Factors Associated with Racial and Ethnic Minority Youths' Mental Health Help-Seeking at School

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FACTORS ASSOCIATED WITH RACIAL AND ETHNIC MINORITY YOUTHS' MENTAL HEALTH HELP-SEEKING AT SCHOOL

A Dissertation

Submitted to the Graduate Faculty of the Louisiana State University and Agricultural and Mechanical College in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in

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ABSTRACT

Despite the high prevalence and associated consequences of mental health problems in youth, adolescents with these problems are often left untreated. This service gap is even greater in racial and ethnic minority youth who not only engage in treatment less frequently, but also experience far greater discrimination and systemic inequality than non-ethnic or racial minority students; factors further contributing to a need for service. Schools may provide an ideal location to treat mental health problems in youth, in part because schools eliminate structural barriers, but also because school staff have an opportunity to observe students across a range of functioning. However, current methods for identification at school, including universal screenings, may fail to identify all students in need of services. Therefore, it is important to understand the factors that most strongly contribute to racial/ethnic minority students' intent to seek help at school in an effort to enhance access to treatment for a historically underserved population.
INTRODUCTION

Mental Health Problems in Adolescence

One study reveals the lifetime prevalence of any mental health disorder in adolescence to be 49.5%, with more severe impairments occurring in 22.2% of 13-18-year-olds (excluding substance use disorders; Merikangas et al., 2011). According to this epidemiological study, anxiety disorders are the most common in this age group affecting nearly one third of all adolescents (31.9%), followed by behavior (19.1%), mood (14.3%), and substance use disorders (11.4%). Moreover, 40% of adolescents surveyed who met criteria for one disorder subsequently met criteria for another lifetime mental health problem, suggesting comorbidity is the norm and not the exception in the case of adolescent mental health. Approximately 50% of mental health problems develop by age 14, with 75% of mental health problems emerging by early adulthood (American Psychiatric Association [APA], 2020). Specifically, Merikangas et al. (2011) report the median age of onset for anxiety, behavior, mood and substance use disorders to be 6-, 11-, 13- and 15-years-old, respectively, suggesting there are particularly sensitive developmental periods in an individual's life.

Relationally, the onset of certain psychopathologies may be related in part to the developmental sensitivity that occurs in adolescence. First, very few periods are marked with as much or as quick physiological and hormonal change in an individual's lifetime as during adolescence. Markedly, adolescents undergo pubertal increases of sex hormones which involve associated development in secondary sex characteristics (Spear, 2000). Additionally, changes in the adolescent brain (specifically the prefrontal cortex and limbic regions) are likely to impact teens' motivations, sensitivity to novel and rewarding stimuli and subsequent behavior. Peer relationships grow increasingly important during this period, due in part to these developmental
changes, and also due to societal structures and expectations toward increasing independence from home and family. Other behavioral changes include increased risk- and sensation-seeking, which may include school misconduct, substance use and other antisocial behavior. Though generally speaking, this behavior is developmentally normative, in some cases it may have an unbalancing effect, potentially exacerbating pre-existing sensitivity to mental health problems in youth.

Within the school setting, children with a suspected disability may be referred for a psychoeducational evaluation to determine their eligibility for special education services under the Individuals with Disabilities Education Improvement Act (IDEA, 2004). Upon the conclusion of a school psychoeducational evaluation, a student deemed eligible for special education services will receive an individualized education plan (IEP) developed collaboratively between the family and educators to guarantee the child’s receipt of services at school. Specifically, students deemed eligible for emotional and behavioral supports fall under the category of emotional disturbance. Data from the 2016-2017 IDEA Part B Child Count indicate that less than 1% of the student population qualify under the eligibility category of emotional disturbance, but this is likely not the total proportion of students receiving supports in school for mental health challenges (Mitchell et al., 2019). Indeed, it is not uncommon for students with other eligibilities to receive mental health supports in their IEPs. In fact, data from the 2016-2017 school year indicate 6.8 million youth ages 3-21 (12% of youth in American public schools) received special education services under IDEA (Lipscomb et al., 2017) and data from the National Research Council and Institute of Medicine (NRC & IOM; 2009) suggest 12-14% of students experience a mental, behavioral or emotional health challenge at any given point in their school career. Accordingly, in more recent years, schools have adopted a multi-tiered system of
support for students so that individuals may receive emotional and behavioral support at school before their challenges escalate to the extent that they meet the high eligibility requirements under IDEA (Mitchell et al., 2019).

**Risks Associated with Untreated Mental Health Problems**

Furthermore, the risk of untreated mental health problems can pose serious risks to a person's physical, mental, social, occupational, and academic wellbeing. Indeed, untreated mental health problems are associated with future mental health problems, chronic pain and physical impairment, job instability, incarceration and even suicide (Tandon et al., 2009; Sulkowski et al., 2012). Specifically, those with a mental health disorder are 40% more likely to develop cardiovascular and metabolic problems than the general population, and those with severe impairments die on average 25 years earlier than the general public (National Alliance on Mental Illness [NAMI], 2019). Unmanaged psychological illness is also related to poor behavioral health choices including missing doctors’ visits and engaging in poor lifestyle choices (Sulkowski et al., 2012). Individuals suffering with mental illness are also more likely to be unemployed, and less productive when employed. Moreover, the effect mental health problems have on the workforce has significant financial impact on the country. It is estimated the U.S. loses 300 billion dollars per year due to productivity loss (NAMI, 2019).

Psychological illness can also have a devastating impact on adolescents’ social wellbeing and quality of life. Not only are youth with mental health problems at a greater risk of incarceration, but 70.4% of those in juvenile detention have a diagnosed mental illness (NAMI, 2019). It is evident that adolescent mental health presents a crisis to those suffering, their families and society as a whole. Overall, suicidality has increased by 31% in the U.S. since 2001. Data from the Center for Disease Control (CDC; Kochanek et al., 2019) revealed that in 2017,
suicide was the second most common cause of death for individuals' ages 10-14; a rate that has increased 56% in this age group in the less than two decades, surpassing deaths by homicide in the latest reporting year. It is not unlikely that this upward trend is related to untreated anxiety and depression in this age group, as experience of internalizing distress is associated with greater instances of self-harm and resulting hospitalizations (Hawton et al., 2015).

Mental, emotional and behavioral health problems also have a significant impact on youths' academic, psychological, social, and interpersonal functioning at school. High school students with major depression are more than twice as likely to drop out of school than are their peers, as those with psychological problems are likely to miss school and struggle to keep up with schoolwork (Kern et al., 2017). Furthermore, students with elevated aggressive and disruptive behavior are at increased risk for academic failure, peer rejection, substance use and delinquency (Schaeffer et al., 2006). Results of a longitudinal study revealed similar outcomes, in that those students with emotional and behavioral disorders in first grade were more likely to have academic difficulties and placement in special education in the twelfth grade (Darney et al., 2013). On the other hand, positive emotional and behavioral health is associated with academic success and social wellbeing at school (Levitt et al., 2007). Moreover, specific interventions delivered at school have been found to curb the negative effects of untreated mental health problems (Kern et al., 2017). Altogether, the evidence suggests there is great value in the early treatment of emotional and behavioral problems in students to enhance youths' positive development across domains.

**Barriers to Mental Health Treatment**

Not all who experience an emotional or behavioral problem will require services in order to recover; problems may ameliorate with time and environmental change. However, adolescents
with mental health problems should receive swift and effective treatment to curb any short-term decrements in their functioning, as well as the potentially devastating longer-term impacts of untreated mental illness. Certainly, treatment engagement may help curb the associated risks that accompany psychological illness while also helping an individual manage his/her condition and learn positive coping strategies to enhance his/her wellbeing. Unfortunately, according to the literature, up to 70% of those with a mental health problem never receive treatment (Perou, 2013; World Health Organization [WHO], 2001 via Kohn, et al., 2004; Merikangas et al., 2011). Research estimates reveal similar trends for adolescents specifically, with 60% of youth with depression and 80% of youth with anxiety going untreated (Merikangas et al., 2011).

There are a number of factors, both structural and individual that may contribute to this service gap. Structural barriers are those barriers defined by their practical and logistical nature. These may include insufficient or lacking health insurance coverage, insufficient means for travel, inability to take time away from essential activities (i.e., work) to access healthcare professionals, and an inability to afford the cost of treatment. Individual barriers are those defined by a person's thoughts, knowledge or feelings that may contribute to lower or absent intent to seek treatment. Examples of individual barriers include attitudinal barriers, social and knowledge barriers. More specifically, attitudinal barriers preventing care may include a low perceived effectiveness of treatment, while a common social barrier includes a fear of experiencing social stigma for accessing psychological care. Knowledge barriers may include a lack of knowledge surrounding the need for treatment or surrounding what constitutes positive mental health (Merikangas et al., 2011).

Surveys conducted by the WHO and synthesized by Andrade et al. (2014), suggest that low perceived need is the largest barrier to adults initiating treatment while perceived
ineffectiveness of treatment is the most common reported cause of treatment drop-out. However, women and younger people with psychological disorders were more likely to recognize a need for treatment. Further, of those who recognized a need for treatment, the most common reported barrier was a desire to handle a problem on one's own. Overall, WHO data reveal attitudinal barriers were more significant than structural barriers for decisions to both initiate and continue treatment in adults. Importantly though, structural barriers were more important for those with severe impairment (compared to mild or moderate impairment) from a mental health disorder and may be more salient for ethnic minority communities who have a higher proportion of individuals under economic duress.

Though much help-seeking literature examines intentions and attitudes of adults, there are distinct trends in the barriers and facilitators to treatment in adolescent populations. Several barriers to adolescent mental health treatment have been identified in the literature and include mostly attitudinal and knowledge barriers. For example, Wilson et al. (2011) identified that adolescents and emerging adults specifically expressed a need for autonomy and a preference for informal sources of help (e.g., friends, or parents) as major factors contributing to their intent to seek treatment; factors likely tied to their normative development towards independence and increased peer salience (Wilson et al., 2005; Kroger, 2004). Moreover, the qualities of the most common adolescent mental health disorders (anxiety and depressive disorders) include feelings of nervousness, hopelessness and low motivation, all of which can contribute to help negation, a phenomenon that describes the treatment avoidance so common in adolescent populations. Indeed, Wilson et al. (2005) found that suicide ideation was positively associated with less intent to seek psychological help, an association explained in part by adolescent's attitudes, beliefs and prior mental healthcare experiences. In fact, an estimated 50% of adolescents with psychological
needs actually avoid services (Biolcati et al., 2018). Gulliver et al.'s (2010) synthesis of barriers to adolescent care identified stigma, mental health literacy and a preference for self-reliance as the greatest barriers to mental health services.

As long as treatment occurs outside of the school setting, it is similarly important to capture parent and guardian perspectives for this still maturing and financially dependent population. Reardon et al. (2016) captured parents' perspectives on adolescent barriers to psychological help-seeking in a systematic review and identified barriers to treatment across several domains. Financially, many parents reported that cost of treatment and lack of insurance coverage was a barrier to their child's treatment. Structurally, parents reported a hard-to-navigate administrative system, long wait times, travel challenges and location of service providers as barriers. Perceived language/cultural barriers were reported specifically by racial and ethnic minority parents. Attitudinally, parents reported lack of trust and confidence in service providers and concerns around confidentiality presented barriers to treatment. Parents also reported barriers to treatment related to the consequence of accessing care. By far the most commonly reported obstacle related to receiving care was the perceived negative attitudes of others, or social stigma. Knowledge barriers also play a role in parents' perceptions of barriers. Specifically, parents reported challenges surrounding recognition of symptoms, symptom severity, and where to access care as barriers to help-seeking in both themselves and their children.

**Disparities in Minority Mental Health Treatment**

Although much prevents adolescents' treatment receipt for mental health problems, the need versus service use gap is even more pronounced for racially and ethnically diverse groups (Substance Abuse and Mental Health Services Administration, [SAMHSA], 2018). Not only is there a substantially larger service gap for diverse youth in America than exists for White youth,
but the experience of perceived racism and systematic discrimination can further hinder youth's psychological functioning (Chou et al., 2012). First, there is strong evidence to suggest minorities are disproportionately affected by stigma in the mental health help-seeking process whereby cultural norms and experiences of prejudice and racism hinder psychological treatment seeking and engagement (Clement et al., 2015; Gary, 2005). However, the most common barrier cited in the literature for explaining low access to care among ethnic minority groups include negative attitudes about the effectiveness or usefulness of treatment. These negative attitudes may stem from cultural beliefs about psychological disorders and psychotherapy generally or to beliefs about potential providers' abilities to understand their cultural perspectives and identities (Sun et al., 2016).

In addition to these communities accessing care at lower rates, ethnically diverse groups are also more likely than majority groups to receive misdiagnoses and poor-quality care when they do receive it (Valdez et al., 2019). Consequently, provider bias related to race and ethnicity may further contribute to less treatment-seeking in these groups broadly (NAMI, 2020). Not only can the experience or fear of bias hinder help-seeking in minority populations, but there is also much research that emphasizes the cost racial and ethnic discrimination has on minority mental health (e.g., de Freitas et al., 2018). Indeed, the experience of discrimination is associated with greater psychological distress, lowered self-esteem, self-efficacy, and well-being in individuals, likely hindering social, academic and psychological functioning (de Freitas et al., 2018). Moreover, studies show that nationally 90% of African Americans and 77% of other racial and ethnic minorities experience racial discrimination daily, compared to only 21% of White Americans (Ogunyemi et al., 2019). Perceived discrimination is consistently associated with psychological distress in the three most predominant panethnic minority groups in the U.S.
(African Americans, Hispanic Americans and Asian Americans; Chou et al., 2012). It is estimated African Americans are 10% more likely to experience psychological distress than other groups due to unmet psychological needs (Health and Human Services Office of Minority Health [HHSOM], via NAMI, 2020). Additionally, racial/ethnic minority communities are more likely than majority communities (i.e., European Americans/White Americans) to experience socioeconomic disparity; a factor that contributes to worse mental health outcomes in these groups (NAMI, 2020). For example, in 2017, 11% of African Americans had no health insurance. However, within the U.S., Hispanic Americans have the highest rates of uninsured individuals varying between roughly 8 and 27 percent by subcultural group (i.e., 19.3% of Mexicans, 7.9% of Puerto Ricans, 13.7% of Cubans and 27.2% of Central Americans; Berchick et al., 2018).

Though experiences of overt discrimination can have devastating impacts on racial and ethnic minority youth, so to can experiences of more covert discrimination and racial microaggressions. Microaggressions are defined as the, "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007). While discreet, accumulated experiences of microaggressions are associated with a host of negative mental health outcomes: from decreased confidence, to low self-regard and increased experiences of anxiety and depression (Wong et al., 2014). Moreover, these effects persist even when controlling for other stressors (e.g., poverty; Gee et al., 2009). Microaggressions can present a unique barrier to mental health counseling through their impact on racial and ethnic minority coping strategies. For instance, one systematic review revealed positive associations between the experience of microaggressions and disengagement, cultural
mistrust and stigma for seeking psychological help within the learning environment (Ogunyemi et al., 2019). Another study cited the positive relationship between psychological distress and negative attitudes around help-seeking in an African American sample (Obasi et al., 2009).

**Mental Health Treatment in School**

Addressing the service gap is of high priority from a professional, ethical and public health perspective. Thus, considerable effort has been made to address disparities in treatment engagement for racial and ethnic minority youth. One of these efforts includes the investigation into the appropriateness and feasibility of mental health treatment in locations that may reduce structural barriers to mental health treatment. Accordingly, schools may provide an ideal setting for treatment of all adolescents, regardless of their ethnic or racial identity as all individuals attend school. Mental health treatment in an educational setting eliminates cost and travel barriers, as these services take place during the school day and are considered part of standard educational services. Moreover, school staff and teachers spend a considerable amount of time with students which allows them to observe students across a range of functioning from academic, to physical, social and interpersonal. Research shows that students are more likely to attend follow-up visits with school-based providers than with primary care providers (Stempel, 2019). It has also been suggested that schools can normalize mental health help-seeking thereby increasing service utilization in youth (Thorley, 2016). Finally, school-based service use is associated with improved mental health outcomes, and improved grades and attendance (Ballard et al., 2014).

Results from a 2017 survey by Ahrnsbark et al. aimed to outline the source of emotional and behavioral treatment for adolescents and found that although most teenagers do not seek care, educational settings do remain a common source for treatment. Specifically, of those
adolescents with an emotional or behavioral problem, 14.7% (3.6 million) received care in a specialty mental health setting (i.e., inpatient or outpatient clinic), 13.1% (3.2 million) in an educational setting, followed by 2.9% (708 thousand) in a general medical setting, 0.4% (108 thousand) in a child welfare setting and 0.2% (53 thousand) in a juvenile justice setting (Ahrnsbark et al., 2017). A national SAMHSA (2014) survey revealed trends in treatment settings by racial/ethnic groups. Interestingly, though the most common racial/ethnic demographic in treatment at general medical settings are White adolescents, African American youth comprise the most common racial/ethnic group treated in an educational setting for similar problems. However, it is unclear whether this data is driven by the reduction of structural barriers or by the over-identification of minority youth for emotional and behavioral disorders in school (Cokley et al., 2014). As African American populations are more likely to be affected by poverty and socio-economic inequalities, it is no surprise that the reduction of structural barriers increases help-seeking behavior in this group (Ali et al., 2019). For this reason, schools may play a particularly important role in providing equitable treatment for students who are socioeconomically disadvantaged.

The first step in schools’ promise for addressing disparities in mental health and ensuring a wholistic approach to supporting students’ academic achievement is mental health risk identification. Accordingly, schools use a variety of methods to identify or refer students for emotional or behavior health services at school, each with their accompanying strengths and weaknesses. For example, many schools rely on office discipline referrals (ODRs), or teacher referrals more generally, to inform decisions on behavior supports needed for students. However, ODRs are not standardly used across or even within school settings, resulting in great level of variability and subjectivity in this method (McIntosh et al., 2018). Moreover, ODRs are more
likely to identify externalizing behavioral symptoms, as these tend to be more disruptive to the learning environment. Though identification of externalizing symptoms may result in further identification of comorbid internalizing distress (as these symptoms are frequently comorbid in adolescence; Fanti & Henrich, 2010), this is not regularly the case. For those students with pure internalizing problems (i.e., without externalizing symptoms), the likelihood of being sent to an administrator's office is expectedly low. Not only are ODRs inadequate for capturing students' internalizing problems, they also disproportionately identify students of color (in particular African American males), perpetuating educator biases and structural racism (Losen & Gillespie, 2012).

Given the shortcomings of ODRs, schools may choose to implement emotional and behavioral screening procedures for their students. Student screenings may be completed by teachers, students or even parents based on the developmental level of the student as well as the school team or district's selection. A great benefit to universal mental health screeners is that by assessing all students, risk for an entire student population can be measured, and the likelihood of overlooking any particular student's risk is lowered (Siceloff et al., 2017). In addition, many have been validated on diverse student populations and have pre-established evidence for measurement equivalence across student demographic groups, reducing the degree of bias that may emanate from their application. However, there remains great variability in the proportion of schools that use screening procedures, the procedures and tools used across schools, and in the understanding of and response to screening results within each school. More specifically, there is evidence to suggest many schools do not regularly use screeners to assess their students' socio-emotional-behavioral functioning with one estimate suggesting less than 15% of schools systematically evaluate mental health needs of their students (Bruhn et al., 2014). There is also
great variability in the mental health screening instruments used across schools, with some schools struggling to find measures that are at once psychometrically sound, developmentally appropriate and useful for addressing their students' needs (Siceloff et al., 2017). Indeed, screening tools will vary by domain of interest (e.g., externalizing problems, internalizing problems, etc.) and according to informant. For instance, when screeners are completed by school staff, they may not be free of implicit bias, creating the possibility that teachers completing screeners for their students will disproportionately identify minority students as at-risk for social, emotional and behavioral problems compared to White students (Girvan et al., 2017). Finally, some schools may also struggle to implement systematic decisions based on their screening results, a failure perhaps related to limited availability or training of school staff implementing these procedures. Even for those schools who implement evidence-based screenings regularly and reliably, these are often only completed twice a year, leaving the possibility of missing symptoms or crises that arise between these bi-annual assessments. Instead, many mental health services delivered at school results from a "refer-test-place" method which identifies mental health needs only once a psychoeducational evaluation and an IEP are completed; at which point the student is already at the highest level of risk and demonstrating significant and disrupting challenges (Dowdy et al., 2010).

**Student Mental Health Help-Seeking**

At the secondary level, there may be an expectation for students to self-identify for mental health services. This expectation may be due to adolescents' natural progression towards independence and maturity, or due to the multiple roles of social workers, psychologists and other school mental health staff maintain (Siceloff et al., 2017). It is not uncommon for these professionals to have a full workload of tasks aside from mental health screening (e.g.,
psychoeducational evaluations, mental health treatment, crisis and classroom management, and administrative tasks). Therefore, it is crucial to understand the factors that may contribute to adolescents' intent to ask for the help they need.

One way to understand the process by which adolescents engage in treatment is to consider the youth help-seeking pathway proposed by Srebnik et al. (1996) that suggests help-seeking occurs in three stages, from problem recognition, to the decision to seek help, and finally, to the pattern of service utilization. The first step of Srebnik et al.'s 1996 model is problem recognition and is best understood as a person's subjectively perceived existence of a mental health problem. The second step, help-seeking, is defined as a person's decision to seek professional help for their mental health problem (i.e., the development of the intent to seek help). Finally, the specific way a person engages with services or service providers encompass the final step of the help-seeking pathway. Each phase in the help-seeking pathway precedes its subsequent phase. Additionally, Srebnik et al. (1996) propose various factors that influence each step of the help-seeking pathway from problem recognition to service utilization.

First, factors that affect an individuals' problem recognition (i.e., step one) are comprised in his/her illness profile (Srebnik et al., 1996). The illness profile includes both symptom type and severity, perceptions of functioning, wellbeing, as well as an understanding of behavior as a mental health problem. Through the conceptualization of the illness profile, more severe symptomatology relates to greater help-seeking intent and greater mental health knowledge relates to a better understanding of the behavioral symptoms of disorder. Only once a person recognizes his/her problem will they continue to consider a decision to seek help (i.e., the second step of the help-seeking pathway). Similar factors affect a person during his/her decision to seek help (i.e., step two) and during his/her engagement in treatment (i.e., step three). These factors
include the individual's predisposing characteristics and their perceived barriers and facilitators
to treatment. Predisposing characteristics encompass a person's demographic characteristics and
the sociocultural values and beliefs of the individual and their family. Sociocultural values and
beliefs include level of ethnic identity and acculturation, attitudes and knowledge surrounding
illness and preferred/available coping strategies. Perceived barriers and facilitators, like
predisposing characteristics, can also impact a person's help-seeking and ultimate treatment
engagement. Barriers and facilitators include economic factors (e.g., income and insurance
coverage), service characteristics (e.g., access to and attitudes and availability of providers),
community and social networks (e.g., social network strength and helpfulness and knowledge of
services) and policy (e.g., federal, state and local healthcare policy; Srebnik et al., 1996).

One behavioral prediction model commonly used to explain behavioral intent or engagement is
the Theory of Planned Behavior (TPB; Ajzen, 1985, 1991). According to the TPB, behavioral
intent is the direct antecedent to behavioral engagement, and describe a person's motivational
intent to engage in that behavior. This theory suggests intent is determined by three factors,
attitudes, subjective norms and perceived behavioral control. Attitudes are shaped by an
individual's beliefs about the outcome for engaging in a particular behavior. In this way, a person
will have more positive attitudes towards a behavior they believe to have a favorable outcome.
Subjective norms are shaped by a person's normative beliefs or social pressure to engage or
avoid a particular behavior. A person's subjective norms depend on their anticipated approval or
disapproval from important others for engaging in a particular behavior (i.e., injunctive norms).
SNs may also depend on whether or not important others in an individual's life are engaging in
behavior themselves (i.e., descriptive norms). Finally, perceived behavioral control reflects the
perceived ease or difficulty of performing a behavior. Further, perceived behavioral control may
be conceptualized as a measure of barriers and self-efficacy that may impede or facilitate behavioral engagement. The TPB is commonly used to explain mental health help-seeking (Rise et al., 2010; Schnyder et al., 2017).

Unfortunately, there has been limited research into the factors that are associated with student help-seeking within a secondary school setting. Instead, much mental health help-seeking research is focused on help-seeking generally (i.e., community setting, or non-specified setting; e.g., Andrade et al., 2014; Gulliver et al., 2010). Help-seeking research in educational settings tends to focus on higher education (i.e., university or college students; e.g., Hunt & Eisenberg, 2010). Though research on mental health help-seeking in a secondary school setting is more limited, this literature reveals some unique trends. Specifically, a systematic review by Gronholm et al. (2018) examined the role social stigma has on student engagement in school-based mental health treatment. On one hand, the authors found many students had inhibited help-seeking due to a fear of stigmatization. In large part, this fear was related to the proximity of their peers to the treatment setting, and the associated worry that treatment at school lacked confidentiality. On the other hand, much research reveals adolescents cope with emotional difficulties by speaking with their peers. Specifically, when adolescents are asked to rate their preferred sources of help-seeking, peers and other informal sources rank highest (e.g., Allouche, 2020). These findings reveal the complex roles peers may play in adolescence, at once providing help and impeding help-seeking. Low levels of mental health literacy, or an ability to recognize certain symptoms as signs of psychopathology also impede adolescents' help-seeking at school (Beaudry et al., 2019). Though generally increased symptomatology is associated with greater problem recognition, internalizing problems may specifically inhibit students' intent to seek help, with research suggesting those who report greater internalizing difficulties also report
significantly lower intent to seek help (Allouche, 2020). Trends in student help-seeking also reveal demographic disparities, with females promoting more favorable attitudes (and subsequent intent to seek help) than males, gender diverse/nonconforming students promoting more favorable intent to seek help than females, and White students promoting more favorable attitudes and intent than racially/ethnically diverse students (Allouche, 2020; NAMI, 2020).

**Ethnic and Racial Disparities in Student Mental Health Help-Seeking**

There is also variability across school settings in how much mental health treatment is elective (i.e., student- or family-driven) and how much is determined by a staff referral or psychoeducational evaluation. With evidence to suggest most schools tend toward the latter (e.g., Dowdy et al., 2010), it is possible the large number of racial/ethnic minority students treated for mental health in a school setting is further evidence to the biases and prejudice that remain in the educational system, particularly regarding the detrimental implicit associations made about Black male students’ behavior, as well as the documented evidence of the role of colorism more broadly on discipline practices. And although schools eliminate structural barriers and offer opportunities for students to self-identify for mental health support, it is impossible for them to be free of bias, however implicit, or to control for the exposure to discrimination their students of color experience. Schools are unique in this way, forming a culture apart from a student’s homelife, but still connected and essential to a student's identity and life.

Thus, it is unclear to what extent minority students' low intent to seek help would persist in any given school context. Evidently, it is not enough to examine how many minority students receive school mental health treatment to understand trends in their help-seeking behavior. Not all school mental health treatment is elective. Indeed, there are various barriers to elective mental health treatment that can impact minority students' intent to seek help. Most notably, racial and
ethnic minority youth are differentially affected by experiences of racism and perceptions of social stigma than White youth, (Ogunyemi et al., 2019), a circumstance that undeniably impacts their help-seeking at school. Accordingly, there is much evidence to suggest Black youth are more likely to be over-identified for behavior concerns, but under-identified for mental health needs (Cokley et al., 2014). This trend is likely related to the low levels of cultural competence held by many schoolteachers, who may fail to recognize they treat or react differently to their racially and ethnically diverse students than their White students. Additionally, teachers may fail to recognize that the behavior of their minority students (e.g., impulsivity, aggression) are signs of underlying mental health concerns (e.g., anxiety or depression). Not only do minority students face the stressors that accompany any standard adolescent development, but they also face the chronic exposure to race-related stressors.

Though there are a number of factors that contribute to less-favorable help-seeking attitudes, there are also factors that promote more positive associations with minority help-seeking. For example, one study revealed for some racial and ethnic minority youth, a positive school climate can act as a protective factor against the deleterious effects of microaggressions and experiences of daily discrimination on attitudes toward mental health help-seeking (Townsend et al., 2017). The same study revealed that a positive school climate was also associated with less stigmatizing beliefs and greater mental health literacy, factors that may differentially impact ethnic and racially diverse students. Therefore, it is possible schools with a more positive school climate also promote more equity in treatment of their diverse school populations. Though it is possible a positive school climate reduces the deleterious effects of the experience of racism, it is also possible that a more positive environment simply contains fewer instances of overt and covert discrimination, bias and overall cultural incompetence.
Nonetheless, it is essential to better understand how and why ethnic and racially diverse students seek emotional help at school as schools present an opportunity to treat all students early and equitably.

**Study Purpose**

The present study aimed to contribute to existing knowledge on adolescent help-seeking in several ways. First, to our knowledge, this was the first study to conceptualize all stages of the help-seeking pathway within a secondary school setting. Previous research has similarly conceptualized variables that affect each stage of the help-seeking pathway, from problem recognition to treatment engagement (e.g., Yohani et al., 2018; Chen et al., 2016), but the extent to which these variables relate to the school context remained unknown. Further, a focus on the path to help-seeking, rather than treatment engagement alone, allowed for a more full understanding of the role of adolescents' context and culture, which may be of particular importance in examining this behavior at school (Cauce et al., 2002). Second, there was still very little research on mental health help-seeking for internalizing problems within a school setting. Currently, schools are better able to identify and subsequently address externalizing problems of their students as these are more clearly observable and disruptive in a school environment and because student emotional and behavioral health screening procedures vary widely across schools. Although, as articulated earlier, within the school context, internalizing problems may underly external, disruptive behaviors; therefore, without a consistent and valid method for identifying these underlying issues, they can remain untreated. This reality may disproportionality affect students of color. Finally, this study aimed to contribute to the research base addressing ethnic minority disparities in problem recognition, treatment seeking and treatment engagement for mental health problems at school. While the service gap is of great
concern for the adolescent population generally, it is even greater for racial and ethnically diverse adolescents. Not only is adolescence marked by significant change and flux, but minority students must also navigate complex experiences of accumulated stress due to microaggressions and systemic bias. Further, research on the help-seeking pathway suggests that culture affects all stages of the pathway from problem recognition, to the decision to seek help and service selection/engagement. Also, less is known about the ways in which a school setting may buffer ethnic and racial minority students against the deleterious effects of systemic socioeconomic inequality and discrimination. Therefore, it is possible the reduction of structural barriers may increase help-seeking behavior at school for those students who might otherwise be affected by these barriers in a community setting. Therefore, we planned to contribute to this literature with the aims of better understanding what factors influence students' engagement in the help-seeking pathway specifically at school. A secondary aim of this study was to better understand the factors that affect ethnic and racially diverse students at each stage of the help-seeking pathway.

**Research Questions**

1. Is there a significant relationship between symptom severity and problem recognition within the school population?
   a. Is the relationship between symptom severity and problem recognition different based on self-identified racial/ethnic minority status?
   b. How well do students accurately identify their need (or risk) in comparison to the clinical cut-score for the screening measure?

   Based on theory (Srebnik et al., 1996), it was expected there would be a significant relationship between students' self-reported symptom severity and their problem recognition. Much extant literature (e.g., Cauce et al., 2002; Fabrega et al., 1993; Sue et al., 1994) suggests
racial/ethnic minority youth differ from White youth in terms of what they perceive to be a mental health problem. Though this had not been systematically investigated in a school setting based on student-self report, we still hypothesized racial/ethnic minority youth will report less problem recognition than White youth based on their current symptom severity.

2. What factors are most strongly associated with the decision to seek help at school for those students who perceive they have a problem? a. Does students' identified minority status matter for their decision to seek help as hypothesized by the literature?

3. Does a measure of school climate explain a significant portion of the variance in students' intent above and beyond other known predictors? a. If so, is this difference moderated by racial/ethnic minority status?

For students who perceive they have a problem, it was hypothesized that variables comprising the theory of planned behavior along with past behavior, symptom severity and individual demographics would contribute to their intent to seek help. Specifically, it was hypothesized that attitudes (favorable), subjective norms (positive) and perceived behavioral control (high, via fewer reported barriers) would contribute to greater intent to seek support at school. Based on previous research with this population (Allouche, 2020), it was further hypothesized that gender identity (female and gender diverse/non-conforming), prior engagement in treatment and racial/ethnic minority status (non-minority status) would contribute to greater intent to seek help. It was hypothesized that in addition to the variables of the theory of planned behavior and variables examined in previous research, school climate would explain a significant portion of variance in students' intent to seek help at school. Finally, if there was indeed a difference in help-seeking intent by racial/ethnic minority status, it was hypothesized that race and ethnicity would moderate the relationship between school climate and help-seeking.
intent at school (Townsend et al., 2017). It was expected that a more positive school climate would relate to greater help-seeking intent for racial/ethnic minorities but would not do the same for White students (i.e., the dominant race/ethnicity), resulting in a significant moderation.

4. Of those students offered mental health services, is there a significant difference in those who accept services based on racial/ethnic minority status?

Though much previous research suggests a larger service gap for racial/ethnic minority youth (e.g., Clement et al., 2015; Sun et al., 2016), it was unclear to what extent this pattern would persist if services were offered based on students' self-identified need within an educational context. In fact, there is evidence to suggest racial/ethnic minority students may use school-based services at higher rates than White students (Cokley et al., 2014), though the extent to which this care is elective is unclear. Therefore, there was no specific hypothesis about whether there would be a significant difference in students’ acceptance of mental health services when they were offered based on their racial/ethnic minority status.
METHODS

Participants and Setting

An a priori power analysis was conducted using G*Power 3.1 software in order to
determine the sample size necessary to achieve a small to medium effect ($f^2 = .15$) with
recommended power (.80; Cohen, 1988). The power analysis was conducted using the proposed
analysis requiring the most statistical power, which in our case is a multiple linear regression
with nine total predictors. The results of this analysis indicated the need for 166 eligible
participants. To be eligible for participation, students had to be in grades six through 12 and
currently enrolled in the partnership school in a Southeastern U.S. city. The school had a total
population of 1740 students in grades k-12, a population of 708 students in the high school, and
496 in middle school (1204 students enrolled at the secondary level). Minority enrollment for the
school was 44%, less than the state average of 55%, with 13% of the school eligible for free or
reduced lunch (state average 63%). Mental health services were offered to select students
following completion of the student screening and application of decision criteria. Decisions on
which students to offer services were made according to cut-off scores set by screening measures
and a priori criteria determined by the Student Wellness Team (formed by our school partner).
Traditionally, this team has required two points of data to support tier two services.

Student Screening and Survey Measures

Student screening data was collected in the fall of 2019 in this specific population
(Allouche, 2020). In continued partnership with the School Wellness Team's efforts to
implement universal screening procedures and enhance access to school mental health services,
we collected similar data at a second timepoint in the early winter of 2021. This particular study
used the data from the winter 2021 screening. Accordingly, all measures administered as part of this research are indicated below.

**Demographic Questionnaire Form.** Demographic information on participating students was collected including age, grade, race/ethnic and gender identity. Students were also asked to indicate whether they had ever participated in or were currently participating in mental health services by indicating where they were currently seeking treatment with response choices including *school, community-based office or clinic, both, or, other/prefer not to say*. Students were also asked to indicate where they had ever received treatment with the same response options. Finally, students were asked to rate the frequency of total mental health treatment sessions in which they had ever participated with response choices including *never, a few (1-6 sessions), several (between 7 and 20 sessions), many (more than 20 sessions), or other/prefer not to say* (guided by Ajzen, 2006).

**Behavioral and Emotional Symptoms.** Students were asked to rate their emotional and behavioral strengths and weaknesses using the Behavior Assessment Scale for Children- Third Edition Behavioral and Emotional Screening System Self Report (BASC-3 BESS; Kamphaus & Reynolds, 2015). The BASC-3 BESS assesses students’ risk across internalizing, self-regulation and personal adjustment domains. Total risk was calculated in the Behavioral and Emotional Risk Index, with scores between zero and 60 indicating normal risk, 61 to 70 indicating elevated risk and anything above 71 indicating extremely elevated risk. The BASC-3 BESS was normed on a nationally representative sample of students and, combined with its multiple scaled domains, makes it an appropriate tool for universal screening to inform intervention in our study population. Also, one study found the screener demonstrated predictive validity when compared to measures of school climate and academic performance (Naser & Dever, 2020). Finally,
psychometric evidence of the BESS screener indicated no measurement bias when comparing across race/ethnicity or socioeconomic status in high school samples (Harrell-Williams et al., 2015). The internal consistency of this scale in our sample was .94 and excellent.

**Problem Recognition and Severity.** Students were asked to rate whether they believe they were impacted by their emotional and behavioral symptoms with a single item indicated in the Impact section of the Strength and Difficulties Questionnaire (SDQ; Goodman, 1999; 2001). Initial validation indicates incremental validity for the Impact scale in distinguishing between clinical and community samples than symptom assessment alone (Goodman, 1999). Additionally, this measure of burdensomeness correlated adequately (r = .74) with another previously standardized measure of burden. More detailed subjective impairment was gathered using the severity levels (symptom scores) of the emotional and behavioral screener (see above).

**Intent.** Participants were asked to rate their specific intent to seek help at school by responding to particular scenarios of interest (as suggested by Gibbons et al., 2003). Items were on a 7-point scale ranging from 1 (not at all likely) to 7 (very likely). According to this suggestion, participants were asked to rate their willingness to engage in the following scenarios: "If offered, I would be willing to speak with a school counselor," "I would be willing to sign up for a drop-in session with someone from the Student Support Team", and, "I am willing to receive information about positive mental health from the School Wellness Project," on a seven-point scale ranging from 1 (not at all willing) to 7 (very willing) with higher scores indicating greater intent to seek help (Hammer & Vogel, 2013). Participants were also asked to rate their level of agreement to three items pertaining to engagement in various mental health help-seeking behaviors. Items included, "I intend to seek mental health help from someone within the school," "I plan to seek help from a school counselor, teacher or administrator for my mental health," and,
"I will make an effort to seek help at school for my mental health," and were on a 7-point scale from 1 (very unlikely) to 7 (very likely). Previous studies measuring intent in this way have demonstrated good internal consistency with alphas > .80, as well as good incremental validity over measuring intent alone (Andrews et al., 2008; Zimmerman & Sieverding, 2010; Hammer & Vogel, 2013). One study using a similar scale revealed increases in reported intent to seek treatment following a brief intervention (Buckner & Schmidt, 2009). A similarly scaled item was subsequently used in a study assessing Black adolescents' help-seeking intent (Dean et al., 2016). This sample revealed a .90 and excellent reliability coefficient for the aforementioned intent items.

**Normative Beliefs/Subjective Norm** Participants' normative beliefs were assessed using a measure of public/other stigma and self-stigma. Public/other stigma was measured using a version of the Perceptions of Stigmatization by Others for Seeking Help scale (PSOSH; Vogel et al., 2009) slightly adapted to relate to the school context. For example, "If you were to get help from a mental health counselor, to what degree do you believe that the people you interact with would: react negatively to you?" was adapted to state, "If you were to get help from a school mental health counselor, to what degree do you believe that the people you interact with would: react negatively to you?". Items are on a five-point scale ranging from 1 (not at all) to 5 (a great deal), with higher scores corresponding to higher expectations of stigmatization by one's social network. Internal consistency for this scale ranges from .78 to .93 and has a test-retest reliability of .77 in U.S. samples (Swan et al., 2016; Vogel et al., 2009; Vogel et al., 2017). Internal consistency for this study sample was .93 and excellent.

Self-stigma describes an individual's internalized beliefs of inferiority and low self-esteem about seeking professional psychological help and was measured using a slightly adapted version of
the Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006). Items were slightly adapted to relate to the school context. For example, "I would feel inadequate if I went to a therapist for psychological help," was adapted to state, "I would feel inadequate if I went to a school counselor for help." Items are on a five-point scale ranging from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating higher levels of self-stigma. Items on the SSOSH have demonstrated a high internal consistency (.91) and an adequate test-retest reliability (.72). This scale has been used and cited in adolescent research with further evidence of internal consistency (75 - .90) and has evidence of construct, criterion and predictive validity (Divin et al., 2018). The SSOSH has also been validated across six countries demonstrating adequate invariance across cultures (Vogel et al., 2013). Internal consistency for the SSOSH in this sample was .76 and adequate.

**Behavioral Beliefs/Attitudes.** Participants' attitudes about seeking psychological help were measured using a slightly adapted version of the Attitudes Toward Seeking Professional Psychiatric Help Scale-Short Form (ATSPPHS-SF; Fischer & Farina, 1995). The ATSPPHS-SF is a ten-item measure that assesses an individual's attitudes about seeking help from a mental health professional. Our adaptation changed items so that all items relate to attitudes for seeking help within a school setting. For example, "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts," was replaced by, "The idea of talking about problems with a school counselor strikes me as a poor way to get rid of emotional problems." Items are measured on a four-point scale ranging from 0 (disagree) to 3 (agree) with higher scores indicating greater openness to seeking mental health help. The ATSPPHS-SF was adapted from its original version (Fischer & Turner, 1970) and maintains high levels of internal consistency (.84), with scores on the shortened form remaining highly
correlated with the original scales scores ($r = .87$). The scale has also maintained adequate to high levels of internal consistency when used in adolescent samples (.77 - .82) and similar levels of test-retest reliability (.80 - .82; Elhai et al., 2008; Vogel et al., 2005). Internal consistency of this scale with our sample was .80 and good.

**Control Beliefs/Perceived Behavioral Control.** Participant's control beliefs were assessed using four subscales of the Barriers to Seeking Mental Health Counseling Scale (BMHC; Shea, Wong, Nguyen, & Gonzalez, 2019). Subscales, including Discomfort with Emotions, Lack of Knowledge, Lack of Access, and Cultural Barriers, were chosen for their methodological distinctness from measures already included in the study. Items are rated on a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Items from the Discomfort with Emotions scale include, "It would be awkward for me to talk about my feelings in counseling". Items from the Lack of Knowledge subscale include, "I don't know how mental health counseling works". Items from the Lack of Access subscale include, "I have too many academic or work-related obligations that would deter me from talking to a mental health counselor". Items from the Cultural Barriers subscale include, "I don’t think that most mental health counselors would understand my cultural values". Internal consistency reliability for the Discomfort with Emotions, Lack of Knowledge, Lack of Access, and Cultural Barriers subscales in the present sample was .88, .88, .76, and .79, respectively. Internal consistency reliability for the total BMHC scale was .84 and good.

**Perceived Discrimination.** Students were asked to rate the frequency of their experiences of discrimination using an expanded version of the Everyday Discrimination Scale (EDS; Forman et al., 1997; Williams et al., 2008). This expanded scale is a 10-item measure that asks raters to indicate the frequency of items related to everyday experiences of discrimination.
Sample items include, "You are treated with less courtesy than other people" and, "People act as if they are afraid of you" and the newest item, "You are followed around in stores". Response options ranged from 1 (never) to 4 (often). Initial psychometric properties of this measure indicate one factor with a reliability coefficient of .87. This scale was also developed for use on ethnically and racially diverse adolescence and found to be significantly related to teens' internalizing and externalizing symptoms (Forman et al., 1997; Clark et al., 2004). Internal consistency for this sample was .90 and excellent.

**School Climate.** Students were asked to rate their perception of school climate using the Delaware School Climate Survey (DSCS; Bear, Yang, Pell, & Gaskins, 2014). The DCSC includes a total score, which provides an indication of overall perceptions the school climate as a safe, fair, warm, and generally positive place as well as subscales measuring specific aspects of school climate (e.g., Teacher-Student Relations, Student-Student Relations, Clarity of Expectations, Fairness of Rules, School Safety, Schoolwide Student Engagement, and Schoolwide Bullying. Possible response options ranged from 1 (disagree a lot) to 4 (agree a lot). Higher scores on the subscales indicate a more positive appraisal of that aspect of the school’s climate, except for Schoolwide Bullying (lower scores indicate less frequent bullying, and thus a more positive climate). Internal consistency reliability of this survey with this sample was .94 and excellent.

**Procedures**

Participants were all assenting middle and high school students with parent consent currently enrolled in our partner location. Prior to survey dissemination, parents were notified of the Student Wellness Project mental health screening, at which point they had the opportunity to consent or dissent to their child's participation in the school's universal screening procedures.
Students were also provided informed assent to participate in the survey and notified they could stop responding at any point. Survey administration contained a battery of nine measures along with a demographic questionnaire. Careful consideration to the order of measures was made so that the mental health screening measure (i.e., the BASC-3 BESS) was presented before our outcome variable of interest (i.e., intent to seek help at school) and before other independent variables of interest (attitudes, subjective norms, perceived behavioral control, etc.). In this way, students were primed to consider their current functioning before being asked how willing they were to seek help. Teachers delivered standardized instructions virtually to students via Microsoft PowerPoint (written and provided by researchers) immediately prior to administration as part of the regular school day during the students' advisory block. Those students whose parents had opted out of the screening were given an alternate computer activity during this time delivered to their Google Classrooms. Surveys were created using Qualtrics and sent to students' email addresses at the start of the designated time period with no other allotted work. Subsequent reminder emails were sent daily for the week following initial administration. Four attentional items were placed throughout survey measures that did not already have these items built in to ensure validity of responses. Following data completion, researchers provided school personnel with summary data of student risk to determine overall school needs as well as needs for individual student interventions. Researchers who were also members of the Student Wellness Team at our partner school had access to student information to inform and assign appropriate interventions.

**Analytic Plan**

**Preliminary Analyses.** All analyses were conducted using Microsoft Excel and IBM SPSS Statistics software (version 26). We first assessed for the pattern (e.g., random or non-
random) and amount of missing data for each variable. Based on this assessment, we decided on whether to conduct data imputation or listwise deletion for cases of missing data. Next, we assessed all variables for violations of assumptions for the primary analyses including normality, linearity, homoscedasticity/homogeneity of variance, and multicollinearity.

**Research Question 1 Analyses.** A point-biserial correlation analysis was conducted to determine the strength of association between participants' symptom severity (a continuous variable measured by Behavioral and Emotional Index score) and their subjective perception of a problem (a binary variable measured by their endorsement of experiencing a behavioral or emotional problem). A binary logistic regression was used to determine if symptom severity and race/ethnic minority status have a significant relationship to problem recognition. Specifically, symptom severity and race/ethnic minority status were the predictor variables, while problem recognition was the dichotomous outcome variable of interest in the analysis. If confounding was observed between our potential moderator (race/ethnic minority status) and symptom severity, their product would create a new independent variable (i.e., race/ethnic minority status x symptom severity). With this new variable in the model, we conducted a Wald test of significance. If the Wald test yielded a significant effect, we would infer significant moderation in our sample (Field, 2003). This analysis has been used in a recent study of help-seeking behavior in adolescence, though this particular study examined help-seeking outside of the school (Wang et al., 2019).

Finally, we did a proportion of detection analysis to see how well students accurately recognize they have a problem in comparison to the clinical cut-score (based on signal detection theory; Wilson & Swets, 1954). True hits were represented by students who both recognize they have a problem and are deemed at-risk by the screener cut score. Correct rejections were
represented by students who are neither at-risk nor report they have a problem in need of support. Additionally, false positives will be represented by those students who subjectively believe they have a problem but are not deemed at-risk by the screener. Misses were represented by those who were deemed at-risk by the screener but did not report they had a problem in need of support.

**Research Question 2 and 3 Analyses.** In response to questions two and three, hierarchical multiple regression analyses were used. First, our dependent variable was students' reported intent to seek help at school. Predictor variables included those found to be salient in previous research based on theory and consistency of findings. Therefore, predictor variables included those associated with the TPB (ATT, SN [i.e., self and other stigma], and PBC), symptom severity, demographic variables (gender and racial/ethnic identity), and past behavior (concerning mental health treatment). Atheoretical variables identified in the literature as consistently significant and meaningful were entered into the regression model in step one (i.e., symptom severity, demographic variables, past behavior). Variables comprising the TPB were entered into the regression model in step two to determine what added variance they explained in the outcome of interest, and therefore the validity of this theory within a school context for predicting youths' intent to seek help.

A hierarchical multiple regression was also used to examine the relationship between racial/ethnic minority status and help-seeking intent while controlling for potential confounding variables, as well to test our moderational hypothesis. The dependent (outcome) variable in this analysis was intent to seek help at school. The predictor variables were entered in four steps: (1) covariates identified in previous research and theory (i.e., symptom severity, gender identity, past behavior); (2) the variables associated with the TPB (ATT, SN [self and other], and PBC);
(3) school climate and race and ethnic minority status; (4) the interaction of racial/ethnic minority status and school climate on intent to seek help. This strategy ensured that effects at step four could not be attributed to the variance shared with variables in steps one, two and three (Cohen & Cohen, 1983). The nature of a significant interaction was intended to be probed by following guidelines outlined in Cohen & Cohen (1983).

Research Question 4 Analyses. Logistical barriers prevented the analysis of this question as planned. Instead, a chi-square test of independence was used to determine whether students' and families' assenting to screening to be independent of their racial/ethnic minority identity. Nominal variables included racial/ethnic minority status and assenting or dissenting to school-based mental health screening.
RESULTS

Preliminary Analyses

Descriptive statistics and preliminary analyses were conducted on demographic and study variables to ensure all assumptions for primary analyses were met. Data for each study measure were checked for missing values. Analysis of missing data revealed data to be missing at random. Still, a decision was made to remove all cases listwise from analyses to only use cases for which complete data were available. Further, a total of 10 cases were removed for failure to meet three or more validity checks. Finally, study variables were examined for violations of the assumptions for the primary analyses including normality, linearity, homoscedasticity/homogeneity of variance and multicollinearity.

Demographics, Past Behavior, Perceived Risk

Total enrollment in middle and high school of our partner at the time of our study was 1204 (see Table 1). We received parent consent for 592 students (49.17% of eligible participants). 464 students entered into our survey when prompted by their teachers, with 48 (10.34%) respondents dissenting, and 416 (89.66%) respondents assenting. A total of 401 students completed our survey (96.40% of the 416 assenters; 67.74% of the 592 with parental consent; 33.31% of the 1204 currently enrolled secondary students). Ten cases were removed from our sample for failure to meet attentional checks. Current enrollment at our partner site by racial/ethnic status is in Table 1. Our current sample consisted of 391 secondary school students between the ages of 11 and 18. Participant demographics may be found in Table 2. At the time of the survey, total minority enrollment at the secondary level of our partner site was 37.21%. Alternatively, 32.99% of the current sample identified as a racial/ethnic minority. The present sample reported on their current and past engagement in mental health treatment. In this sample,
298 (76.2%) students were not currently in treatment, 45 (11.5%) were currently in treatment in a community-based office or clinic, 11 (2.8%) were currently in treatment at school, 9 (2.3%) were currently in treatment both in a community-based office or clinic and school, and 28 (7.2%) chose not to respond. In our present sample, 90 (23.0%) students reported ever receiving mental health treatment in a community-based office or clinic, 39 (10.0%) reported ever receiving treatment at school, 35 (9.0%) students reported ever receiving treatment both at school and in a community-based office or clinic, 212 (54.0%) students reported never receiving mental health treatment, and 15 (3.8%) chose not to respond.

Table 1. Enrollment by Racial/Ethnic Status

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<tr>
<th>Grade Level</th>
<th>Grade Count</th>
<th>American Indian</th>
<th>Asian</th>
<th>Black</th>
<th>White</th>
<th>Multiple</th>
<th>Hawaiian-Pacific Islander</th>
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<td>6</td>
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<td>7</td>
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<td>318</td>
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<td>1</td>
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<tr>
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Descriptive Statistics

Descriptive statistics for the survey measures are in Table 4. In addition to overall sample means, summary data by monolithic racial/ethnic status (White and minority), and by multiple racial/ethnic minority status are provided. In our overall sample, the mean BESS T-score was 54.60 (SD = 13.08; approximately five-points below the cut-score), with significant (p <.01)
mean group differences existing between students who identify as White ($M = 53.12, SD = 12.96$), students who identify with a monolithic racial/ethnic minority group ($M = 56.86, SD = 13.27$) and those who identify with multiple racial/ethnic groups ($M = 59.25, SD = 11.91$; less than one-point below the cut-score). Further subgroup comparisons revealed significant differences between students reported internalizing symptoms ($F \ [2, 397] = 5.82, p < .01$), adaptive symptoms ($F \ [2, 374] = 4.87, p < .01$), perceptions of stigmatization by others ($F \ [2, 365] = 6.46, p < .01$), self-stigmatization ($F \ [2, 361], p < .05$), overall barriers to treatment ($F \ [2, 353] = 13.93, p < .01$), cultural barriers ($F \ [2, 352] = 40.41, p < .01$), perception of daily discrimination ($F \ [2, 351] = 4.94, p < .01$) and perception of school climate ($F \ [2, 351] = 5.91, p < .01$). Across all comparisons, White students scored higher in adaptive measures (e.g., personal adjustment and school climate) and lower across clinical measures and measures of barriers to help-seeking (e.g., internalizing symptoms and everyday discrimination) than both students who identified with one racial/minority group or multiple racial/ethnic groups.

Table 2. Participant Demographics

<table>
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Table 3. Pearson Correlations

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<td>12. Barr. Lack of Access</td>
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*Note: BESS (Behavioral and Emotional Screening System); PSOSH (Perception of Stigmatization by Others for Seeking Help scale); SSOSH (Self-Stigma of Seeking Help scale); DSCS (Delaware School Climate Survey)*
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<th>Measure</th>
<th>Overall Mean (SD)</th>
<th>Monolithic Dominant Racial/Ethnic Group Mean (SD)</th>
<th>Monolithic Minority Racial/Ethnic Group Mean (SD)</th>
<th>Multiple Racial/Ethnic Groups Mean (SD)</th>
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<td>53.12 (12.96)</td>
<td>56.86 (13.27)</td>
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<tr>
<td>Internalizing**b</td>
<td>11.13 (6.97)</td>
<td>10.39 (6.81)</td>
<td>12.08 (7.07)</td>
<td>13.57 (7.07)</td>
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<td>Self-Regulation</td>
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<td>6.18 (3.53)</td>
<td>6.40 (3.48)</td>
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<td>Personal Adjustment*a</td>
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<td>17.18 (9.85)</td>
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<td>Barriers**ab</td>
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<td>58.37 (13.14)</td>
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<td>Lack of Access</td>
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<td>15.34 (5.66)</td>
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<td>Everyday Discrimination**a</td>
<td>16.55 (5.98)</td>
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<td>18.17 (5.87)</td>
<td>17.63 (6.36)</td>
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<td>School Climate**a</td>
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<td>91.81 (11.59)</td>
<td>87.12 (11.07)</td>
<td>87.56 (12.34)</td>
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</table>

*Note: BESS (Behavioral and Emotional Screening System); PSOSH (Perception of Stigmatization by Others for Seeking Help scale); SSOSH (Self-Stigma of Seeking Help scale)

*a significant overall sub-group mean comparisons, p < .05

** significant overall sub-group mean comparisons, p < .01

*a significant pairwise difference between monolithic dominant racial/ethnic group and monolithic minority racial/ethnic group, p < .05

b significant pairwise difference between monolithic dominant racial/ethnic group and multiple racial/ethnic groups, p < .0
**Table 5. Mental Health Screening Results**

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<th>Category</th>
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<td>Extremely Elevated Risk</td>
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<td>Low or No Risk</td>
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<td>Total At-Risk</td>
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<td><strong>Internalizing</strong></td>
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<td>95</td>
<td>23.3</td>
</tr>
<tr>
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<td>10.7</td>
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<td>Total At-Risk</td>
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<td><strong>Personal Adjustment</strong></td>
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<td>Total At-Risk</td>
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</table>

*Note:* Behavioral and Emotional Risk was measured by converting a participant’s total raw score on the BESS to a combined gender norm T-score. A T-score of 61 or greater indicates behavioral and emotional risk. Internalizing symptoms were measured by the Internalizing subindex of the BESS. Externalizing symptoms were measured by the BESS Self-regulation Index. Personal Adjustment risk was calculated by the Personal Adjustment Index of the BESS.

**Emotional/Behavioral Risk**

Emotional or behavioral risk in the present sample is detailed in Table 5. Total risk was calculated using the BESS total raw scores converted to combined gender normed T-scores. T-score between 61-70 indicates elevated risk and a score between 71-80 indicates extremely elevated risk. BESS subindices include risk across Internalizing, Self-Regulation, and Personal Adjustment domains. Altogether, 83 (21.2%) and 45 (11.5%) of secondary students screened at elevated and extremely elevated risk on the BESS emotional or behavioral composite, respectively.

**Internalizing Symptoms.** Internalizing symptoms were measured by the Internalizing subindex of the BESS. For 11-year-olds, a score between 12-16 and 17-30 indicates elevated and extremely elevated risk, respectively. For 12–14-year-olds, a score between 13-19 and 20-
30 indicates elevated and extremely elevated risk, respectively. For 15–18-year-olds, a score between 14-22 and 23-30 indicates elevated and extremely elevated risk, respectively. Altogether, 95 (23.3%) and 42 (10.7%) of secondary students screened at elevated and extremely elevated risk for internalizing problems, respectively.

**Externalizing Symptoms.** Externalizing symptoms were measured by the BESS Self-regulation Index. For 11-year-olds, a score between 9-13 and 14-18 indicates elevated and extremely elevated risk, respectively. For 12–18-year-olds, a score between 9-12 and 13-18 indicates elevated and extremely elevated risk, respectively. Altogether, 71 (18.2%) and 26 (6.6%) of secondary students screened at elevated and extremely elevated risk for externalizing problems, respectively.

**Adaptive Symptoms.** Adaptive symptoms were measured by the BESS Personal Adjustment Index. For 11-year-olds, a score between 13-24 and 8-12 indicates elevated and extremely elevated risk, respectively. For 12–14-year-olds, a score between 12-24 and 8-11 indicates elevated and extremely elevated risk, respectively. For 12–14-year-olds, a score between 12-24 and 7-11 indicates elevated and extremely elevated risk, respectively. Altogether, 65 (16.6%) and 21 (5.4%) of secondary students screened at elevated and extremely elevated risk for adaptive symptoms, respectively.

**Research Question 1**

A point biserial correlation was conducted between students' symptom severity score (via the BESS) and their subjective problem perception (via item on the SDQ-Impact). Students' overall symptom severity was correlated to their perception of a problem with an $r$ of .63 ($p < .01$). The correlation between students' subjective perception of a problem and their internalizing symptoms was .59 ($p < .01$). The correlation between students' subjective perception of a
problem and their externalizing symptoms was .54 (p < .01). The correlation between students' subject perception of a problem and their adaptive symptoms was -.48 (p < .01).

A binary logistic regression was conducted to determine whether the relationship between students' symptom severity and their perception of a problem was moderated by their racial/ethnic minority status. Results are in Table 6 below.

Table 6. Logistic Regression

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<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
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<td>19.70</td>
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Note: Variable entered onto step 1: BESS x Minority Status.

A proportion of detection analysis was conducted to see how accurately students identify their need (or risk) in comparison to the clinical cut-score on the BESS. Results of the analysis are in Table 7 and revealed 121 (98.4% of those at-risk) true hits (i.e., students who both recognize they have a problem and are deemed at-risk by the screener cut score), 134 (52.1% of those not at-risk) correct rejections (i.e., students who do not report a problem in need of support nor are at-risk based on the screener), 123 (47.9% of those not at-risk) false positives (i.e., students who report a perception of a problem in need of support but are not deemed at-risk by the screener), and 2 (1.6% of those at-risk) misses (i.e., students who do not perceive they have a problem; yet, are deemed at-risk by the screener). Further, this analysis revealed a 98.37% sensitivity rate, and a 52.14% specificity rate. The positive predictive value of the problem recognition is 49.59%, while the negative predictive value is 98.53%.
Table 7. Crosstabulation: Problem Perception x BESS Risk

<table>
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<td>%</td>
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Research Questions 2 & 3

A hierarchical linear regression was conducted to test whether the variables comprising the theory of planned behavior contributed a significant portion of variance to our outcome, intent to seek help at school, above and beyond atheoretical variables previously identified in research (i.e., gender identity, past treatment, and symptom severity). To test this hypothesis, we first added three atheoretical variables (step 1), followed by the three variables comprising the theory of planned behavior (i.e., attitudes, subjective norms [self and other], and perceived behavioral control; step 2).

Subsequent variables were added to our hierarchical regression to examine the relationship between racial/ethnic minority status and school climate on help-seeking intent while controlling for potential confounding variables, as well as to test our moderational hypothesis. Variables added to step 3 included school climate, perception of daily discrimination and race/ethnic minority status. Variables added to step 4 include the interaction of racial/ethnic minority status and school climate. The model summary of this regression is in Table 8, and corresponding coefficient statistics are in Table 9. Step 3 was the final step in our regression to contribute significant variance to the outcome variable (i.e., intent to seek help at school; F change [3, 213] = 2.98, p < .05). All significant variables in the model at step three include Attitudes (β = .35, p = .00), PSOSH (β = .22, p = .00), Barriers (β = .23, p = .01), and School Climate (β = .21, p = .01).
Table 8. Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R²</th>
<th>Adjusted R²</th>
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<th>F Change</th>
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a. Predictors: (Constant), BESS, Past Treatment, Gender
b. Predictors: (Constant), BESS, Past Treatment, Gender, Attitudes, SSOSH, PSOSH, Barriers
c. Predictors: (Constant), BESS, Past Treatment, Gender, Attitudes, Self-Stigma, Other Stigma, Barriers, School Climate, Everyday Discrimination, Minority Status
d. Predictors: (Constant), BESS, Current Treatment, Lifetime Treatment, Gender, Attitudes, Self-Stigma, Other Stigma, Barriers, Everyday Discrimination, School Climate, Minority Status, Minority Status x School Climate
Table 9. Hierarchical Regression Coefficients\textsuperscript{a}

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<th>Model</th>
<th>$B$</th>
<th>Std. Error</th>
<th>$\beta$</th>
<th>$F$</th>
<th>Sig.</th>
<th>Zero-order</th>
<th>Partial</th>
<th>Part</th>
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<td>-.15</td>
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<td>1.45</td>
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<tr>
<td></td>
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<td>.08</td>
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<td>-.02</td>
<td>-.07</td>
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</table>

\textit{Note:} PSOSH (Perception of Stigmatization by Others for Seeking Help scale); SSOSH (Self-Stigma of Seeking Help scale); DSCS (Delaware School Climate Survey)

\textsuperscript{a} Outcome: Intent to seek help at school
Research Question 4

Due to logistical challenges related to the COVID-19 pandemic, the question of whether self-identification as a minority status was related to engagement in mental health services was not able to be explored as planned. However, we investigated whether self-identification as a racial/ethnic minority affected intent to engage in the mental health screening. A chi-square test of independence was conducted to see whether the proportion of minority students who assented to the screening was significantly different than the proportion of minority students who dissented (i.e., active parent dissent, no response, and student dissent). As the current sample of survey respondents was made up of only those students whose parents actively assented to screening and who assented to the screening themselves, the group of dissenters was comprised of children of parents who actively dissented or who did not respond to consent, as well as those students who actively dissented or did not complete the screening. Results of this analysis are in Table 10 and reveal significant differences between the proportion of assenters and dissenters based on minority status ($\chi^2 [3, N = 1198] = 44.11, p < 0.001$). Specifically, while more White students assented to screening than expected (262 observed, 242.95 expected), fewer Black students assented than expected (60 observed, 99.62 expected). The opposite result was observed for dissenters with fewer White students dissenting to screening than expected (487 observed, 513.05 expected) and more Black students dissenting than expected (250 observed, 210.38 expected). On the other hand, more students who identified as multi-racial/ethnic were observed assenting than expected (42 observed, 25.39 expected) while fewer multi-racial/ethnic students were observed dissenting than expected (37 observed, 54.61 expected). Fewer Asian students were observed assenting than expected (14 observed, 17.03 expected), and more Asian students were observed dissenting than expected (39 observed, 35.97 expected).
A subsequent chi-square test of independence was conducted to test whether this pattern also existed when passive consent was used prior to the pandemic. For this analysis, data gathered using passive consent in the fall of 2019 from the same partner school was used. The fall 2019 sample of assenters was comprised of those students whose parents passively consented (i.e., did not actively dissent) and who subsequently participated in the screening. On the other hand, dissenters included children of parents who actively dissented as well as those students who actively dissented to participate in the screening. Results of this chi-square are in Table 11 and reveal significant differences in the proportion of assenters to dissenters based on racial/ethnic minority group. Specifically, there were more White students and fewer Black students who assented to treatment than expected (281 observed, 271.80 expected and 110 observed, 133.05 expected, respectively) and fewer White students and more Black students who dissented to treatment than expected (148 observed, 157.20 expected, and 100 observed, 76.95 expected, respectively). There were more multi-racial/ethnic students observed assenting than expected (49 observed, 37.38 expected) and fewer dissenting than expected (10 observed, 21.62 expected). With passive consent, more Asian students were observed assenting than expected (13 observed, 10.77 expected), and fewer Asian students were observed dissenting than expected (4 observed, 6.23 expected).
Table 10

*Chi-Square Test of Independence (Current Sample; Active Consent)*

<table>
<thead>
<tr>
<th></th>
<th>Assent</th>
<th>Dissent</th>
<th>Row Totals</th>
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<tbody>
<tr>
<td>White</td>
<td>262 (242.95) [2.79]</td>
<td>487 (513.05) [1.32]</td>
<td>756</td>
</tr>
<tr>
<td>Black</td>
<td>60 (99.62) [15.76]</td>
<td>250 (210.38) [7.46]</td>
<td>310</td>
</tr>
<tr>
<td>Multi-Racial/Ethnic</td>
<td>42 (25.39) [10.87]</td>
<td>37 (54.61) [5.15]</td>
<td>79</td>
</tr>
<tr>
<td>Asian</td>
<td>14 (17.03) [0.54]</td>
<td>39 (35.97) [0.26]</td>
<td>53</td>
</tr>
</tbody>
</table>

*Column Totals*  
374  
824  
1198 (Grand Total)

*Note:* () = expected cell totals, [] = the chi-square statistic for each cell; $X^2 (3, N = 1198) = 44.11, p < 0.001$

Table 11

*Chi-Square Test of Independence (Previous Sample; Passive Consent)*

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<th>Assent</th>
<th>Dissent</th>
<th>Row Totals</th>
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</thead>
<tbody>
<tr>
<td>White</td>
<td>281(271.80) [0.31]</td>
<td>148 (157.20) [0.54]</td>
<td>429</td>
</tr>
<tr>
<td>Black</td>
<td>110 (133.05) [3.99]</td>
<td>100 (76.95) [6.90]</td>
<td>210</td>
</tr>
<tr>
<td>Asian</td>
<td>13 (10.77) [0.46]</td>
<td>4 (6.23) [0.80]</td>
<td>17</td>
</tr>
</tbody>
</table>

*Column Totals*  
453  
262  
715 (Grand Total)

*Note:* () = expected cell totals, [] = the chi-square statistic for each cell; $X^2 (3, N = 715) = 22.86, p < 0.001$
DISCUSSION

The purpose of this study was to better understand adolescent help-seeking in several ways. First, we aimed to analyze student engagement across all levels of the help-seeking pathway (from problem recognition to engagement in treatment/services; Srebnik et al., 1996). Next, we assessed the utility of the theory of planned behavior in explaining students’ intent to seek help at school. Finally, we examined differences in students' behavior across the help-seeking pathway based on racial/ethnic minority status.

At the first stage of the help-seeking pathway, students must recognize they have a problem. We investigated how accurate students' subjective problem recognition was in comparison to their identification based on a screener cut score. Overall, students' problem recognition was significantly related to their screener risk status. Further analyses were conducted to better understand this relationship and revealed a single item pertaining to students' subjective perception of a problem acted as an incredibly sensitive (though not specific) way to capture those who would be at-risk via a normed screener (i.e., the BESS). As such, the positive predictive value suggested that just under half (49.59%) of students who believed they had a problem would in fact be identified as at-risk for an emotional or behavioral problem via the BESS, while the negative predictive value of 98.53% suggested that nearly all students who did not believe they had a problem would in fact be identified as within normal or low risk via the BESS. Altogether, these data suggest that a single item inquiring about participants' perception of a problem may appropriately reduce the number of students who need be screened for emotional or behavioral problems at the secondary level with little risk of missing students who are at-risk. In other words, this single item of problem perception may function as an efficient and effective first gate of mental health screening. Given logistic barriers that may get in the
way of longer mental health screening tools, future effort should be placed into the viability and reliability of students' problem recognition as a first step to mental health screening. Of course, future studies in school settings should be conducted to identify whether this item would function similarly across other samples of students. A secondary analysis was used to see whether students' racial/ethnic minority status impacted the relationship between their problem recognition and symptom severity. Contrary to our hypothesis, students' self-identified racial/ethnic minority status did not moderate the association between symptom severity and problem recognition. That is, the relationship between these variables does not vary based on broad pan-racial/ethnic group membership, suggesting, at least in this sample, problem recognition may operate similarly across groups. Given that the sample is all fairly acculturated and either bilingual or English dominant, this finding makes sense.

A secondary aim of this study was to assess the utility of the theory of planned behavior in understanding students' intent to seek help at school. Only those students who responded affirmatively to a single item related to their perception of a personal emotional or behavioral problem were included in the analysis. This decision was made to gauge intent in a sample of students who could be expected to intend to seek treatment as we would not expect those students who did not agree they had a personal emotional or behavioral problem to intend to seek treatment, and therefore, excluded them from analysis. Results revealed significant findings for all theory of planned behavior variables (i.e., attitudes, subjective norms, and perceived behavioral control), suggesting this theory has utility within the school context. In fact, these variables explained the majority of the variance in our outcome of interest (i.e., intent to seek help; 16% of a total 24%). Even when controlling for our atheoretical variables, more positive attitudes, lower perception of stigmatization by others and fewer endorsements of barriers were
related to greater help-seeking intent at school. As hypothesized, students' favorable attitudes about receiving treatment were associated with greater intent to engage in treatment in school. This is consistent with patterns of treatment seeking associations within the community context and with other populations. In other words, more favorable perceptions of counseling and therapy generally result in more reported likelihood of seeking help at school. Notedly, this pattern was displayed within the sample of students who reported they had a problem, and regardless of students' symptom severity.

Contrary to our hypothesis, self-stigma, or the feeling that one's self-worth or esteem would be diminished for seeking treatment, was not significantly associated with help-seeking intent. Although, this finding should be further explored given a near significant result (p = .07). The present study’s findings may be due to the fact that on average, our sample responded neutrally or disagreed with items relating to their endorsement of self-stigma. In other words, overall, our sample did not believe they would have lower self-esteem for seeking treatment. On the other hand, it may be possible that students are more likely to avoid treatment-seeking behaviors for fear of stigmatization by others even when the fear of self-stigmatization would not have this same effect. It is possible our sample reflected this unique adolescent developmental stage where peer salience is at its peak and affecting decision-making accordingly.

Student-endorsed barriers were also significant factors in students' intent. Barriers ranged from the individual (e.g., discomfort with emotions, lack of knowledge), to the group (e.g., cultural barriers), to the structural (e.g., lack of access to treatment). As the school eliminates structural barriers to treatment (i.e., cost, travel, insurance, therapist availability, etc.), we may expect the remaining barriers to persist within the school (i.e., the individual and cultural barriers). In the present study, two individual barriers were found to be negatively associated with help seeking
intent (discomfort with emotions, lack of knowledge), while structural and cultural barriers were not. However, given the underrepresentation of the sample, particularly among monolithic racial/ethnic minority students, this finding should be interpreted with caution. Altogether, this study found that students' attitudes, fear of stigmatization by others, and individual barriers were significant factors in their intent to seek help at school. These findings are promising in that all these variables are amenable to intervention: attitudes may be improved, fear of stigmatization may be reduced, and individual barriers (e.g., lack of knowledge, discomfort with emotions) may be removed.

Contrary to hypotheses, no atheoretical variables controlled for in our model were significantly associated with intent in our final step in the model. More specifically, in our sample of students who perceived they had a problem, symptom severity, gender identity, and previous engagement in mental health treatment were not significantly associated with their intent to seek help at school. Though it was hypothesized that gender identity (female and gender diverse/non-conforming), prior engagement in treatment, and racial/ethnic minority status (non-minority status) would contribute to greater intent to seek help, these patterns were not found in our data. Contrary to previous research in this sample and others (McNair & Bush, 2016; Allouche, 2020), males did not endorse significantly less intent to seek help than their female or gender diverse/non-conforming counterparts. Similarly, prior engagement in mental health treatment was not significantly related to students' willingness to seek help. Finally, in the sample of students who believed they had a problem, greater symptom severity was not significantly associated with intent to seek help. It is possible that once individuals perceive they have a behavioral or mental health problem in need of support, other factors commonly
associated with help seeking become less relevant. In other words, these factors might be more influential at the problem recognition stage of the help seeking pathway at school.

In addition to controlling for atheoretical variables and including the theory of planned behavior variables, a measure of school climate, perceived discrimination, and racial/ethnic minority status were also included to our regression on help-seeking intent. Of these additional variables, the measure of school climate was significantly associated with help-seeking intent, with more positive reports of school climate relating to greater intent. It was hypothesized that more positive perceptions of school climate might serve as a particular protective factor for racial/ethnic minority youths, but our sample did not reveal any significant associations by race/ethnic status. Again, this finding should be interpreted with caution given the underrepresentation of the study sample. Regardless, in our sample, it is important that students who stated they had a problem were more likely to seek help if they had more positive perceptions of the school climate.

Across all analyses, racial or ethnic minority status was not associated with students' help-seeking, from problem recognition to intent. However, it is very likely that our sample suffered a range restriction from a potential sampling bias. Indeed, our sample was comprised only of those children of parents who actively consented for their child(ren) to participate (along with students who subsequently assented). Therefore, it is unknown if those parents and/or students had a baseline level of trust in the school system greater than those who dissented. As such, it is unknown if data of the entire secondary school would yield a different result (i.e., reveal variations according to racial/ethnic minority status). Our investigation into this potential sampling bias revealed screening assenters to be disproportionately more White and less Black than would be expected based on school enrollment. Given this, it may be inferred there are
significant barriers to engage in mental health services broadly at school, as evidenced by the disproportionality in survey consenters/assenters. Importantly, this discrepancy was not only found in our current sample using active consent but was even observed in a previous sample at the same partner site in a previous year where passive consent was used. This suggests that, even when dissenting was more effortful (i.e., since passive consent requires active dissent), Black families were still less likely to engage in mental health screening at school. Thus, it is possible the present study was limited in its investigation into differences by racial/ethnic minority status along the help-seeking pathway, in part because racial/ethnic minority families were more hesitant to engage in the pathway to start. Not only does our study reveal minority groups engage in less active service utilization, but they also engage in less passive service utilization (i.e., they are consciously refusing potential identification for service use disproportionately to multiracial and dominant racial/ethnic groups). As racially/ethnically diverse groups are more likely to suffer mistreatment by the medical system (e.g., Valdez et al., 2019; NAMI, 2020), it is possible a mistrust based on a history of mistreatment in community or medically based systems has trickled into broader systems mistrust. However, given this longstanding history, it may be unfair to ask ethnic minority families of color to automatically trust school systems who do not explicitly prioritize the dismantling of inequitable practices. Future studies should examine the relationship between school-level factors and families' willingness to engage (either passively or actively) with mental health identification measures.

Though this study did not find significant differences in associations to problem recognition or intent by racial/ethnic minority groups, it did reveal significant differences in the willingness to engage in school mental health screening as well as mean differences on key study variables across racial/ethnic minority status. Our study identified key differences among those
students who identified with a monolithic racial/ethnic dominant group (White students), from those who identified with a monolithic racial/ethnic minority (Black, Hispanic/Latinx, Asian or Asian American, etc.), and from those who identified with more than one racial/ethnic group. The decision was made to separate students by monolithic dominant/minority and multiple ethnic racial groups for two reasons. First, our students who identify with more than one racial/ethnic category represent diverse identities, and the extent to which their experiences are similar to those of minority students who identify with a single racial/ethnic group is uncertain. While multi-racial/ethnic individuals share a bi- or multi-cultural identity and the need to navigate multiple social worlds, they cannot be easily categorized. The scholarly literature suggests that their experiences and attitudes differ significantly depending on the race(s) or ethnic identities that comprise their background and how society views and interacts with them. Second, our analysis of student/family engagement revealed an interesting trend with multi-racial/ethnic students, in that, this group was more likely to engage in mental health screening than would be expected based on their population at school. This trend was observed to be significant at two time points (the current and past screenings) and was in the opposite direction of the Black students/families and in a similar direction as the White students/families. As such, a decision was made to explore how multi-racial ethnic students responded overall to our survey items, separate from our monolithic racial/ethnic minority students. Subgroup comparisons revealed significant differences between students' overall behavioral and emotional symptoms, their internalizing symptoms, adaptive symptoms, perceptions of stigmatization by others, self-stigmatization, overall barriers to treatment, cultural barriers, perception of daily discrimination, and perception of school climate. Across all variables, White students scored higher in adaptive domains (e.g., personal adjustment) and lower in clinical domains (e.g., internalizing symptoms,
self-regulation symptoms) and barriers (e.g., cultural barriers) than monolithic racial minority students. Monolithic racial minority students scored higher in adaptive domains (e.g., personal adjustment) and lower in clinical domains (e.g., internalizing symptoms, self-regulation symptoms) than multi-racial/ethnic students. Despite multi-racial/ethnic students in our sample engaging in screening at higher-than-expected rates, they still scored similarly to, and even more disparagingly than our monolithic racial/ethnic minority students (Black and Asian students who engaged in screening at rates lower-than-expected). It is possible that this population of students was more likely to engage in the screening process due to their heightened expressed mental health risk and/or a greater level of trust in the school than their monolithic racial/ethnic minority peers. Notably, based on trends identified in the U.S. multi-racial population, one parent likely identified as White for the vast majority of multi-racial/ethnic minority students in the sample. This parent may have been the one who consented to the mental health screening.

While schools have great potential to protect ethnic and racial minority students against structural barriers to mental health treatment, they are not free of bias, and as such, may encompass unique barriers for students who might benefit from receiving these services. Though proportionally, more Black students are treated for their mental health at schools than are treated in a community setting, it is likely these students are not electing treatment. Instead, it is more likely they are being overidentified as a result of detrimental associations made about minority students’ (and specifically Black male students’) behavior. It is therefore also important to recognize that hesitancy for racial and ethnic minority populations to engage in mental health help-seeking at school may be an adaptive response to unjust and inequitable discipline practices and overrepresentation in special education. Moreover, internalizing problems may underly externalizing behaviors. Without a consistent and valid method for identifying these underlying
issues for all students, they can remain untreated; a reality that may further disproportionality affect students of color. Finally, the observed disproportional engagement by racial/ethnic minority status suggests that, without intentional and proactive efforts to address inequalities affecting Black and minority families at a structural level, school teams will remain unable to address the needs of this population. In the spring of 2020, our partner site was the target of protests by some alumni and current members of the student body who demanded school administration actively engage in specific ant-racist work and dismantle their symbols of White supremacy. The response to these demands at the school level was slow and unenthusiastic, disappointing many, and likely contributing to the low engagement of families of color in this school-based mental health initiative.

Limitations

This study has several limitations that should be noted and addressed in future research. Not only does our sample reflect a sampling bias through inclusion only of families who were comfortable engaging with our research and the school's screening (via active assent), but our school partner may also reflect a larger sampling bias, in that our partner school's administration’s openness and availability to screening students may already reflect a more positive school climate and staff readiness for proactive mental health assessment than may be found at other schools. It may be that the use of passive consent would reduce this disengagement by racial/ethnic minority families, though our past research suggests that minority family hesitancy to engage in school mental health screening may persist even with the use of passive consent. Still, future research should explore whether trends found in our study may be replicated across subgroups and in other school settings. Next, our study did not measure students' engagement in mental health treatment at school, but rather, measured their behavioral
intent, a close proxy, for treatment engagement. Future studies would be strengthened by using a direct measure of engagement in mental health treatment. Still, a strength of this study was in our direct measure of engagement in school screening, measurement that revealed interesting trends across racial/ethnic subgroups in this school. Our study also had a substantial number of students state they identify as multi-racial/ethnic, but it is likely students in this category represent diverse identities with differing levels of association with a minority identity or experience. Therefore, future studies would be strengthened with the use of a more nuanced measure of racial/ethnic identity. Finally, logistical barriers related to the COVID-19 pandemic prevented us from pursuing analyses related to racial/ethnic disparities in treatment engagement at school. School safety and distancing precautions deprioritized our ability to screen students as scheduled. As such, we were delayed in our communications to parents for consent, in the administration of the survey, and ultimately, delayed in offering treatment to students at-risk.

**Conclusion**

This study is the first to our knowledge to investigate adolescents' mental health help-seeking along the help-seeking pathway (Srebnik et al., 1996). First, we found that an item related to adolescents' subjective perception of a problem was a highly sensitive, though not specific tool to identify those who would be at-risk via a nationally normed screening tool. This finding suggests there may be utility to regularly asking students about their perceived need for support, as those who will not report a need, may not require screening (i.e., they would likely not be found at-risk via a normed screener). Next, this study assessed the utility of the theory of planned behavior to investigate factors related to high school students' willingness to seek mental health support at school, finding that attitudes, subjective norms (via a measure of social stigma), and barriers significantly predicted help-seeking intent. As these perceptions are amenable to
change, findings suggest that the theory of planned behavior may be used to identify important points of intervention. Findings also indicated that above contributions made by the theory of planned behavior, a measure of school climate was significantly associated with student’s intent to seek help. This finding indicates schools may contribute to students' willingness to seek help at a structural level.

A secondary aim of this study was to examine differences in help-seeking behavior among adolescents of varying racial/ethnic statuses. Findings suggest Black students and families were significantly less likely to assent to screening than their White or multi-racial/ethnic counterparts. While it is important to understand what factors relate to adolescents' acceptance of or reluctance to engage in treatment, it is also crucial to identify barriers to their appropriate and systematic identification in the first place. For schools to be able to respond to all individuals in their diverse student body, they must be proactively engaged in work to earn and deserve the trust of their racially/ethnically diverse families. Until then, there may be incomplete or reluctant engagement from students and families of color. Not only are studies that consider why adolescents do or do not seek help for their mental health problems essential for optimizing pathways to treatment for youth, so too are studies that examine barriers to engagement at a family and schoolwide level. Results of this study highlight important factors to target when developing interventions to increase mental health help-seeking behaviors in a secondary school setting.
APPENDIX A. SURVEY QUESTIONS

Consent, Demographics, & Past Behavior

Students, we are asking for you to fill out a survey with questions related to your past behavior, thoughts, and emotions. We will take great care to keep the information private, so that your information will be shared only with people with a need to know (e.g., principal, school counselor, school social worker, etc.).

1. Please enter your first name

2. Please enter your last name

3. You have the right to choose not to take the survey. Please indicate below if you DO or DO not wish to take the survey.
   a) I DO wish to take this survey
   b) I DO NOT wish to take this survey

4. What is your grade?
   a) 6th grade
   b) 7th grade
   c) 8th grade
   d) 9th grade
   e) 10th grade
   f) 11th grade
   g) 12th grade

5. What is your gender?
   a) Boy / Man
   b) Girl / Woman
   c) Gender-diverse / non-conforming
   d) Other, I identify as: ____________________________________________

6. What is your racial/ethnic identity?
   a) African American or Black or Caribbean Black
   b) White or Caucasian
   c) Latinx or Hispanic
   d) Asian or Asian American
   e) Native American or Native Indigenous
   f) Multi-racial or multi-ethnic
   g) Other, I identify as: ____________________________________________
7. Are you attending school in-person or online?
   a) In person
   b) Online

8. Are you currently receiving support for your mental health (counseling, therapy, psychological help)? If so, where?
   a) Yes, at school
   b) Yes, at a community-based clinic or office
   c) Yes, both of the above
   d) No, I am NOT currently receiving mental health services
   e) Other / Prefer not to say

9. In your lifetime, have you received support for your mental health (counseling, therapy, psychological help). If so, where?
   a) Yes, at school
   b) Yes, at a community-based clinic or office
   c) Yes, both of the above
   d) No, I am NOT currently receiving mental health services
   e) Other / prefer not to say

10. In your lifetime, how many mental health support sessions have you attended? Mental health support sessions may include counseling, therapy, psychological help.
    a) Many sessions (more than 20 visits in my lifetime)
    b) Several sessions (between 6 and 20 visits in my lifetime)
    c) A few times (between 1 and 6 visits in my lifetime)
    d) I have never received mental health services

BASC-3 BESS

This form contains sentences that young people may use to describe how they think or feel or act. Read each sentence carefully. Select Never if the sentence never describes you or how you feel. Select Sometimes if the sentence sometimes describes you or how you feel. Select Often if the sentence often describes you or how you feel. Select Almost always if the sentence almost always describes you or how you feel. Give the best answer for you for each sentence, even if it is hard to make up your mind. There are no right or wrong answers. Please do your best, tell the truth, and respond to every sentence. Note: Survey items not included due to copyright restrictions.
SDQ Impact

1. Overall, do you think that you have difficulties in any of the following areas: emotions, concentration, behavior or being able to get on with other people?
   a) No
   b) Yes, minor difficulties
   c) Yes, definite difficulties
   d) Yes, severe difficulties

2. How long have these difficulties been present?
   a) Less than a month
   b) 1-5 months
   c) 6-12 months
   d) Over a year

3. Do the difficulties upset or distress you?
   a) Not at all
   b) Only a little
   c) A medium amount
   d) A great deal

4. Do the difficulties interfere with your everyday life in the following areas?
   a) Home
      i. Not at all
      ii. Only a little
      iii. A medium amount
      iv. A great deal
   
   b) Friendships
      i. Not at all
      ii. Only a little
      iii. A medium amount
      iv. A great deal

   c) Classroom activities
      i. Not at all
      ii. Only a little
      iii. A medium amount
      iv. A great deal

   d) Free time or leisure activities
      i. Not at all
      ii. Only a little
      iii. A medium amount
      iv. A great deal
5. Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?
   a) Not at all
   b) Only a little
   c) A medium amount
   d) A great deal

**Intent 1**

Please rate your willingness to engage in the following behaviors on a scale from *Not at all willing* to *Very willing*.

1. I am willing to receive help or support from someone on the School Wellness Team (e.g., school counselor), if offered
   a) Not willing
   b) Somewhat not willing
   c) Neither willing nor unwilling
   d) Somewhat willing
   e) Very willing

2. I am willing to sign up for a 30-minute drop-in session for mental health support
   a) Not willing
   b) Somewhat not willing
   c) Neither willing nor unwilling
   d) Somewhat willing
   e) Very willing

3. I am willing to receive information about positive mental health from the School Wellness Team
   a) Not willing
   b) Somewhat not willing
   c) Neither willing nor unwilling
   d) Somewhat willing
   e) Very willing

**Intent 2**

Rate the likelihood you will engage in the following behaviors on a scale from *Very unlikely* to *Very likely*.

1. I intend to seek mental health help from someone within the school
   a) Very unlikely
   b) Unlikely
   c) Somewhat unlikely
   d) Neither likely nor unlikely
2. I plan to seek help from a school counselor, teacher or administrator for my mental health
   a) Very unlikely
   b) Unlikely
   c) Somewhat unlikely
   d) Neither likely nor unlikely
   e) Somewhat likely
   f) Likely
   g) Very likely

3. I will make an effort to seek help at school for my mental health
   a) Very unlikely
   b) Unlikely
   c) Somewhat unlikely
   d) Neither likely nor unlikely
   e) Somewhat likely
   f) Likely
   g) Very likely

4. I intend to seek mental health help from someone outside of the school
   a) Very unlikely
   b) Unlikely
   c) Somewhat unlikely
   d) Neither likely nor unlikely
   e) Somewhat likely
   f) Likely
   g) Very likely

5. I plan to seek help from a community counselor, social worker, doctor or psychologist for my mental health
   a) Very unlikely
   b) Unlikely
   c) Somewhat unlikely
   d) Neither likely nor unlikely
   e) Somewhat likely
   f) Likely
   g) Very likely

6. I will make an effort to seek help at home or in the community for my mental health
   a) Very unlikely
   b) Unlikely
   c) Somewhat unlikely
   d) Neither likely nor unlikely
Attitudes

Read each statement carefully and indicate your degree of agreement using the scale below. In responding, please be completely candid.

1. If I thought I was having a mental or emotional breakdown, my first thought would be to get professional help
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

2. Talking about problems with a psychologist or counselor seems to me as a bad way to get rid of emotional problems
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

3. If I were experiencing a serious emotional crisis, I would be sure that psychotherapy or counseling would be useful
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

4. I admire people who are willing to handle their problems and fears without getting professional help
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

5. I am paying attention to this survey
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree
6. I would want to get psychological help or counseling services if I were worried or upset for a long time
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

7. I might want to have psychological / mental health counseling in the future
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

8. A person with an emotional problem is not likely to solve it alone; he or she is more likely to solve it with professional help
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

9. With the amount of time and money involved in psychotherapy / counseling, I am not sure that it would benefit someone like me
   a) Disagree
   b) Partly disagree
   c) Partly agree
   d) Agree

10. People should solve their own problems, therefore, getting psychological counseling should be their last resort
    a) Disagree
    b) Partly disagree
    c) Partly agree
    d) Agree

11. Personal and emotional troubles, like most things in life, tend to work out by themselves
    a) Disagree
    b) Partly disagree
    c) Partly agree
    d) Agree

   **Perception of Stigmatization by Others for Seeking Help.** Imagine you had an emotional or personal issue that you could not solve on your own. If you got counseling services
for this issue, to what degree do you think that the people in your life (family, friends, etc.)
would...

1. React negatively to you
   a) Not at all
   b) A little
   c) Some
   d) A lot
   e) A great deal

2. Think bad things about you
   a) Not at all
   b) A little
   c) Some
   d) A lot
   e) A great deal

3. See you as seriously disturbed / messed-up
   a) Not at all
   b) A little
   c) Some
   d) A lot
   e) A great deal

4. Think less of you
   a) Not at all
   b) A little
   c) Some
   d) A lot
   e) A great deal

5. Think you were a risk to others
   a) Not at all
   b) A little
   c) Some
   d) A lot
   e) A great deal

6. Think you brought them shame
   a) Not at all
   b) A little
   c) Some
   d) A lot
   e) A great deal
Self-Stigma of Seeking Help

People at times find that they face problems that they consider getting help for. This can bring up feelings about what getting help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1. I would feel inadequate if I went to a school mental health counselor for psychological help
   a) Strongly disagree
   b) Disagree
   c) Agree and disagree equally
   d) Agree
   e) Strongly Agree

2. My self-confidence would not be threatened if I got professional help
   a) Strongly disagree
   b) Disagree
   c) Agree and disagree equally
   d) Agree
   e) Strongly Agree

3. Getting psychological help or counseling would make me feel less intelligent
   a) Strongly disagree
   b) Disagree
   c) Agree and disagree equally
   d) Agree
   e) Strongly Agree

4. My self-esteem would increase if I talked to a therapist or counselor
   a) Strongly disagree
   b) Disagree
   c) Agree and disagree equally
   d) Agree
   e) Strongly Agree

5. My view of myself would not change just because I made the choice to see a therapist or counselor
   a) Strongly disagree
   b) Disagree
   c) Agree and disagree equally
   d) Agree
   e) Strongly Agree

6. It would make me feel inferior to ask a therapist or counselor for help
   a) Strongly disagree
b) Disagree  
c) Agree and disagree equally  
d) Agree  
e) Strongly Agree  

7. I would feel okay about myself if I made the choice to seek professional help  
a) Strongly disagree  
b) Disagree  
c) Agree and disagree equally  
d) Agree  
e) Strongly Agree  

8. If I went to a therapist, I would be less happy with myself  
a) Strongly disagree  
b) Disagree  
c) Agree and disagree equally  
d) Agree  
e) Strongly Agree  

9. My self-confidence would stay the same if I got professional help for a problem I could not solve  
a) Strongly disagree  
b) Disagree  
c) Agree and disagree equally  
d) Agree  
e) Strongly Agree  

10. Select "Strongly Agree" for this item  
a) Strongly disagree  
b) Disagree  
c) Agree and disagree equally  
d) Agree  
e) Strongly Agree  

11. I would feel worse about myself if I could not solve my own problems  
a) Strongly disagree  
b) Disagree  
c) Agree and disagree equally  
d) Agree  
e) Strongly Agree  

**Barriers to Seeking Mental Health Counseling Scale**  

Please use the 6-point scale to rate the degree to which each item describes your level of agreement with the following statements.
Discomfort with Emotions Subscale.

1. I would feel embarrassed about sharing my feelings with a mental health counselor
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

2. I would feel nervous about showing the emotional side of me during the mental health counseling process
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

3. I feel comfortable expressing my feelings to a mental health counselor
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

4. It would be awkward for me to talk about my feelings in counseling
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

5. I fear going to counseling because I don’t like to share my feelings
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

Lack of Knowledge Subscale.

1. I don't know where to seek mental health counseling
a) Strongly disagree  
b) Disagree  
c) Somewhat disagree  
d) Somewhat agree  
e) Agree  
f) Strongly Agree  

2. I don't know what kind of mental health counseling services are available  
a) Strongly disagree  
b) Disagree  
c) Somewhat disagree  
d) Somewhat agree  
e) Agree  
f) Strongly Agree  

3. I don't know how mental health counseling works  
a) Strongly disagree  
b) Disagree  
c) Somewhat disagree  
d) Somewhat agree  
e) Agree  
f) Strongly Agree  

Lack of Access Subscale.

1. I don't have the time to seek or stay in counseling  
a) Strongly disagree  
b) Disagree  
c) Somewhat disagree  
d) Somewhat agree  
e) Agree  
f) Strongly Agree  

2. I have no financial means (e.g., insurance, money) to afford mental health counseling services  
a) Strongly disagree  
b) Disagree  
c) Somewhat disagree  
d) Somewhat agree  
e) Agree  
f) Strongly Agree  

3. I have too many responsibilities to other people (e.g., family, friends, significant others) that would prevent me from seeking mental health counseling  
a) Strongly disagree  
b) Disagree
4. I have too many academic obligations that would deter me from talking to a mental health counselor
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

**Cultural Barriers Subscale.**

1. I perceive that most mental health counselors would not be sensitive to issues related to my cultural identity
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

2. I don’t think that most mental health counselors would understand my cultural values
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

3. I doubt that most mental health counselors have adequate training to explore issues related to my cultural identity
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
   d) Somewhat agree
   e) Agree
   f) Strongly Agree

4. I don’t think culture would be an obstacle to my seeking help from a mental health counselor
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
d) Somewhat agree
e) Agree
f) Strongly Agree

5. I think that cultural differences between most mental health counselors and myself would be a barrier in counseling
   a) Strongly disagree
   b) Disagree
   c) Somewhat disagree
d) Somewhat agree
e) Agree
f) Strongly Agree

**Everyday Discrimination**

Please respond to the items below based on how often you feel you have been bullied or discriminated against because of things like your race, ethnicity, gender, age, religion, physical appearance, sexual orientation, or other characteristics. Select your response on a scale from *Never* to *Often* based on the frequency of each experience day-to-day.

1. You are discouraged from seeking academic opportunities including higher education or AP classes
   a) Never
   b) Rarely
c) Sometimes
d) Often

2. You are treated with less courtesy than other people
   a) Never
   b) Rarely
c) Sometimes
d) Often

3. You are treated with less respect than other people
   a) Never
   b) Rarely
c) Sometimes
d) Often

4. You receive a poorer service than other people
   a) Never
   b) Rarely
Delaware School Climate, Part I

This survey is about how you feel about your school this year. Please choose one answer that best shows how you feel about each statement. In this school...

1. Most students turn in their homework on time

c) Sometimes
d) Often

5. People act as if they think you are not smart
   a) Never
   b) Rarely
   c) Sometimes
   d) Often

6. People act as if they are afraid of you
   a) Never
   b) Rarely
   c) Sometimes
   d) Often

7. People act as if they think you are dishonest
   a) Never
   b) Rarely
   c) Sometimes
   d) Often

8. People act as if they think you are not as good as they are
   a) Never
   b) Rarely
   c) Sometimes
   d) Often

9. You are called names or insulted
   a) Never
   b) Rarely
   c) Sometimes
   d) Often

10. You are threatened or harassed
    a) Never
    b) Rarely
    c) Sometimes
    d) Often
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

2. Teachers treat students of all races with respect  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

3. The school rules are fair  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

4. Students are safe in the hallways  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

5. Rules are made clear to the students  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

6. Most students try their best  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

7. Teachers care about their students  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot

8. The consequences of breaking rules are fair  
a) Disagree a lot  
b) Disagree  
c) Agree  
d) Agree a lot
9. Students threaten and bully others
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

10. Students know how they are expected to act
    a) Disagree a lot
    b) Disagree
    c) Agree
    d) Agree a lot

11. Students are friendly with each other
    a) Disagree a lot
    b) Disagree
    c) Agree
    d) Agree a lot

12. Most students feel happy
    a) Disagree a lot
    b) Disagree
    c) Agree
    d) Agree a lot

13. Students feel safe
    a) Disagree a lot
    b) Disagree
    c) Agree
    d) Agree a lot

14. Students worry about others bullying them
    a) Disagree a lot
    b) Disagree
    c) Agree
    d) Agree a lot

15. Students know what the rules are
    a) Disagree a lot
    b) Disagree
    c) Agree
    d) Agree a lot

16. Students care about each other
    a) Disagree a lot
    b) Disagree
    c) Agree
d) Agree a lot

17. Teachers listen to students when they have problems
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

18. The School's Code of Conduct is fair
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

19. Students know they are safe in this school
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

20. It is clear how students are expected to act
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

21. Students respect others who are different
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

22. Adults who work here care about the students
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

23. Most students follow the rules
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

24. Most students like this school
   a) Disagree a lot
25. Teachers like their students
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

26. Students bully one another
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

27. Classroom rules are fair
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

28. Most students work hard to get good grades
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

29. Students treat each other with respect
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

30. Students get along with each other
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot

31. I am lying on this survey
   a) Disagree a lot
   b) Disagree
   c) Agree
   d) Agree a lot
APPENDIX B. IRB APPROVAL LETTER

ACTION ON EXEMPTION APPROVAL REQUEST

To: Anna Long  
Psychology

From: Dennis Landin  
Chair, Institutional Review Board

Date: August 2, 2019

Re: IRB# E11532

Title: The School Wellness Project: Mental Health Screening and Help-Seeking in Adolescence

New Protocol/Modification/Continuation: Modification

Brief Modification Description: Change PI to Anna Long, title change, updated the description of the mental health screening, expanded the instruments, updated several other accompanying documents based on school input and what schools might be interested in the PI analyzing.

Review date: 8/2/2019

Approved [X]  Disapproved [ ]

Approval Date: 8/2/2019 Approval Expiration Date: 3/10/2022

LSU Proposal Number (if applicable):

By: Dennis Landin, Chairman

PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING – Continuing approval is CONDITIONAL on:

1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
8. SPECIAL NOTE: Make sure you use bcc when emailing more than one recipient. Approvals will automatically be closed by the IRB on the expiration date unless the PI requests a continuation.

*All investigators and support staff have access to copies of the Belmont Report, LSU’s Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at http://www.lsu.edu/irb
REFERENCES


Losen, D. J., & Gillespie, J. (2012). Opportunities suspended: The disparate impact of disciplinary exclusion from school. Civil Rights Project/Proyecto Derechos Civiles. doi:ED534178


VITA

Sam Allouche was born in Paris, France. She received her Bachelor of Science in psychology and Master of Science in behavioral health from Tulane University in New Orleans, Louisiana. Sam received her Master of Arts in school psychology from Louisiana State University. She is currently a fifth-year doctoral student in school psychology at Louisiana State University under the supervision of Dr. Anna Long with an anticipated graduation date of August 2022. Her clinical and research interests include enhancing mental health treatment accessibility as well as the implementation of culturally responsive practices in a school setting.