

IMPROVING TIER-1 MENTAL HEALTH PROGRAMS
IN SCHOOLS

Honors Thesis

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Abstract

Tier-1 mental health education programs are designed to educate young people about general mental health issues in school settings and everyday life situations. In practice, however, they have not been efficient at delivering a generalized mental health education to individual's ages 5-18 years old, because these programs do not consider socioeconomic, sociocultural, and gender differences; and these factors are important to effectively educate individuals. The thesis of the present study is that if these factors are included in the design and implementation of tier-1 programs, they will succeed in educating individuals about mental health issues. Accordingly, the present study reviewed research assessing socioeconomic, sociocultural and gender factors in determining the successful implementation of tier-1 mental educational programs. The main findings and their implications to the development and implementation of tier-1 programs are discussed in this paper.

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Introduction

Mental health education programs for young students are gaining popularity in several countries all over the world. This is due to the increased pathology of adolescent mental illness, or the increased awareness of when mental illness first starts displaying symptoms. There are three tiers of mental health intervention programs (Murphy, Abel, Hoover, Jellinek & Fazel): 1) Tier-1 programs are defined as being programs that promote mental health awareness and are implemented in “whole school populations;” 2) Tier-2 programs target specific populations of students, such as the Positive Thoughts and Actions Program for adolescents exhibiting early signs of childhood depression. (Duong, Cruz, King, Violette & McCarty 2015); And 3) Tier-3 of these programs are designed to help students who have already been diagnosed with disorders. The three tiers can all be labeled as “school mental health programs”, but each tier has different goals and is designed to target different populations. Tier-1 mental health programs have more interventions in schools (Fazel, Patel, Thomas & Tol, 2014) and generated more research than tier-2 and tier 3 programs (Macklem, 2011), for this reason the present paper focused on Tier-1 mental health programs.

The aim of this paper is to examine tier-1 mental health education programs and to suggest changes to improve their implementation and delivery. Tier-1 programs are designed to educate a general population of students and serve as preventive and educational models. Tier-2 and tier-3 programs are more complex than tier-1 programs, because tier-2 and tier-3 are only preventative models, addressing populations of students displaying signs of psychological disorders or students currently diagnosed with

psychological disorders. Tier-2 and tier-3 programs are like one another, but each of them is different from tier-1 programs, because tier-2 and tier-3 programs are designed with goals and procedures that are different from the goals and procedures of tier-1 programs.

It has been suggested that if gender differences are considered, tier-1 programs will be more effective in educating students in elementary, middle, and high school settings. For example, differences in signs and symptoms of mental illness between girls and boys are important to identify unique learning experiences, based on societal gender roles and stereotypes. In addition to gender differences, socio-economic status and socio-cultural differences are two of the key factors in determining individual differences in health issues and the development of mental illness. The design of curricula should look at the socio-economic status of the school population to ensure the greatest impact on student learning and education regarding mental health. Thus, tier-1 mental health programs should also consider cultural and societal differences to prevent problems due to standardization. Accordingly, the first goal of this paper is to examine socio-economic, socio-cultural, and gender factors determining the standardization and efficacy of current tier-1 mental health programs. The second goal is to recommend changes to these programs that will make them more effective; and the last goal is to identify gaps in the existing evidence and highlight the areas where further research is needed.

Socio-economic and socio-cultural issues

Because tier-1 programs are more accessible to students than tier-2 and tier-3 programs, tier-1 programs should be implemented properly to reduce the need for implementing tier-2 and tier-3 programs. With the proper implementation of tier-1

programs, the development of mental illness in adolescents can be prevented or flagged at earlier stages. Therefore, streamlining tier-1 programs is vital to reduce the rate of mental illness in youth and adolescents.

When implementing tier-1 programs into schools, both the socio-economic and socio-cultural climates must be considered before choosing a program. This is true for schools in different countries and schools in different regions of the same country. For example, a program that is appropriate in US public schools may not be appropriate in Chinese public schools, and a program that is appropriate in Massachusetts may not be appropriate in Texas. Even different cities within the same state may not benefit from the same program. Student's economic class and their cultural experience must be considered to decide what program will best address their needs.

Socio-economic and socio-cultural factors are the best predictors of the way in which an adolescent views mental illness. Each socio-economic class and culture will have different ways of accomplishing relatively similar goals through tier-1 mental health programs. However, each program has children beginning at different starting points depending on these two factors. Children from lower class schools will have more to learn about mental health literacy (MHL) and stigma reduction than children from middle income and higher income schools. A program must be chosen and tailored to the student demographic by considering their previous knowledge or lack thereof. Tier-1 mental health programs mainly serve to teach mental health literacy, the reduction of stigma towards mental health, and promote positive mental health behaviors. Poor MHL and stigma towards mental illness can prevent students from reaching seeking services. (Holman, 2015). It has been shown that social class is negatively correlated with help-

seeking behaviors, and cultures that value resiliency as part of an individual's identity are also negatively correlated with seeking out professional help (Holman, 2015).

A high proportion of the world's children and adolescents (80%), resides in low and middle-income countries (LMICs, [Fazel, Patel, Thomas, & Tol, 2014]). However, the majority of Tier-1, 2 and 3 mental health programs have been implemented in high income countries (HICs). This gap in implementation of tier-1 programs makes difficult to study the effectiveness of mental health programs on adolescents in LMICs. The available evidence suggests that the implementation of tier-1 programs in LMICs could yield positive results (Fazel, Patel, Thomas, & Tol, (2014). One reason for this is the lack of funding for mental health education in LMICs, where MHL and mental health promotion are not the most pressing issues.

Another factor that determines what type tier-1 program is implemented and what content it covers, is the fact that each culture has it's own definition of mental health and mental illness. According to Fazel, Hoagwood & Ford, (2014) "responsibility for the mental health of children is affected by differences in cultures, aims and social structure of health vs. school systems." An example of sociocultural differences in mental illness can be seen in the rates of social anxiety disorder (SAD), where Russia and the United States have higher rates of SAD than Asian cultures (Hofmann, Asnaani & Hinton, 2010). This has been attributed to different ways of life, like individualism vs. collectivism. Asian cultures emphasize collectivism, which prioritizes harmony within the group, the individual's gains and progress are not important. The opposite happens in Russia and the United States, which both countries emphasize individualism, causing the individual's gains and progress are very important. Thus, individualistic cultures

emphasize the individual's progress over that of the whole group. Cultural expectations determine what a mental illness is, as well as the rate in which it develops.

Due to sociocultural and socioeconomic differences, the first change that needs to be made in implementation of tier-1 programs, is to identify inexpensive, but successful programs in LMIC schools. For a program to be sustainable, it must be cost effective. Programs that employ mental health professionals, or third-party organizations, have shown to be successful but too expensive. A successful example of a sustainable and low-cost tier-1 program is the OpenMinds program developed in the UK. This program is conducted and led by university students in public UK schools. The implementation of the OpenMinds program is a promising tier-1 program that requires little to no cost and producing good results that would help combat the shortage of mental health education in UK schools (Patalay, Annis, Sharpe, Newman Clarke, Main, Ragnathan & Clarke, 2017).

Additionally, a program must be chosen to compliment the needs of the student's population and it should focus on skill's deficiencies or lack of knowledge of the group. For example, a mental health program in Chicago should focus on the dangers of gangs and gun violence on the adolescent's mental health. While this program may be appropriate in Chicago, it may not work in a city such as Boston where there is less instances of gang and gun violence. Socio-economic and socio-cultural factors are the best predictors of an adolescent's level of MHL, as well as, their level of stigma towards mental illness and likelihood of receiving mental health services.

Gender differences in mental health

It has been shown that young boys and girls are experiencing adolescence from different perspectives. Mental health problems that present themselves during adolescence are a result of “a complex interaction of genetics, social circumstances and sociocultural environmental factors, (Droogenbroeck, Spruyt & Keppens, 2018). This complex interaction must be considered when delivering mental health education to both genders. Boys and girls have very different life experiences due to societal gender roles and cultural norms that have been ingrained into their lives since birth, and these differences should be treated as such. In terms of mental health and mental illness, boys are more likely to externalize their problems while girls are more likely to internalize their problems (Wareham & Boots, 2011). Examples of how boys externalize their mental health problems include being disruptive in class, being violent or aggressive, doing poorly in school, and making impulsive decisions. Examples of how girls internalize their mental health problems include psychosomatic complaints (headaches, chest pains, and stomach aches), physical and emotional withdrawal, isolation, depressive thought processes, and suicidal ideation, (Colins, Damme, De Clerq, Grisso, Guy, Schmid, Vanderplasschen, Verbecke & Vermeiren, 2016). The reason why boys and girls express symptoms of mental illness differently, is related to gender conceptions of socially defined roles of men and women (Droogenbroeck, Keppens, Spruyt, 2018). In many cultures, girls are expected to be more emotionally sensitive than boys. Because of these gender roles, boys also have a more difficult time acknowledging their mental health issues than girls. Girl’s gender roles in society cause them to be more compassionate, understanding, and empathetic; for this reason, girls have been found to have lower levels of stigma towards mental illness and higher levels of MHL (Holman,

2015). Thus, the differences in externalization of mental health issues in both boys and girls directly contributes to the disproportionate ratio of which gender is being referred for mental health services. Further research is needed to determine if there should be an alternative tier-1 mental health programs for transgender students.

Because of the differences in how both genders express symptoms of mental illness, the ratio of boys and girls who are referred for mental health services is not equal. According to Green, Clopton & Pope (1996), boys are more likely to receive referrals for mental health services than girls due to boys' tendency to externalize their maladaptive behaviors. In their study, teachers were more likely to refer a child with externalizing behaviors (86%) than with internalizing behaviors (55%). Also, teachers were less likely to refer a child for mental health services that was doing well academically. Their results showed that girls were able to continue doing well in school while experiencing internal mental health symptoms. It was concluded that teachers believed internalizing symptoms in girls will improve as they mature, highlighting that educating teachers about mental issues is important, as well as it is educating students about mental health issues.

One problem in school mental health practice is that the teacher's interpretation, or other adults' interpretation of the child's behavior, is what determines if a child receives a referral for mental health services. Because adolescents spend most of their time in school, however, a teacher is more likely to refer a student for mental health services than the parent of the student. Educating teachers about how to identify signs of mental illness, especially in girls with internalizing symptoms, is the most important component to implement a productive tier-1 mental health program. Thus, the teacher's

awareness and active participation in tier-1 mental health programs are a crucial factor for a tier-1 program to be effective.

Discussion & Conclusion

The present review found that there is a large scope of Tier-1 mental health education programs being established in schools both in the United States and internationally. It is difficult to compare the efficacy of programs cross culturally due to confounding variables that could be affecting the design and implementation of said Tier-1 mental health programs. There is an evident lack of standardization of Tier-1 mental health programs even within a singular country due to socio-cultural and socio-economic differences. Gender differences to design and implement tier-1 mental health programs, are not considered, even though there is reliable research that boys and girls express and experience mental health and mental illness differently. Another important factor that was not reviewed in the present study is a discrepancy regarding which types of professionals should be delivering Tier-1 mental health education programs in schools. Across several countries and even within the United States, school professionals have difficulties deciding if teachers, school counselors, social workers, and outsourced mental health professionals should be responsible to develop and implement tier-1 mental health programs.

Not only is it important to decide who should implement these programs but deciding what the content of tier-1 programs should be focused on. The present review recommends a basic, standardized Tier-1 mental health education program that can be adapted to fit a school's needs, factoring in socio-economic, socio-cultural and gender

differences that are present in each school setting. However, one possible limitation of the present review is that it was not able to analyze the efficacy of tier-1 mental health programs internationally, because of the large scope and variety of programs that have been implemented. The results obtained in studies that analyze the efficacy of tier-1 mental health programs have not been replicated due to their complexity and lack of standardization. It is difficult to determine if these programs as a whole are effective.

In conclusion, while the present review was unable to determine the efficacy of current tier-1 mental health programs, it was able to identify important factors that should be considered when creating and implementing these programs. The present review also recognized other factors that may be limiting the success and efficacy of current tier-1 mental health programs. More research of every aspect of tier-1 mental health education programs is necessary to improve their content and implementation in schools.

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