council on Social Work Education (CSWE) provides an innovative framework to comprehensively assess and intervene in adolescent mental health.

Main themes from the social work practice competencies include the 1) Problem Statement, 2) Human Behavior and the Social Environment, 3) Social Work Theory and Practice, 4) Social Welfare Policy and Services, 5) Diversity, 6) Values and Ethics, 7) Social and Economic Justice, and 8) Research. Critical analysis of adolescent mental health by applying the social work competencies uncovers an urgent need to investigate the use of curriculum-based mental health interventions in the United States public school system. Following this critical analysis, a proposed research design outlines further action to be taken by professionals and students in the social science field who intend to improve adolescent mental health.

Problem Statement

Going beyond the mere absence of a disorder, the World Health Organization defines mental health as “a state of well-being in which the individual realizes his or her own abilities,

can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community."[1] Currently, research indicates that one in five youth in the United States will suffer from a mental health disorder, with 50 percent of adult disorders emerging before age fourteen and 70 percent before age eighteen.[2] As adolescents transition from childhood to adulthood, they often experience normal developmental stressors or chronic life stressors that have the potential to negatively affect their emotional well-being and later prosperity in adulthood. Be that as it may, research estimates that seventy percent of youth who have a mental health need do not access mental health services.[3] The alarming rate at which mental health disorders emerge, coupled with the lack of accessing mental health services, affirms society's obligation to equip adolescents with necessary knowledge, skills, and resources.

Human Behavior and the Social Environment

The most common barriers that prevent adolescents from accessing help are the high levels of stigma associated with mental health and seeking help and low levels of mental health literacy about disorders and treatment.[4] These two factors also contribute to the premature termination of mental health treatment for the thirty percent of adolescents who do seek help.[5] The theory of social stigma best explains the high levels of stigma associated with mental health and seeking help and the theory of cognitive development best explains the low levels of mental health literacy about disorders and treatment.

Erving Goffman's theory of social stigma defines stigma as a mark of disgrace attached to certain characteristics or behaviors that society labels as undesirable.[6] Internalized as early as three years old, stigma solidifies by adulthood as adolescents acquire negative attitudes and engage in social distancing from peers with mental health disorders.[7]

Stigma emerges from the interaction between "normal" adolescents and "abnormal" adolescents through the four social-cognitive processes of cues, stereotypes, prejudice, and discrimination.[8] Society identifies characteristics associated with mental health disorders, such as physical appearance, impaired social skills, or psychiatric symptoms.[9] These cues reinforce the false belief that these adolescents are "abnormal" and adopt mental health stereotypes that view adolescents as weak, incompetent, or dangerous.[10] A gap develops between adolescents' virtual social identity and actual social identity because society views these adolescents as tainted and discounted, rather than as whole and intact.[11] The adolescents' virtual social identity, or their assumed characteristics, builds on these stereotypes and may bear little resemblance to their actual social identity, or their actual characteristics.[12] With stereotypes informing adolescents' virtual social identity, society develops prejudices that lead to discriminatory behaviors as adolescents with mental health disorders interact with their social environment.

Through socialization with this detrimental environment, adolescents learn about the devaluing and discriminating perceptions of mental health. Adolescents with diagnosed mental health disorders face discredited stigma when society recognizes differences that set them apart from "normal" adolescents.[13] As a result, adolescents with diagnosed mental health disorders internalize the stigma into feelings of shame, discouragement, anger, hurt, or low self-esteem.[14] Adolescents without a diagnosed mental health disorder face discreditable stigma when society neither knows nor perceives these differences.[15] Adolescents internalize the stigma into feelings of secrecy, anxiety, disloyalty, and dishonesty as they maintain a facade of normalcy.[16] Subsequently, adolescents without a diagnosed mental health disorder engage in activities that foster acceptance among peers and the larger society.

Adolescents encountering discreditable stigma employ impression management to guard against discriminatory attitudes and behaviors. Through impression management, adolescents intentionally present themselves in a way that will be accepted by peers and the larger society.[17] Preoccupied with social image and peer acceptance, adolescents without a diagnosed mental health disorder attempt to conceal the discreditable characteristics by engaging in activities that prevent its discovery.[18] Adolescents avoid help seeking to prevent labels, discrimination, and negative emotions associated with mental health.[19] Social desirability outweighs participation in mental health services that would otherwise ameliorate the symptoms.[20]

Goffman's theory of social stigma illustrates adolescents' interaction with the self and social environment, but diversity among the population and setting influences the credibility of this theory's application. Individual factors such as age, gender, social class, race, and ethnicity affect adolescents' projection of meaning to deviant attitudes and behaviors.[21] Definitions of psychopathology vary across cultures, contexts, and time because the current environment socially constructs meaning to roles, rules, and expectations.[22] With the social environment continually evolving, the understanding of the dynamics of mental health stigma and its effect on adolescents accessing mental health services through the theory of social stigma does not remain constant, but instead depends on the meaning that the current physical and social environment attributes to mental health.

Jean Piaget's theory of cognitive development explains the dynamics of mental health literacy and its effect on adolescents accessing mental health services. The theory of cognitive development describes the intellectual abilities, mental activities, and behaviors through which adolescents attain and construct knowledge.[23] Currently, adolescents' existing cognitive structures prevent them from recognizing disorders and obtaining mental health information,

knowing accurate risk factors, causes, self-treatments, and professional help, and developing attitudes that promote recognition and appropriate help seeking.[24] Adolescents with and without diagnosed mental health disorders rely on erroneous knowledge to guide interactions with their social environment.

Established during infancy and modified throughout life, schemata are cognitive structures that identify, process, and organize adolescents' environment by grouping analogous events, feelings, or images.[25] Schemata help preschool children begin to identify mental health problems in their peers.[26] While adjustments to this schema by adolescence generate an increased ability to identify a wider range of disorders, adolescents' mental health recognition still proves to be low, inconsistent, and varied by disorder; one study indicates that only 42.4 percent of adolescents correctly identify depression and only 27.5 percent of adolescents correctly identify anxiety.[27] Furthermore, adolescents use their existing schemata to falsely attribute personal blame to individuals with a mental health disorder.[28] Limited and erroneous mental health knowledge prevents adolescents from correctly modifying existing schemata that would aid in the recognition of mental health disorders and acquisition of mental health information.

When encountering unknown experiences, adolescents modify existing schemata through adaptation to better interact with their social environment by either employing assimilation or accommodation. Using the process of assimilation, adolescents incorporate and interpret novel stimuli, such as new mental health information, into existing schemata.[29] In contrast, using the process of accommodation, adolescents create new or modify existing schemata to interpret novel stimuli.[30] They tend to distort novel mental health knowledge to conform to the existing schemata, rather than adjust or create new schemata.[31] Their mental health knowledge becomes inaccurate and inconsistent, such as falsely believing that social contact, exercise, relaxation,

avoidance of stressful situations, and avoidance of drugs and alcohol can prevent the development of a mental health disorder.[32] Adolescents struggle to acquire accurate mental health knowledge when this novel information differs greatly from their current understanding.

Adolescents' intelligence enables them to successfully interact with their social environment and achieve harmonious adjustment, or equilibrium, between themselves and their surroundings.[33] Acquiring mental health knowledge becomes an active process of achieving and re-achieving equilibrium through continuous interaction between adolescents and their social environment.[34] Limited and erroneous mental health knowledge prevents teens from modifying thoughts and behaviors that would make accessing mental health services become equilibrium. False beliefs that mental health should remain secretive nurture the lack of communication about mental health to and between adolescents.[35] This poor mental health literacy correlates with low seeking help and service use, as well as high stigma and discriminatory behaviors.[36] Young people's existing schemata and equilibrium hinders access to mental health services, but these obstacles are not proportionate and universal across all settings.

Piaget's theory of cognitive development illustrates adolescents' interaction with the self and social environment, but diversity among the population and setting influences the credibility of this theory's application. Although cognitive structures are innate, cognitive development largely depends on adolescents' interaction with their social environment of family, peers, schools, and institutions.[37] Larger cultural, geographic, and socioeconomic differences between environments also affect the amount of and accuracy of adolescents' mental health knowledge. This diversity between environments affects the way through which adolescents interpret the world and construct their cognitive structures. With the social environment continually evolving, the understanding of the dynamics of mental health literacy and its effect on adolescents

accessing mental health services through the theory of cognitive development does not remain constant, but instead depends on the availability of accurate mental health knowledge in the social environment.

Social Work Theory and Practice

The United States can provide adolescents with a foundation for healthy emotional functioning by implementing interventions that promote a positive school climate. In the form of school-based or curriculum-based programs, universal mental health interventions promote the development of skills and strategies needed to achieve or maintain healthy emotional functioning as well as prevent stigmatization that results from targeted interventions.[38] Schools must recognize, mobilize, and enhance their inherent assets to create mutually beneficial relationships between adolescents and their communities.

Universal mental health interventions administered in schools have the potential to reduce mental health stigma and improve mental health literacy by targeting adolescents who do not receive mental health services. Community leaders, such as those in the World Health Organization, identify schools as a natural environment to reach diverse risk-level adolescents because adolescents spend most of their waking day in classrooms with specially trained multidisciplinary staff.[39] Mental health providers recognize schools as the third most likely location where adolescents learn about mental health, following peers and family.[40] Schools already provide a critical context for cognitive, socioemotional, and behavioral development and by building upon this existing infrastructure, schools can foster a healthy environment that promotes positive mental health, builds resilience, and provides resources to buffer negative stressors.[41] Be that as it may, middle schools and high schools face barriers that prevent engagement in effective universal mental health interventions.

Middle schools and high schools experience challenges accessing and implementing evidence-based universal mental health interventions. In the United States, adolescent interventions designed to reduce mental health stigma and improve mental health literacy remain limited. Studies involving youth-led approaches, such as Let's Erase the Stigma, and knowledge-contact approaches, such as In Our Voice, provide promising methods of school-based intervention, but most lack evidence to support implementation across diverse school settings.[42] Likewise, universal mental health interventions for children cannot generalize to adolescents due to developmental differences between age groups and differences between school settings.[43] International research empirically supports universal mental health interventions, but their replication and generalizability in United States schools remain unclear.[44] Be that as it may, studies involving curriculum-based approaches, such as Headstrong, provide promising methods of intervention that American social workers must acknowledge and explore.[45] Schools have an obligation to investigate innovative interventions and support research that aim to reduce mental health stigma and improve mental health literacy in adolescents.

Curriculum-based mental health interventions administered in schools have the potential to reduce mental health stigma and improve mental health literacy by integrating mental health goals and educational services. Federal sources, such as the U.S. Surgeon General, the President's New Freedom Commission on Mental Health, and the No Child Left Behind Act, support the closer alignment of education and mental health in the classroom as a method to reach diverse risk-level adolescents and prevent stigmatization that results from targeted intervention.[46] Furthermore, schools' inherent access to social workers through existing mental health services aid in fostering a safe and efficient school environment. Schools that establish

curriculum-based mental health interventions recognize their responsibility and unique capability to promote adolescent health through an intrapersonal, interpersonal, and environmental method.

Middle schools and high schools that utilize curriculum-based mental health interventions understand the barriers that prevent healthy emotional functioning and recognize the needs that must be met in order to improve adolescent mental health. Headstrong, a curriculum-based mental health intervention implemented in Australia, identifies poor mental health knowledge and mental health stigma as potent barriers preventing adolescents from recognizing problematic functioning, disclosing distress, and accessing care.[47] Headstrong exemplifies an effective model of intervention that overcomes these barriers by improving mental health literacy and reducing mental health stigma among adolescents.[48] Curriculum-based mental health interventions recognize that the problem manifests in the adolescents' cognitions and affects, the interactions between adolescents and their peers, and the entire school environment. Therefore, social workers must implement these interventions to engage adolescents in activities that target and restructure intrapersonal, interpersonal, and environmental factors that inhibit positive mental health.

School curriculum incorporates diverse activities that optimally promote skills, strategies, and resources needed to achieve or maintain healthy emotional functioning. Headstrong is comprised of five diverse components, including Mood and Mental Well Being, the Low Down on Mood Disorders, Reaching Out — Helping Others, Helping Yourself, and Making a Difference, that build upon assumptions about the problem's dynamics.[49] Curriculum-based mental health interventions assume that the earlier adolescents recognize and address mental health difficulties, the less likely adolescents will experience impaired functioning.[50] For example, the Mood and Mental Well Being component introduces adolescents to concepts of

mental health, values, perceptions, and stigma that restructure faulty cognitions contributing to dysfunctional belief systems about mental health.[51] Curriculum-based mental health interventions also assume that explicitly teaching adolescents practical help-seeking strategies eliminates barriers preventing access to mental health care.[52] As seen in the Helping Yourself component, classrooms provide adolescents with safe opportunities to experiment with stigma reducing and help-seeking behaviors that peers might otherwise reject in a different setting.[53] Lastly, curriculum-based mental health interventions assumes that engaging in mental health awareness action empowers adolescents to modify their psychosocial and physical environment in ways that reduce mental health stigma and enhance help-seeking behaviors.[54] Through the Making a Difference component, adolescents actively propose, develop, and implement local actions to raise awareness and correct faulty mental health beliefs.[55] Strengthening the mental health functioning of all adolescents provides an opportunity for adolescents to build mutually beneficial relationships with their peers, schools, and wider communities.

While middle schools and high schools that utilize curriculum-based mental health interventions promote healthy emotional functioning of adolescents, implementation requires intensive and collaborative effort from the multidisciplinary school staff as well as the acquisition of additional resources. Curriculum-based mental health interventions require already overburdened teachers, school social workers, and administrative staff to closer align existing educational services with new mental health goals.[56] Although Headstrong only utilizes ten classroom hours over a span of five to eight weeks, implementation requires teachers to revise existing curriculums and school social workers to divert attention away from adolescents with the most mental health needs.[57] Headstrong's implementation in Australian schools require teachers to participate in an interactive one day workshop that informs staff about this curriculum

resource, provides ways to support students, and increases awareness of available mental health resources.[58] School social workers can utilize this opportunity to provide mental health training and expertise to the school staff. Limited resources and opportunities, however, may result in the failure to develop staff support, understanding, and skills, which presents a major barrier to successfully implementing curriculum-based mental health interventions.[59] Building upon schools' existing infrastructure requires additional effort and resources from school social workers, but this optimal position in altering adolescent behavior and interpersonal relationships has the potential to improve access to mental health care.

Curriculum-based mental health interventions provide promising results that encourage schools to integrate mental health goals and educational services as a means to reduce mental health stigma and improve mental health literacy. A study involving Headstrong indicates that this curriculum-based mental health intervention effectively improves mental health literacy among adolescents.[60] Be that as it may, mental health knowledge declines over time and requires supplemental teaching to retain gains.[61] Mental health and anti-stigma interventions have greater and longer term impacts when integrated into the curriculum rather than in brief or isolated workshops.[62] Implementation of the Headstrong curriculum reduces stigma around depression, which reiterates positive associations between education and stigma reduction in adolescents.[63] Integrating mental health goals and educational services lengthens the duration of the mental health intervention and sustains the impact of improved mental health literacy and reduced mental health stigma in order to change adolescents' attitudes toward help-seeking.

Curriculum-based mental health interventions administered in schools have the potential to reduce mental health stigma and improve mental health literacy by implementing organizational changes that create individual changes in adolescents' beliefs and behaviors. This

model of intervention engages all adolescents, social workers, teachers, and administrative staff in activities that target and restructure intrapersonal, interpersonal, and environmental factors that inhibit positive mental health. Diversity between school environments, access to resources, and adolescent mental health needs varies the role of social workers in providing universal mental health interventions. With an obligation to provide adolescents a foundation for healthy emotional functioning, social workers and school leaders must create mutually beneficial relationships between adolescents and their environment by integrating mental health interventions into the curriculum.

Social Welfare Policy and Services

Contemporary American social welfare policy and services retroactively address adolescent mental health, rather than proactively prevent the emergence of mental health disorders. The Chambers Model illustrates the proposed policy of Mental Health in Schools Act of 2015 as it addresses this social problem.[64] Through this policy's funding, the Safe Schools and Healthy Students Initiative provides comprehensive mental health services to all adolescents in schools.

A comprehensive understanding requires an analysis of the social problem's definition, causes and consequences, ideology, and benefiters and losers.[65] Awareness of these four elements generates stronger policy solutions that foster a foundation for healthy emotional functioning.

Erroneous assumptions regarding mental health impact current social welfare policies' creation and implementation of programs. The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to

his or her own community." Community leaders rely on the mental health disorder definition to generate attention, implement policies, and construct programs because this definition provides specific and measurable indicators.[66] Society recognizes the importance of mental health, but by failing to provide quantitative markers, universal prevention policies, and programs fail to generate adequate support by key stakeholders.

Adolescent mental health problems emerge when society neglects to address factors that impair adolescent emotional well-being. Causal chains explain the influence that these factors have on the consequences of overlooked emotional well-being.[67] Adolescents experience normal developmental stressors or chronic life stressors as they transition from childhood to adulthood. Certain barriers, such as high mental health stigma and low mental health literary, prevent adolescents from accessing mental health care.[68] Lasting negative consequences emerge for adolescents as they transition to adulthood when current policies and programs fail to address low mental health literary and high mental health stigma.

Society recognizes that adolescents should realize their ability to work productively, cope with normal life stressors, and make a meaningful contribution to their community. By building upon this value statement, an ideology provides relevant information about policy changes and program interventions that will achieve this ideal.[69] Community leaders can achieve this ideal emotional functioning by enhancing existing school infrastructures to foster a healthy environment through programs that destigmatize mental health, improve mental health knowledge, enhance help-seeking efficacy, and connect adolescents to mental health care.

Adolescents with a diagnosed mental health disorder benefit from existing social welfare policies and programs because this vulnerable population receives the attention, funding, and programs. Through policy funding, most schools provide mental health services for adolescents

with a diagnosed mental health disorder, but fail to promote the emotional well-being of all students. This intervention method incurs costs that revolve around the loss of potential gains for adolescents experiencing temporary mental health difficulties, such as to their relationships, academic performance, and future trajectory.[70] Without obvious measurable indicators of these losses, adolescents experiencing temporary mental health difficulties become further disadvantaged.

Social problem awareness generates stronger policy solutions that foster a foundation for healthy adolescent emotional functioning, such as the introduction of the Mental Health in Schools Act of 2015. Proposed to amend the Public Health Service Act, the Mental Health in Schools Act of 2015 revises and extends projects relating to children and violence to provide access to comprehensive school-based mental health programs.[71] Analysis of six elements, including: mission, goals, and objectives, forms of benefits or services delivered, entitlement or eligibility rules, administrative or organizational structure for service delivery, financing method, and interactions among the foregoing elements, help understand the fit between the social problem and proposed policy solution.[72]

The Mental Health in Schools Act of 2015 promotes the healthy development of adolescents within the United States. This proposed policy aims to support local communities and schools apply a public health approach to mental health services.[73] Implementation of this public health approach will provide adolescents with comprehensive age, linguistic, and culturally appropriate services that are trauma-informed.[74] By investing in comprehensive mental health services, the Mental Health in Schools Act of 2015 presents schools with opportunities to foster a healthy foundation for adolescent emotional functioning.

By using a subsidy approach, the Mental Health in Schools Act indirectly administers expert mental health services for adolescents. This proposed policy provides grant funding for local community partnerships to deliver expert services, rather than directly providing benefits or services to this vulnerable population.[75] As the intended beneficiaries, adolescents indirectly and substantially benefit from this grant funding as over a period of five years, community partnerships will utilize credentialed professionals to deliver expert mental health services.[76] Although removed from the financial transaction, adolescents benefit from this subsidy approach.

Eligibility rules assist national leaders distribute limited funding to local community partnerships who demonstrate the most efficient use of these resources. Through administrative discretion, the national leaders identified in the Mental Health in Schools Act of 2015 administer benefits to the proposed programs that best suit the needs of the local communities.[77] An eligible grantee applicant must be a partnership between a local education agency and at least one community agency involved in mental health.[78] National leaders will distribute the grants to partnerships equitably between urban and rural areas.[79] Limited funding availability does not entitle all eligible community partnerships to opportunities that increase adolescent access to mental health care.

The Mental Health in Schools Act of 2015 proposes a federated service-delivery system to improve adolescent mental health care access within schools. This proposed policy creates federations between local schools systems and community agencies to efficiently maximize resources that coordinate mental health services.[80] This partnership administers comprehensive school-based mental health services and supports, staff development for school and community personnel, and training for children with mental health disorders and their families.[81] This

proposed policy relies on the local communities' collaborative efforts to efficiently use resources to improve mental health.

Through taxes, the federal government raises revenue to pay for expenditures appropriated by Congress. Over a period of five years, the Mental Health in Schools Act of 2015 will provide grant funding to a community partnership in an amount no greater than 1million dollars for each fiscal years 2016 through 2020.[82] This proposed policy will authorize appropriations to carry out this section, 200 million dollars for each of the fiscal years of 2016 to 2020.[83] Although directly removed from these financial transactions, adolescents benefit from the financing method through the delivered expert mental health services.

Collaborative efforts from different levels of government improve adolescent mental health care access within local schools. Adolescent mental health care benefits and services administered and financed by the federal government also effect the local levels of government.[84] Unfortunately, limited grant availability does not allow all eligible community partnerships with funds to implement their programs. While improving the well-being of targeted adolescent populations, the policy fails to create lasting change for all American adolescents. Mental health program funding addresses this social problem, but policies proposing systems level change may more efficiently improve mental health literacy and reduce mental health stigma.

The Safe Schools and Healthy Students Initiative responds to the mental, emotional, and behavioral health of students by implementing programs that improve their social functioning. By integrating local community systems, this grant program promotes mental health, enhances academic achievement, prevents violence and substance abuse, and creates a safe school environment.[85] Rather than solely addressing adolescent emotional well-being, this program comprehensively addresses factors that accompany mental health difficulties. With 2 billion

dollars in funding under the Public Health Service Act, the Safe Schools and Healthy Students Initiative provides services to more than 13 billion youth in 365 local communities across 49 states.[86] The success and effectiveness of each local program relies on the community partnership's ability to sustain the program beyond federal funding.

The success and effectiveness of the Safe Schools and Healthy Students grant program relies on its fit between the social problem, policy, and program. A five year study indicates that this program adequately and efficiently achieved its goal of significantly increasing the number of students receiving school-based mental health services and community-based services.[87] Research indicates a 263 percent increase in the number of students receiving school-based mental health services and a 519 percent increase in students receiving community-based services.[88] Implementing the Mental Health in Schools Act of 2015 would further support this goal by increasing funding as well as revising and expanding the scope of the Safe Schools and Healthy Students program to provide more comprehensive mental health services and supports.[89] This proposed policy would help local communities continue to meet adolescents' mental health needs.

The Safe Schools and Healthy Students Initiative funds local community programs that address diverse factors contributing to all adolescents' emotional well-being. Through equity, this grant program similarly treats adolescents with and without a diagnosed mental health disorder.[90] Comprehensive school-based mental health services provide proportional equity for adolescents to receive mental health services in proportion to their mental health need, while also providing absolute equity for all adolescents to receive mental health services.[91] These school-based mental health services provide additional mental health care access for adolescents with a diagnosed mental health disorder, but acquisition of these services may further stigmatize these

adolescents from the general population. The introduction of mental health promotion, prevention, and early intervention provides opportunities to improve all adolescents' mental health literacy and decrease mental health stigma that arise with help seeking behavior.

The Mental Health in Schools Act of 2015 provides the community partnerships that are funded in the Safe Schools and Healthy Students Initiative with the self-determination to construct their programs. This proposed policy gives entities consumer sovereignty through which they have the freedom to best address the individualized needs of their local communities.[92] The policy outlines detailed expectations for the delivery of services, but the national leaders allow the programs to address diverse factors contributing to all adolescents' emotional well-being. Types of successful mental health programs and services include: screening and assessment, school-based mental health services, child and family support services, and referral and follow-up in and outside school.[93] By involving these components, community leaders improve their success and effectiveness in addressing adolescent mental health needs.

The eligibility criteria for the partnerships participating in the Safe Schools and Healthy Students grant program fosters alliances between local school systems and community agencies. Research indicates that participating schools began to work more closely with community agencies, with more than 70 percent of grantees fielding service delivery teams from diverse systems, 60 percent of grantees establishing a system to coordinate mental health services across agencies, and 60 percent of grantees establishing a cross-agency treatment-monitoring information system.[94] Limited available funding compels national leaders to choose between meeting some of the mental health needs of all adolescents who may experience mental health

difficulties and adequately meeting the mental health needs of adolescents with diagnosed mental health disorder.

Diversity

Significant differences among the population characteristics contribute to the problem's complexity. Mental health problems greatly vary in type and severity, such that 20 percent of youth experience mild impairment while five to nine percent experience serious impairment.[95] Manifestation of mental health problems differ with gender, such that emotional problems typically emerge in females and disruptive behaviors typically emerge in males.[96] Increased risk for mental health problems exist among adolescents of non-white ethnic minorities and low socioeconomic status.[97] Diverse social environments cultivated by the family, school, and community provide adolescents with various protective and risk factors.[98] Individual differences among the adolescent population impacts adolescents' interactions with mental health services.

Personal experiences with their social environment impact adolescents' access to mental health services. Specific symptoms, current distress, adolescent or family preferences, past treatment experiences, provider availability, and economic considerations influence referrals by mental health service providers.[99] Disparity in mental health service access exists across race, such that African American, Asian, and Hispanic adolescents are less likely to access services than white adolescents.[100] Disparity in help seeking behaviors exists across gender, such that females seek professional help more than males.[101] With variation in access to mental health services, unrecognized and untreated mental health problems lead to a variety of negative short-term and long-term outcomes, such as poor educational and vocational achievement, problematic social and personal functioning, and reduced life expectancy.[102] Individual differences among adolescents influence mental health outcomes and success in adulthood.

Significant differences among the population characteristics contribute to the proposed solution. A myriad of intervention approaches address adolescent mental health and yet, adolescent involvement depends on each specific program.[103] School-based mental health interventions either target adolescents who require specific support or target all adolescents regardless of perceived need.[104] Implementation of successful school-based interventions differ due to the variety of available human resources and infrastructures across diverse geographic, sociocultural, and economic environments.[105] Intervention frameworks that acknowledge the multiple adolescent social contexts prevent harmful behaviors and support a foundation for emotional well-being.[106] Successful adolescent mental health interventions incorporate adolescents' diverse social environments.

Presenting a solution that successfully addresses adolescent access to mental health services requires diverse and rigorous research. Existing adolescent mental health research focuses on specific diagnoses, symptoms, and levels of functional impairment rather than globally regarding mental health disorders.[107] Generalizability of study findings limit to specific geographic areas with similar ethnicities and school-based programs.[108] Due to their age, adolescents are already a commonly overlooked population and coupled with undiagnosed and untreated mental health problems, adolescents become even more marginalized. A plethora of diverse research is needed to provide this at-risk population with necessary knowledge, skills, and resources for healthy emotional well-being.

Values and Ethics

Particular attention to values and ethical principles enhances the understanding of adolescent mental health as well as contributes to the ethical decision-making that informs social welfare policies and programs. The values of dignity and worth of a person and social justice

contribute to creating a foundation for healthy emotional functioning. Professionals and students in the social science field may promote the dignity and worth of adolescents by enhancing their capacity and opportunity to improve their mental health.[109] Promotion of self-determination and individual empowerment among adolescents generates positive mental health outcomes and adolescent self-sufficiency.[110] Professionals and students in the social science field may promote social justice by pursing social change regarding mental health and emotional well-being with and on behalf of adolescents, such as equal access to mental health information, services, and resources through curriculum-based mental health interventions.[111] Values and ethical principles guide individual and system-level changes that improve adolescent emotional well-being.

Social and Economic Justice

The social justice issue of ableism must be confronted when distributing mental health resources with fairness, equity, and equality to adolescents. Able-bodied individuals view adolescents with and without a diagnosed mental health disorder as unhealthy, unproductive, and incapable.[112] Widespread discrimination against disability socially excludes these adolescents from actively participating in society.[113] Exemplified in the exchange theory, distributive justice attempts to address this injustice by distributing resources to “deserving” adolescents with diagnosed mental health disorders while depriving “undeserving” adolescents with temporary mental health difficulties.[114] A majority of United States policies and programs fail to create a foundation for healthy emotional functioning for all adolescents by only targeting and providing resources to adolescents with diagnosed mental health disorders.

Research

Qualitative adolescent mental health research examines perceptions regarding adolescent mental health. Specifically, studies intend to understand adolescents’ attitudes and beliefs, such

as: being treated differently due to a mental health difficulty, recognizing stigma as a barrier to accessing school-based mental health services, and knowledge of available school-based mental health resources.[115] Current research also explores mental health service providers and families' understanding of adolescent mental health and school-based mental health efforts.[116] Lastly, qualitative research intends to determine an association between mental health status and relevant variables, such as healthy behaviors.[117] Current qualitative research informs the development and evaluation of mental health interventions.

Quantitative adolescent mental health research evaluates the impact of diverse curriculum-based mental health interventions on variables, such as adolescent mental health literacy, mental health stigma, help-seeking behaviors, psychological distress, and suicidal ideation.[118] Studies also evaluate the effectiveness of school-based mental health interventions, such as In One Voice, Let's Erase the Stigma (LETS), and S.P.E.A.K., on variables such as adolescent mental health awareness, mental health attitudes, adolescent outcomes, and mental health service use.[119] Both qualitative and quantitative adolescent mental health research primarily experience sampling limitations as it draws from isolated adolescent populations; generalizability of these studies' findings require further replication with diverse populations and settings.

Future Studies: A Proposed Research Design

With research still in its beginning stages, this critical analysis of adolescent mental health according to the social work competencies identified in the Council on Social Work Education (CSWE) reveals an urgent need to evaluate the efficacy of curriculum-based mental health interventions in the United States school system. This proposed research design applies Headstrong, an Australian curriculum-based mental health intervention, to a United States high

school with the intention of evaluating the intervention's generalizability and replicability to a setting outside of Australia.

A working hypothesis for this study could be there will be a statistically significant relationship between the use of the Headstrong curriculum and mental health literacy, mental health stigma, and help-seeking behaviors, in that adolescents receiving the Headstrong curriculum will demonstrate higher mental health literacy, lower mental health stigma, and higher help-seeking behaviors when compared to adolescents who do not receive the Headstrong curriculum.

The independent variable is the Headstrong curriculum. The Headstrong curriculum provides teaching and learning activities over a period of five to eight weeks through the five components of: Mood and Mental Well Being, the Low Down on Mood Disorders, Reaching Out — Helping Others, Helping Yourself, and Making a Difference.[120] The researcher will measure the independent variable in terms of whether the sample has received the Headstrong curriculum or has not received the Headstrong curriculum.

The dependent variables are mental health literacy, mental health stigma, and help-seeking behaviors. Mental health literacy is defined as knowledge and beliefs about mental health disorders which aid in recognition, management, and prevention.[121] Adolescents will use the Depression Literacy Scale to self-report mental health literacy because this measure indicates high internal consistency in assessing knowledge and understanding of information covered by the Headstrong program.[122] Mental health stigma is defined as beliefs and attitudes about mental health and mental health disorders that lead to negative stereotyping of people and prejudice against them and their families.[123] Adolescents will use the Social Distance Scale to self-report mental health stigma because this measure demonstrates test-retest reliability and internal

consistency in assessing stigma toward individuals with mental health disorders.[124] Help-seeking behaviors are defined as intentions to seek professional help, views of this support as helpful, and willingness to disclose the presence of mental health disorders.[125] Adolescents will use the Inventory of Attitudes toward Mental Health Services to self-report help-seeking behaviors because this measure indicates strong internal consistency and convergent validity in assessing attitudes toward help-seeking.[126] The three Likert scales measuring the dependent variables provide response categories to help the researcher analyze the impact of the independent variable in a uniform manner.

The researcher will use a combination of nonprobability sampling approaches to select the study's sample. All twelfth-grade adolescents in the Houston Independent School District prove to be the population of interest in this study. Two twelfth-grade classrooms of adolescents from one Houston public high school will be the study's sample. Selection of the sample will exclude adolescents attending private schools, attending home schools, and not attending school.[127] Through convenience sampling, the researcher will select two twelfth-grade classrooms of adolescents from the Houston Independent School District for the sample based on their availability and willingness to participate.[128] To select the sample, the researcher will contact all school principals within this school district to invite study participation. Of the consenting public high schools, the researcher will contact the health teachers to ensure willing implementation of the Headstrong curriculum in their classrooms.[129] The researcher will then send a letter and consent form home to the adolescents and their parents; health classes with completed consent forms from all students become eligible for study participation.[130] Due to selection bias, the use of nonprobability sampling limits the study's generalizability, but proves to be useful in this preliminary and pilot research.

Previous research conducted with the Headstrong curriculum in Australia guides this study. The proposed study will be a quasi-experimental, pretest/posttest comparison group design.[131] As a longitudinal design, data collection will occur before the introduction of the intervention and after the completion of the intervention.[132] Researchers will select one twelfth grade classroom of adolescents to be the intervention group and another twelfth grade classroom of adolescents to be the comparison group. Researchers will select both the intervention and comparison groups from the same high school to ensure similarity between the two groups. During the baseline phase of the experiment, the health teachers in both groups will distribute a questionnaire booklet containing the Depression Literacy Scale, Social Distance Scale, and Inventory of Attitudes toward Mental Health Services for each student to complete.[133] The researchers will measure the dependent variables of mental health literacy, mental health stigma, and help-seeking behaviors before the introduction of the intervention.[134] The health teacher in the intervention group will then deliver the Headstrong curriculum over a period of five to eight weeks instead of their usual health curriculum.[135] The health teacher in the comparison group will deliver the usual health curriculum over the same period of five to eight weeks.[136] After completion of the intervention, the researchers will measure the dependent variables of mental health literacy, mental health stigma, and help-seeking behaviors for both the comparison and intervention groups using the same questionnaire booklet containing the Depression Literacy Scale, Social Distance Scale, and Inventory of Attitudes toward Mental Health Services.

The researcher will use a t-test to conduct a statistical analysis to determine the impact of the Headstrong intervention on adolescents in a United States high school. A t-test will determine whether the intervention group and the comparison group are statistically different from each other based on the dependent variables of mental health literacy, mental health stigma,

and help-seeking behaviors.[137] Conducting a t-test will produce a mean score, t-test score, and p value of these characteristics for intervention group and comparison group.[138] Specifically, the researcher will use a paired-samples t-test to compare the dependent variables between the intervention and comparison groups as well as between the pretest and posttest scores of both the intervention group and comparison group.[139] Through the statistical analysis, the researcher will determine the generalizability of the Australian curriculum-based mental health intervention, Headstrong, to a United States high school.

Conclusion

The alarming rate at which mental health disorders emerge, coupled with the low adolescent engagement in existing mental health services, affirms the obligation by professionals and students in the social science field to explore adolescent mental health using non-traditional methods. A critical analysis of existing adolescent mental health research by applying the social work competencies identified by the Council on Social Work Education (CSWE) provides an innovative framework to comprehensively assess and intervene in adolescent mental health.

Exploration of adolescent mental health according to each social work competency identifies alternative perspectives to ethically inform interventions through programs and policies. Analysis of Erving Goffman's theory of social stigma and Jean Piaget's theory of cognitive development illustrates the barriers of high mental health stigma and low mental health literacy that contribute to the low adolescent engagement in mental health services. Amending current policy, such as the Public Health Service Act, provides additional funding for comprehensive mental health programs, such as the Safe Schools and Healthy Students Initiative.

Critical analysis of adolescent mental health by applying the social work competencies uncovers an urgent need to investigate the use of curriculum-based mental health interventions,

such as Headstrong, in the United States public school system. A research design has been proposed to guide further action that must be taken by professionals and students in the social science field who intend to address adolescent mental health.

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