Sacrificing the Mentality of Childhood: Poverty's Impact on Children with Mental Illnesses

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Introduction:

Grenderline, an 11-year-old from Washington D.C., and her two younger siblings, have suffered from severe emotional episodes, troubles focusing in the classroom, and difficulty sleeping over the past year. These symptoms are not the joyful and happy sentiments society often associates with childhood. Rather, these three suffer from mental health challenges stemming from the Covid-19 pandemic and a limited history with mental healthcare (Levin). Grenderline's life has become a constant battle with her own mental health and she is not alone in this fight. According to the CDC, up to a fifth of children from all income brackets are thought to suffer from a mental illness ("Child Mental Health"). Low-income children are disproportionately affected with one-third to one-half of children thought to have mental health challenges ("Child Mental Health"). Grenderline's family, supported by a single mother, fall into this low-income bracket and face the added stressors inherent to a life in poverty. As many impoverished environments present daily difficulties with adequate food and housing, children in critical stages of development are met with a taxing mental toll when no healthcare resources are utilized. This situation describes the correlation between poverty and the disadvantages faced by children struggling with a mental illness. The difficulties associated with a life in poverty expose its severe cost on childhood mental health and illuminates how efforts to educate and reallocate resources can greatly improve the course of a child's life.

Scope and Scale Analysis:

The presence of severe childhood poverty in the United States is a devastating and demanding issue. Understanding the scope and scale of childhood poverty exposes its correlation to mental health issues in the United States. Using the 2020 Supplemental Poverty Measure,

considered the best representation of childhood poverty as it factors in tax credits and government benefits, 9.7% of children are classified as impoverished ("The State of America's Children 2020 - Child Poverty"). Though this number has shown a slight decrease from 12.6% in 2019, its burden on childhood health is still impactful. The correlation between disadvantages faced by those in poverty and their health status is termed the "social causation theory" (Johnson et al., 490) This theory posits that a culmination of added stressors stemming from a low-income household, struggles with daily food or shelter, and violence or upheaval in one's surrounding environment can all contribute to worse health outcomes (491). To imagine this status during periods of critical development only magnifies its severe effects on a child's outcome. Recognizing that a child's environment is a critical component of their health is therefore a central piece in analyzing the intensity of this problem on low-income children.

Mental illness in children can manifest in a multitude of complex fashions. Though these illnesses are not confined to low-income children, several factors can contribute to an increased presence and severity when this particular population does not receive necessary healthcare. According to the CDC, mental disorders in children are "serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day" ("Child Mental Health"). Using the American Psychiatric Association's Diagnostic and Statistical Manual, several signs, symptoms, and specific diagnoses are particularly prevalent in children. For example, anxiety, depression, oppositional defiant disorder, and conduct disorder are common diagnoses for school aged children ("Child Mental Health"). These illnesses can prevent a child from routine daily functioning and long-term success. Impacting their ability to succeed in school, to form meaningful relationships, and to develop in other social environments, children who do not receive care for these illnesses face

devastating disadvantages. Acknowledging the potential and severity of these illnesses in all children is therefore an essential component of adequate healthcare.

The realm of poverty and the realm of mental illness do not exist in separate spheres. Rather, a strong correlation exists between children growing up in low-income environments with little healthcare resources and their worse mental health outcomes. It is estimated that around 13 – 20% of all children, regardless of income, suffer from a mental illness ("Child Mental Health"). However, this data is primarily based on parental surveys and parental reporting of official diagnoses. When considering only low-income children, these numbers are potentially much higher due to the severe underutilization of healthcare services. According to a study looking only at children in families receiving Supplemental Security Income, an estimated 50% of children suffered from a mental illness ("National Academies of Medicine"). Additionally, the CDC reported that children experiencing three or more Adverse Childhood Experiences, which are instances of violence, trauma, or dysfunction in their home lives, were over 3 times more likely to suffer from mental illness ("Child Mental Health"). The overlap of these two populations supports the severe impact that poverty can have on one's mental health. The significant size of this problem should not be underscored as a common childhood phase. Understanding the present and future danger that an unaddressed mental illness presents to a child depicts the necessity of mitigating its consequences on low-income children.

Daily encounters with intense disadvantages prevent low-income youth with mental illnesses from achieving many freedoms inherent in a dignified human's life. These detriments are aptly explained through Nussbaum's Capabilities Approach. Nussbaum argues that the capabilities of an individual are not simply the presence of resources and means (76). Instead, having capabilities is reflective of the freedom for choice and action (76). She argues that an

individual is not in possession of their full capabilities when their own autonomy is not emphasized. Additionally, capabilities apply not only to recognizing a disadvantaged status. They also magnify a deeper meaning of poverty and poverty studies. To recognize the limitations that are faced by individuals of a lower income status allows an outsider to sympathize with an external circumstance. However, external circumstances are often limited to a material perspective, focusing on barriers to goods such as money or higher end resources. This shortsightedness prevents one from understanding how it is not just the daily inconveniences of being low-income that defines what it means to be extremely poor. Instead, it is the intense detriment to these important and necessary capabilities that defines poverty and conveys a much stronger impact on the quality of an individual's life. Therefore, taking a capabilities approach implores a more sympathetic lens of understanding poverty and its impact. It requires that people not only acknowledge a disparity but truly understand its causes and necessity for change.

Many of Nussbaum's Capabilities are nonexistent when considering the disadvantages that low-income children suffering with a mental illness face. By using this approach, a better grasp of how inadequate resources can entirely control a child's life becomes apparent. Stripped of their ability to act as functioning, autonomous individuals due to often debilitating mental illnesses, the severe impact and life-long burden of this problem is exposed through a capabilities analysis.

The Capabilities of Life and Bodily Health are two of the most limited capabilities faced by low-income children with a mental illness. Nussbaum describes the Capability of Life as having the ability to live a normal length life and Bodily Health as the ability to be a healthy and nourished human being (78). Though these capabilities seem to resonate with physical health, lacking mental health is equally detrimental to a child's lifestyle. According to a study published

in JAMA Psychiatry on how childhood psychological disorders impacted adulthood functioning, people with psychological issues during childhood are far more likely to suffer poor mental health outcomes as an adult (Copeland et al., 893). Their findings highlighted the presence of continued mental health issues, low rates of academic success, and increased rates of self-harm in adults who were diagnosed with or had borderline symptoms of a psychiatric problem as children (894). Similarly, research by the British Medical Journal found higher rates of PTSD, higher cortisol levels due to high stress, and cognitive impairments in adults who had a mental health issue as a child (Nelson 3). These symptoms and experiences in all children would be extremely detrimental to their ability to live a healthy lifestyle. When encountered in environments that provide little support to overcome these symptoms, a child's development of the Bodily Health Capability is strongly impacted.

A devastating impact on the Capability of Life is also a common result of poverty's correlation to high rates of mental illness. Studies have shown that the combination of intense mental health struggles and the inability to access adequate healthcare can impact suicide rates in afflicted communities. In a recent study comparing the adolescent suicide rates between low- and high-income areas, researchers found that the lowest income regions had a 37% higher suicide rate than upper income communities (McCarthy). Recognizing that these statistics represent tragic impacts on a child's life, impacts not often associated with the perceptions of childhood, exposes the reality of this problem. Affected in ways that will dramatically upend the course of their lives, low-income children with a mental illness are extremely disadvantaged in their capabilities for a healthy and dignified life.

As a mental illness can impact normal childhood development, prevent formation of supportive relationships, and complicate the typical freedom of youth, the capabilities of

Emotion and Affiliation are also lost in this population. Nussbaum describes Emotion as the ability to love, grieve, and express feelings for others and Affiliation as the ability to live towards and show concern for others. For children from all socioeconomic backgrounds, developing interpersonal skills requires a supportive and nurturing environment. However, the presence of mental health issues such as depression, anxiety, and behavioral disorders in addition to limited healthcare interventions can increase the deficits of these capabilities. Research shows that symptoms of social withdrawal, mood changes, and inability to express emotions are common behaviors in children suffering from a mental illness (Copeland 6)**.** Unjustly prevented from normal childhood experiences and interactions, low-income children with a mental illness can struggle to develop socially in relation to their peers. Additionally, this same research showed that insufficient development of these interpersonal skills as a child can continue to impact adulthood functioning. Higher rates of continued mental illness, lower mental health literacy, and decreased ability for successful functioning in stressful situations were all heightened in adult populations who experienced an untreated mental illness as a child (Copeland 8). Therefore, lacking the full ability for Emotion and Affiliation cannot be underscored for these children. It creates a severe and life-long burden that requires significant understanding and change.

The impact and extent of limited mental health resources for low-income children is a demanding issue in the United States. Not only is this particular group subjected to the proven stresses of poverty, they are forced to overcome mental struggles with little to no professional support. By denying their human right to multiple of Nussbaum's capabilities, these children suffer the burdens of poor mental health. This issue requires resounding analysis of the social structures that form this oppression and steps to help correct the tragic impact on low-income children.

Structural and Social Cause:

A resolution for the struggles faced by low-income children with mental health difficulties cannot be addressed without considering the causes. Though understanding the scale and scope magnifies the severity, without understanding the problem's source, little impactful changes can be made. However, recognizing the actual barriers at fault is often misconstrued with an incorrect attitude of blame. When justification for the scale and severity of this issue is placed on an individual level, this population continues to suffer grave consequences. Too often, an individual's fault or an outcome of a biological predisposition is cited as the source of either poverty or a mental illness. However, this shortsightedness fails to understand the larger, structural barriers that create these harms. An analysis of these injustices reveals the insurmountable structural barriers that low-income children face when mental health resources are so desperately needed.

Understanding the severity of mental illness in low-income children from a social group perspective and on an individual level are both necessary in addressing its causes. Where a social group analysis allows recognition for the structural sources of blame, honoring the importance of the individual is imperative for the concept of mental health treatment. Mental illness is diverse and unique in its manifestations. Every child deserves individualized recognition and care, especially with the unstable circumstances faced by many children in low-income households. Therefore, it must first be emphasized that each child should not be thought of as only a piece of a common population when considering their individual battle with poverty and mental illness.

However, addressing the causes of these individualized struggles requires a social group analysis. This lens illuminates the social structures, institutional barriers, and misconstrued policy efforts that thwart adequate care for low-income children. Iris Marion Young offers a

description of the term social group as a unified, collective group of individuals with shared experiences and goals (Young 714). This term is applicable to many low-income households with children struggling to succeed with a mental illness. For example, limited resources, housing and food insecurity, and few health professionals are all commonalities that may be encountered by low-income children and factors that correlate to higher rates of mental illness. These problems all represent bigger picture issues that must be addressed to impact long-term change. Therefore, maintaining the importance of the individual while addressing the structural originations of this problem forms the next step of this analysis.

The complexity of navigating and overcoming institutional structures poses a significant barrier to low-income children with a mental illness. Even with laws in place to ensure equality of care, several issues for low-income individuals remain. Today's most applicable law is the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The purpose of this law is to insure equality of coverage between physical and mental healthcare. However, this law has not been entirely successful in removing institutional barriers to care. The first significant structural problem is a result of inadequate health insurance coverage and resource allocation. The availability of sufficient healthcare resources can present struggles to individuals of all income brackets. Even with funds to source out-of -pocket care, households across the country face the bureaucratic red tape that often extends timely delivery of healthcare. However, when numerous other financial stressors face these particular low-income households, the allocation of funds to a child's mental health often suffers.

One manifestation of the barriers created by poverty's financial constraint is through forced seeking of "out of network" services (Meleck et al., 2019)**.** These out of network options are found outside of a patient's initial healthcare provider group, presenting both monetary and

accessibility constraints. For example, a recent report conducted by the Mental Health Treatment and Research Institute demonstrated how this process can be extremely costly for patients (Meleck et al., 2019). Insurance groups are not required to cover out of network treatment and patients are often forced to pay out of pocket. This problem is particularly prevalent in children who are 10.1 times more likely to have to seek out of network providers for mental healthcare. This leaves low-income households, already facing strict financial barriers, with little provisions to even initially access care options.

In addition to the shortcomings of insurance coverage options, a lack of mental healthcare providers and appointments thwarts the care options for low-income children. According to a report on the status of psychiatrist presence in the U.S., provider insufficiency is a significant problem in a diverse array of areas across the country. This report states that the U.S. is short nearly 15 psychiatrists per 100,000 people to meet adequate coverage standards (Harrar). Certain parts of the United States such as rural and low-income communities are most in need and most severely impacted (Harrar). Additionally, acceptance of insurance payments and availability of appointments is extremely limited for those who cannot pay out of pocket. In a study on insurance coverage for psychiatric care in the United States, researchers found that psychiatrists accept far fewer insurance policies than other areas of the medical field (Bishop et al., 4). This study showed that only 43% of patients seeking care who had either Medicaid insurance coverage or private coverage were able to get covered appointments in a timely manner (4). The presence of monetary barriers limiting access to healthcare is a problem faced by individuals and families across the country. Therefore, the severity of inadequate care when financial barriers are even further exacerbated must not go unnoticed for low-income children with mental illnesses.

Though the source of high mental illness rates may be simply blamed on the parents and healthcare providers, understanding the structural causes rather than individual causes of this barrier illuminates more impactful sources. First, the rules and policies surrounding health insurance are shrouded in complexity. Studying the difficulties with acquiring and understanding health insurance policies, researchers cited testimonies from parents describing consistent confusion with health insurance plans (Bhargava and Loewenstein, 2505). Individuals were unable to answer simple questions regarding their deductibles and co-pays and often selected plans far more expensive than necessary (2505). Imagine navigating this process while caring for one's sick child and managing the daily stressors caused by poverty. Though parents are held to a standard of accountability, the structural barriers they face must be addressed before an attitude of blame is approached.

Additionally, recognizing the structural limitations faced by healthcare providers is a necessary consideration. Even if aiming to uphold values of equal patient care, providers are forced to navigate a delicate balance between the healthcare field and their own personal circumstances. Recent data shows that psychiatry and pediatrics are two of the lowest paying specialties in the medical field (Moore). However, like their graduating medical peers, they still face an average of over $240,000 in debt after school (Moore). Therefore, their inability to treat patients of all income status must be understood by factoring in their own financial circumstances, regardless of their will to help these children. This scenario again depicts the impact of structural barriers, like medical school tuition and health insurance inadequacy, that are key determinants in the ability for providers to offer equal care. Understanding these limitations exposes the harms created by the institutional aspects of the healthcare system on low-income children struggling with mental health challenges.

The grave disadvantages these children face from institutional limitations is magnified when analyzing the symbolic perceptions and stigmas regarding mental health. Negating the severity of their struggles or demonstrating assuming attitudes, the barriers encouraged by societal practices are equally detrimental to the mental health of these children. Several of these issues cannot point directly to a cause-and-effect analysis yet are important in understanding how symbolic conceptions limit care for low-income youth in the United States.

The cost of discrimination based on race and ethnicity can gravely impact the physical and mental health of individuals. For both children and adults, this connection is important to acknowledge when considering rates of mental illness. Though a specific race does not signify every low-income child suffering from a mental illness, it is important to consider how the culmination of race, low-income, and societal stigma can affect who is most strongly impacted by this disadvantage. Research has shown that before even attempting to overcome the stigmas surrounding help seeking for a mental illness, a child's mental health can be negatively impacted by their race. According to an analysis of the effects of discrimination on mental health in adolescents, researchers found that children experiencing racial or ethnic discrimination were more likely to suffer from anxiety and depression (Vines et al., 2). They reported how an accumulation of stressors faced when one encounters daily discrimination and exclusion can have negative impacts on the mental health (Vines, 8). To then add the stressors that may coincide with a life in poverty such as food, housing, and school insecurity, the additive effects become very severe for these children. Therefore, stigmas surrounding both mental health and particular social groups create disadvantages for a select portion of the population. Similar to Marilyn Frye's bird cage analogy, these sentiments of racism and discrimination may not be overt, especially in young populations. However, with discrimination acting as only one wire of

the cage, a multitude of other disadvantages combine to negatively impact the health of certain children (Frye 12). Therefore, the symbols of discrimination convey a message of undeserved inequality in healthcare which contributes to higher rates of mental illness.

Stigmas surrounding the use of mental healthcare services also pose a barrier to children in need of treatment and their families. These stigmas originate from society's perception of help seeking behaviors for a mental illness. Especially for the presence and necessity of mental healthcare for a child, attitudes and perceptions can be extremely convoluted and divided. According to the *Journal of Child and Family Studies*, over half of parents who do not seek help for a child's mental illness do so because they fear negative associations from friends and family (Eaton et al., 3110). Parents often worried how their own parenting style would be perceived or that receiving mental healthcare would impact their child's treatment (3111). For example, this research stated that mothers felt accused of "failing to be good parents," "not raising their child correctly," or that their child's mental illness was a result of their inability to provide for their child (3116). To understand these stigmas specifically in low-income households, it is important to again recognize how culminating stressors contribute to the severity of this issue. Not only are these families at risk of experiencing mental health stigmas found in all income brackets, they may also experience extenuating disadvantages that can increase the impact on their children. For example, where one community may be privileged in their access and utilization of resources, a lack of exposure and limited resources in a low-income community creates a different idea of the common knowledge concerning the importance of mental health. Therefore, with limited understanding for the seriousness of a child's mental illness and engrained perceptions that their children may face further discrimination if they are to seek help, access to care for childhood mental illness continues to be under-resourced and under-utilized.

Understanding the barriers to childhood mental healthcare is a multifaceted and complex issue. An approach to correcting this issue must truly acknowledge the severity posed by mental illness while focusing on legitimate reasons for its origination. Though the child is the most important component of this story, individual blame provides no resolution to the problems faced. Instead, focus on the structural institutions and large-scale social perceptions illuminates the intense disadvantages posed upon these children. In order to achieve greater equality in the field of mental healthcare, low-income children must secure a stable and immediate support system instituted through structural and social changes.

Ethical Analysis and Recommendations:

Addressing the structural and social causes of the inadequate healthcare and support provided to low-income children with mental illnesses illuminates necessary recommendations for change. With a goal of providing equal and adequate care, the extenuating circumstances that face many impoverished households must be a central consideration. This condition requires recognition of the individuality of mental illness with an understanding of its structural origination. To increase not only the quality of mental healthcare but the quality of a child's life, a comprehensive and corrective response must address the injustices faced by this population.

Establishing equality in resource distribution is a complex and endless pursuit. To deny one individual the benefits of healthcare while offering these goods to another poses an obvious ethical dilemma. With all things being equal, it seems the only apparent answer to this question would be to equally split the available resources in a way that bests support both individuals. However, structural limitations and hierarchies of power provide consistent barriers to the goal of improving outcomes for these children. Achieving this goal has also been blurred by a limited

understanding for the terms equality and inequality. Equality of resources is often interpretated as an exact sameness between two individuals with inequality being the exact opposite. Where one child is provided a certain number of resources, another child is provided with the same. However, through inherent resource limitations and the necessity of recognizing the conditions implemented by the status of poverty, these definitions are almost impossible to achieve and not technically necessary to improve the lives of these children. Understanding what equality of mental healthcare provisions looks like requires acknowledging that certain low-income children inherently need a greater allocation of support. To be further established in this section, equality requires that culminating life stressors and extenuating circumstances be considered. Therefore, equality may not necessarily be an equal way but instead a more just way to distribute resources to those in need.

With this concept of equality, several areas require critical evaluation to determine what constitutes fairness, what demands reparations for perpetuating injustices, and what moral responsibility one has to act on this situation. Understanding these three components and their structural realities evidences the unjust status faced by this particular population. It also provides justification for why society has the obligation to act in establishing positive change.

Two factors in the suffering faced by low-income children with mental illnesses provide reasonings for how the barriers they face are not simple and insignificant problems. Rather, they are forms of injustice perpetuated by societal inequities that demand an equally serious response. First, the struggles faced by children suffering from extreme poverty are too often equated to the problems faced by upper-income children. Though not to negate the necessity of preventing a mental illness in any child, these children are not on level playing fields in terms of resources and support. Therefore, recognition for the high-risk indicators faced by low-income children

necessitates attention in varied fashions. Low-income children constantly encounter added stressors with food insecurity, housing, and instability in their home lives (Koball and Yang). Additionally, they do not benefit from the expendable income and support that can be used to help alleviate these struggles. In an analysis of the equality of healthcare, Philosopher Norman Daniels poses the idea that equality of opportunity stems from justifiable access to adequate healthcare (Daniels 104). Using this analysis, in order to provide all children with the human right to succeed, there must be greater attention given to the status of low-income children regarding mental health.

The second source of injustice is seen in the unequal distribution of resources perpetuated by structural inequities in the United States. Again, this allocation tends to favor high income populations with little recognition of problems created for the opposite side of the income spectrum. Where this disparity is most evidenced is in the industry of health insurance and healthcare. Described in the analysis of structural inequalities, the limitations of low-income health insurance options, difficulties with navigating physician and appointment availability, and inability to source out of pocket payments are common problems that can be exacerbated by a low-income status. As access to unlimited resources is no plausible option, secondary measures must be taken to ensure a more just distribution of goods. Continuing to perpetuate the severity of mental illness by not addressing equal rights to healthcare access should not be a tolerated option.

The scale and impact of these injustices poses a serious and legitimate threat to low-income children suffering from a mental illness. The presented structural barriers prove that the status of these children must be addressed. The following policy recommendations provide changes and solutions to better support the mental health of low-income youth populations.

Engaging in efforts to enact these changes is a responsibility of those dedicated to bettering the lives and outcomes of low-income children with mental illnesses.

Education provides critical insight to illuminate the problems, causes, and necessary changes that are required for any injustice present in society. Therefore, the action of increasing education in a multitude of populations is a recommended first response to help alleviate the suffering felt by low-income children with a mental illness. Initial goals of education must be focused on policy makers, those in charge of creating the laws and rules that structurally impair the healthcare system. As previously described, the struggles faced by low-income children are primarily caused by institutional barriers such as limited flexibility in public insurance options, constrained access to resources, and limited recognition for the presence of illness. As these structural issues originate from injustices established in the action of policy formation, it is imperative that their knowledge and perspective is changed. Policy makers must acknowledge the severity of mental illness. Ignoring the 57% increase in childhood suicide rates over the past 10 years or the 50% of children who do not receive any treatment for a diagnosed mental disorder is an extreme display of failing to support those in need (Curtin 3). Therefore, there should be greater acknowledgement by those in charge of the severity of a mental illness, especially in higher-risk, low-income children.

The increase in mental health awareness by policy makers is necessary to advance more specific policies that will support low-income children with healthcare access. As explained in the structural evaluation of this issue, even if diagnosed with a mental illness, low-income children struggle to actually receive or attend healthcare appointments. Therefore, actions to increase mental healthcare resources in the commonplace of schools provides a perfect opportunity for lawmakers to engage in structural change. Policy changes affecting the resources

provided in schools are supported by “Mental Health America” the largest, community-based nonprofit organization fighting to increase mental health policy in the United States Government (“Mental Health Policy”). Their most recent policy initiative, H.R. 1109, poses the goal of increasing school-based comprehensive health programs, and for good reason. Mental health programs in schools have shown to be extremely beneficial and provide a host of positive changes. As this bill has stalled in recent congressional efforts, its potential for enacting solutions to the structural problems plaguing low-income youth speaks to the necessity of educating and holding those in charge accountable.

The essence of this proposed bill is to increase funding for school-based programs that can identify the presence of a mental illness, assist in treating this illness, and increase awareness and engagement in the concept of mental health within the school community. These integrative programs are termed Comprehensive School Mental Health Systems (CSMHSs) and provide a multi-tiered and dynamic form of increasing mental healthcare access (McCance-Katz 4). CSHMHs provide a solid, evidence-based framework to help increase the support provided to all school age children (5). There are three central components of CSHMHs that when implemented correctly, have shown positive benefits in increasing the general mental wellbeing of all children. First, these programs demonstrate complex integration between the school, community-based programs, healthcare providers, and social work agencies. This involves communication directly between daily providers like teachers and external healthcare providers, a greater involvement of the child’s family, and care that does not stop at the doors of the school. These relationships establish a well-rounded and long-term form of treatment for the child. Second, CSHMHs are multi-tiered meaning their care ranges from larger, class-wide curriculum to individualized care needed for specific students. Again, this aspect provides greater opportunities for early

intervention and addressing of problems. This component can be particularly beneficial to address low-income children. Rather than continuing to negate the impact of their background, providing both a comprehensive curriculum and targeted care can ensure they receive the equitable treatment they need and deserve. This step helps provide all students, not just those with outside resources, opportunities to receive consistent and equitable healthcare access. Finally, screening models within a CSHMH allow providers to ensure high-risk students receive the extra support and care that their situations often necessitate. This addition of screening again satisfies the need to increase attention for how the limitations of an impoverished household can impact a child's development of a mental illness.

There are several benefits demonstrated by previous instances of enacting comprehensive school mental health systems in schools across the United States. According to research by John Jameson and Kurt Michael, of the children who are able to access consistent care, 70% receive these resources solely from the school environment (5). This heavy reliance on schools due to limitations of outside resources speaks to the potential school settings have in their ability to increase utilization of care. Offering services in schools that can identify and treat a child's mental illness in conjunction with community partners and the child's family provides the well-rounded care that is thwarted by current structural barriers. Though the feasibility of this goal may seem questionable, a recent endeavor by a grade school provides support for its success (Powers and Swick 134). This school enacted a "School Based Support Program" in which relationships with community partners were established to create a comprehensive, in-school mental health service (135). This program provided training for teachers to lead classroom mental health lessons, strong partnerships with external mental health professionals, and dedication to direct student and family involvement in the identification and treatment of a

mental illness. Following one year of evaluating the impact on students, researchers found that consistent participation in individualized mental healthcare by needy students increased significantly. Students demonstrated greater health literacy and more willingness to engage with healthcare programing. This success supports the ability for school integration to overcome barriers that prevent access to care. By providing funding to incorporate comprehensive programs into school, the impact on low-income children can be alleviated.

Integration of mental healthcare into school settings has also shown positive impacts in establishing and maintaining relationships that foster mental health support. The possibility of this benefit was described by Dr. Prveetha Patalay in a podcast hosted by "The Association for Child and Adolescent Mental Health" (Patalay)**.** Dr. Patalay describes how trusting and supportive relationships are essential for children to grow in their mental health. These relationships can be established through school environments that have the resources to cultivate a positive mental health climate (Patalay). Dr. Patalay's description of developing these relationships has shown to be a successful reality of school based mental health. According to research on the benefits of school based mental health programming, research shows that these resources are more beneficial when provided in a natural environment by trusted individuals (Jameson and Michael 7). Also supported in a study mentioned by Dr. Patalay, students were more willing to openly discuss and opt for care options when provided in a school setting. Potentially lacking support in one's homelife, utilizing the environment and relationships developed in school can therefore be a pertinent improvement to the healthcare options for low-income children.

A second structural barrier that perpetuated high rates of mental illness in low-income children is the presence of social discrimination and stigma. The first way to target the goal of

education on decreasing mental health stigma is again through implementation of comprehensive programs into schools. Similar to the unique nature of a school's ability to provide a source of consistent care, their ability to mold and educate the minds of the next generation provides another opportunity for positive change. In a review of different models used to integrate mental health literacy and education into the public, several methods showed that adolescents demonstrated significant, positive changes in their attitudes regarding mental health. Several studies found that in particular, elementary school children responded well to the practice of simple, open discussion regarding mental health ("National Academies of Science Engineering and Medicine"). In a report provided by the American Foundation for Suicide Prevention, research showed that teacher guided lessons and peer conversations along with daily incorporation of mental health check-ins showed positive results in strengthening the community's development of a mental health culture ("American Foundation for Suicide Prevention"). These students demonstrated higher mental health competence regarding the signs and symptoms of a mental illness in themselves and their peers. They also expressed ideas that "help seeking was a sign of strength" and a greater willingness to accept and provide support to those with a mental illness. By fostering these attitudes of mental illness from a young age, a precedent is set for its normalization in future generations.

This success can be contributed to the influential minds of young children and the benefits fostered by a compassionate and dedicated school faculty. In a podcast hosted by the Association for Child and Adolescent Mental Health, Dr. Aisha Chachar suggested that integrating mental health literacy into schools would provide much more than a method of improving the mental health of particular individuals (Chachar). Instead, similar to the conclusions of previous research, she argued that engaging with the important subject of mental

health in younger generations can offer long lasting population changes. By normalizing the discussion and treatment of mental illness in the natural environment of a school, children are more likely to adopt these behaviors and extend the practices beyond school. This change addresses a social stigma in society against the importance of mental health. Prioritizing the agenda of mental health through school children pushes its message to the forefront of societal recognition. Emphasizing this message, the structural change of reducing the harmful stigma barrier begins to move in a corrective direction. As Dr. Chachar emphasized, increasing the education and awareness in schools and school children is an essential step in the betterment of opportunities for all individuals struggling with mental illness.

Policy in action often falls short of its theoretical goals. With every bill signed into action, every source of increased funding, or every initiative started to better the situation of a marginalized group, problems and subsequent counterarguments arise. Though these previous recommendations pose needed solutions, several following counterarguments may be suggested as to why these changes may fail. However, a deeper understanding of the ethical justifications behind these changes shows that even with inherent issues in application, adjustments must be made to help better the situation for low-income children with mental illnesses. The following section will provide possible shortcomings of these recommendations along with an ethical defense to promote a forward thinking rather than blame-worthy response.

The first concern of incorporating mental health awareness and treatment into schools is with the successfulness of its actual implementation and function. School wide curriculum efforts are known to struggle with adequate funding, meet apathetic attitudes from students, or suffer from inconsistency and a lack of dedication. Therefore, some may argue how and if an increase in funding can actually promote real improvements in mental health literacy and

treatment. Rather than spending money on this effort, why not spend money on resources that provide known benefits, even if not mental health focused? However, acknowledging why these mental health programs are necessary and recognizing ways to ensure the successfulness of this goal can adequately refute these attitudes of question.

To deny the opportunities that comprehensive mental health programs in schools offer to low-income children suffering with a mental illness is an ethically irresponsible act of society. This statement is supported by the work of philosopher Norman Daniels in his concept termed the "Accountability for Reasonableness" (Daniels 117). The Accountability for Reasonableness is Daniels' ethical response to the question of how to allocate limited healthcare resources to a population. This principle provides the reasons and rules that justify decisions of distribution in ways that a person cannot reasonably reject. Therefore, with a "reasonable" justification for why a certain population is allocated a different proportion of resources than another, an ethically sound practice of distribution is followed. Though Daniels is not a contractualist like fellow philosopher T.M. Scanlon, the original theorist behind contractualism, his principles are closely associated with Scanlon's ideas. The principle of contractualism concerns the morality of individual acts. Scanlon argues that an act can be morally wrong if an individual is able to reasonably reject the reasoning or outcomes of this act. Therefore, a key difference exists between Scanlon and Daniels. Where Scanlon's concerns lie in individuality, Daniels' argument is more closely associated with the structural concerns initiated by the ideas of John Rawls. This connection focuses Daniels' argument on a larger scale, attempting to bring greater morality to institutional and social practices.

Daniels' principle of "Accountability for Reasonableness" therefore provides an accurate lens to analyze the large institution of healthcare and the ethics behind its distribution. Rather

than analyzing the morality behind individual treatment, Daniels' argument creates a system of resource distribution that would best recognize and support every social group involved. One component of this principle and an accurate description to support justice regarding mental healthcare allocation to low-income children is seen in Daniel's statement that "reasons given must respect the moral diversity of those who are affected by the decisions" (124). Daniels believes that in order for decisions to be made in a just manner, one must consider the prior circumstances and moral rights of those directly impacted.

This argument emphasizes recognition for the unjust status of this low-income children suffering from inadequate mental healthcare funding. To argue that this group does not face extenuating circumstances impacting their mental health or that they are not deserving of healthcare opportunities provided to their peers offers no acceptable counterargument. Therefore, the structural problems that result in these inequalities must be considered as the source of an individual's struggles. By providing a large increase in funding for mental health incorporation into schools, a step is taken to equate opportunities for this population. This requirement to provide funding also poses a potential counterargument that stresses the cost-benefit analysis of this issue. A protest for the necessity of increasing spending arises when one assumes that funding can only be increased for School A if it is also increased for School B. This belief may be encountered from individuals with personal connections to a certain school, regardless of the prior financial status of the school, students, and associated families. Though this statement argues for technical equality, it ignores the aforementioned severe disadvantages faced only by a certain group of students. Therefore, recognizing the limited circumstances of these children is essential to argue for a system that does not distribute healthcare resources in an exactly equal fashion. Forced to overcome challenges that often only plague their particular school and home

lifestyles, there is no justification for not allocating a greater source of funding to these schools. The concern of funding distribution therefore is answered with a need for fairness over a need for equality. This necessary condition honors Daniels' belief that the "diversity of those who are affected" be a top priority when deciding how to justly allocate resources.

Increasing positive mental health awareness and attitudes is a reoccurring and pressing issue in today's society. With experiences of mental health struggles common throughout the global pandemic, the concept of mental health is no longer a taboo subject. However, with increasing normalization of open discussion, it must be recognized that access to mental health resources remains an elusive ideal to some populations. In particular, low-income children face extreme difficulties with access to this care. At an age where developing minds are easily influenced and shaped, the necessity of mental health care to help these struggling children thrive cannot be ignored. Additionally, the results of severe disadvantages such as food, housing, and school insecurity should be recognized as having a significant impact on mental health. To better the lives of children across the country, children such as Grenderline and her siblings, greater resource allocation and support must be given to low-income children struggling with a mental illness. Supporting their opportunity for life, success, and happiness, mental healthcare for low-income children deserves impactful change in the United States.

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