ACCESS DEFINED: TOWARDS A BETTER UNDERSTANDING OF BLACK YOUTH'S ACCESS AND UTILIZATION OF SCHOOL MENTAL HEALTH SERVICES

by

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(Under the Direction of Sycarah Fisher)

ABSTRACT

Mental health challenges continue to be a major concern for children and adolescents. In 2016, over 7 million (16.5%) youth between the ages of 6-17 experienced a mental health disorder (National Alliance on Mental Illness [NAMI], 2021). More concerning, the prevalence rate of suicide among Black youth has increased exponentially over the past two decades (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019; Lindsey et al., 2013). While school mental health services are praised for meeting the mental and behavioral health needs of students, less is known about factors impacting access and utilization of school mental health services and the increasing rate of suicide within the Black youth community in addition to the variability in utilization rates indicates a need for an exploration of barriers and facilitators to accessing and utilizing school mental health services. Despite recognition and documentation in research on the importance of peer relationships and the repeated calls

to leverage those relationships to facilitate access and utilization of school mental health services few peer-to-peer intervention programs targeting accessing and utilizing school mental health services exist.

The current studies explored the barriers and facilitators to accessing school mental health services for Black youth, the importance of peer relationships within the context of school mental health for Black middle school youth, and the desirability, feasibility, and required components of a peer-to-peer medicated intervention program to expand the reach of school mental health services. Black middle school youth (n = 20) completed the Strengths and Difficulties Questionnaire and additional surveys examining their level of knowledge of school mental health providers in addition to their peer relationships and mental health. Black youth and school mental health providers (n = 6) also participated in focus group discussions and interviews.

Black youth primarily knew their school counselor and students in the eighth grade reported higher levels of overall stress compared to 6th and 7th graders. More than half of Black youth scored within the high or very high range on the peer relationships scale, suggesting peer relationship problems. Across studies, Black youth and school mental health providers discussed positive adult-student relationships as key factors in accessing and utilizing school mental health services. Additional qualitative findings for studies 1 and 2 are discussed in more detail in each study.

INDEX WORDS: Black youth, middle school, school mental health services, access, utilization, peer, intervention

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DEDICATION

I dedicate my dissertation to my grandparents who worked tirelessly, prayed without ceasing, and loved me unconditionally so that I could have opportunities and reach goals beyond their wildest dreams. I also want to dedicate this work to my mother and father for their unwavering support throughout this journey, the sacrifices they made so that I could pursue my purpose, their words of encouragement that sustained me, and for never letting me give up, even when it would have been easy.

Lastly, I want to dedicate my work to the millions of Black youths whose voices go unheard and are undervalued when it comes to the matters affecting them directly. Your voice matters, your opinions matter, your lives matter.

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CHAPTER 1

INTRODUCTION

Mental health is defined as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community"(World Health Organization, 2018). Mental health well-being is vital across the developmental continuum, from childhood and adolescence all the way to adulthood (Centers for Disease Control and Prevention, 2021). Despite this fact, mental health challenges continue to be a major concern for children and adolescents. In 2016, over 7 million (16.5%) youth between the ages of 6-17 experienced a mental health disorder (National Alliance on Mental Illness [NAMI], 2021). Additional data indicates that while mental health challenges such as suicide are declining globally, the suicide rate in the Americas, which includes the United States, has increased by 17% between 2000 and 2019 (World Health Organization, 2021). The data is even more dire for Black youth as suicide rates for Black youth have increased by 73% over a 26-year period (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019; Lindsey et al., 2013).

State data provided in the 2021 State of Mental Health in America report ranked Georgia 17th for mental health prevalence and access for youth, suggesting a lower prevalence of mental illness and higher rates of access to care for youth compared to other states (Reinert et al., 2021); however, this data is not disaggregated by race or ethnicity. National survey data on mental health service utilization indicates that Black youth between the ages of 12-13, who experience at least one major depressive episode are the least likely to receive treatment for their depression compared to their White, Hispanic/Latino, and Multi-racial peers (31.1% vs. 42% vs. 31.8% vs

36%; Center for Behavioral Health Statistics and Quality, 2021). The novel Coronavirus (COVID-19) global pandemic exacerbated existing mental health challenges for youth and adolescents, and data show that emergency room visits for attempted suicide and mental health challenges both increased by 31% during this time (Leeb, 2020; Yard, 2021).

Community-based mental health services are well documented as being underutilized in the Black community among adults and adolescents due to systemic (e.g., scheduling challenges, child care availability, access, transportation, quality, insurance costs) and individual (e.g., stigma, mistrust, psychoeducation, perceptions regarding need, misdiagnosis) level barriers (Kazdin & Wassell, 2000; Lindsey et al., 2013; Mishra et al., 2009; Owens et al., 2002; Snowden, 2001, 2003; Thompson et al., 2004). Specifically, "Black Americans must navigate a maze of obstacles that are built of systematic oppression, institutional inequalities, and structural disparities when seeking mental health services" (Burkett, 2017, p. 814).

School mental health (SMH) services have been touted as an alternative to the challenges students and families face with accessing community-based mental health services (Ali et al., 2019; Bains et al., 2017; Duong et al., 2021; Farmer et al., 2003; Snowden & Yamada, 2005). Increased *access* to mental health services is one of the most highly significant and referenced benefits of SMH services (Allison et al., 2007). Student's academic success and overall mental health outcomes have also been found to improve as a result of SMH services (Hoover & Mayworm, 2017; Walrath et al., 2004). Despite well-documented research outlining the benefits of SMH services for the overall school community and individual students (Walrath et al., 2004), less is known about factors impacting *access* and *utilization* of SMH services for Black adolescents (Lindsey et al., 2013; Office of the Surgeon General [US] et al., 2001). Furthermore, in the school mental health literature, "*access*" is undefined operationally and is often referred to

as the mere presence of services or presumed availability of services. Using the term "*access*" lends itself to the assumption that mental health service availability in schools translates to an opportunity to utilize services. This could not be further from the truth as many youth with mental health problems, particularly those from minoritized groups, face some of the same barriers to obtaining mental health services in schools as they do in community-based settings (Lindsey et al., 2013). Thus, it is critical to identify barriers and facilitators to mental health service access and utilization within school-based settings for Black youth.

In addition to identifying barriers and facilitators to access and utilization of SMH services for Black youth, it is also critical to identify existing resources within the school that may serve to facilitate SMH service utilization for this population. One important resource and leverage point for all youth is their peers. Peers play an important role in adolescent development as they often identify social norms regarding mental health and service utilization from their peers (Helsen et al., 2000; Lombardi et al., 2019; Roach, 2018). In addition, adolescents primarily confide in their peers about their mental health struggles (Hasking et al., 2015). Leveraging peers as support may be a potential way to connect Black youth with SMH services. Despite this fact, little research has examined the use of peer programs in increasing the access to and use of SMH services, specifically for Black youth.

Purpose of the Present Study

Guided by Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner,1979), two studies were proposed. The first proposed study seeks to identify the barriers and facilitators to school mental health service access for Black youth. More specifically, this study will examine Black youth's and SMH provider perceptions of *access* and resulting *utilization* of school mental health services. The second study explores the barriers and facilitators related to the development

of a universal peer-to-peer mediated intervention program aimed towards expanding the reach of SMH services to Black youth. The proposed studies do not examine individual-level barriers and facilitators, such as perceptions of effectiveness (Anglin et al., 2008; Murry et al., 2011; Samuel, 2015; E. Ward et al., 2013), stigma (Dept. of Health and Human Services & U.S. Public Health Service, 1999; Leger et al., 2018; Mishra et al., 2009; Office of the Surgeon General [US] et al., 2001; Sen et al., 2020), and personal fortitude (Abram et al., 2008; Anglin et al., 2008; Planey et al., 2019; Samuel, 2015; Ward et al., 2009b), as this work has been addressed in the literature; however, we recognize that these variables may naturally present themselves during focus group discussions and interviews. These proposed studies contribute to the field by examining microsystem barriers and facilitators that impact school mental health access and utilization for Black youth.

Mental Health Outcomes

Approximately half of mental health challenges have an onset during childhood or adolescence (Kessler et al., 2007; Keyes, 2006; National Alliance on Mental Illness, 2012). Unaddressed mental health needs due to systemic and individual barriers are linked to a host of detrimental outcomes. Not only are there detrimental effects at the personal level for individuals with mental illness (i.e., substance use disorder, unemployment, suicide, etc.), but families, communities, and society are also impacted due to the increase in uncompensated care provided by families, costs for hospitalizations and emergency room visits, and the overall economic implications at both the community and societal level (National Alliance on Mental Illness, 2021). At the individual level, adults with severe mental illness earn approximately $16,000 less annually (Kessler et al., 2007). While the cost estimates provided have been gathered at the adult level and are representative of the workforce population, these statistics are important to provide

as 50% of lifetime mental illnesses typically occur before 14, well before employment; however, without adequate and appropriate treatment the detrimental impacts are pervasive in adulthood (National Alliance on Mental Illness, 2021).

For school-aged students, there is a bidirectional relationship between mental health challenges and academic outcomes (Rose et al., 2017). Many symptoms of mental health make it difficult for students to meaningfully engage in their academics. For example, symptoms of anxiety and depression such as difficulty concentrating, sleep disturbances, decreased interest in previously enjoyable activities, and impairment in important areas of functioning may make it challenging for students to stay awake during the school day or focus on instruction, which can negatively impact their grades (Jones, 2007a). On the other hand, state and school achievement requirements and the growing academic demands may lead to mental health challenges for students. As an example, nationally, students begin standardized testing in the 3rd grade, and several states base grade retention criteria on standardized performance, thus placing enduring pressure on students to perform well, which can lead to a manifestation of anxiety or depression (Barksdale & Thomas, 2000; Greene & Winters, 2006). Few studies have examined self-reported test anxiety by race; however, one study highlighted that Black middle school youth reported higher levels of test anxiety compared to their White peers on rating scales measuring test anxiety (Crocker et al., 1988).

Students struggling with mental health challenges may be absent from school for prolonged periods of time (Schwarz, 2009). Schools that do not allow students to use excused absences for mental and behavioral health needs, do not provide access to mental health services, or support students academically while absent due to mental health challenges may contribute to an accumulation of absences and missed instruction which increases the probability of student

dropout (Schwarz, 2009). For instance, a year after unenrollment, 24% of high school dropouts stated that they experienced depressive symptoms months prior to dropping out (Dupéré et al., 2018). Behavioral symptoms of mental health challenges may also manifest as disruptive, such as hyperactive behaviors, frequent disobedience, feelings of irritability or anger, and temper tantrums (NAMI, n.d.). Further, Black youth experiencing mental health challenges may use substances in order to cope with mental health challenges (e.g., depression; Clark, 2014; Opara et al., 2021). An inability to recognize these symptoms as possible manifestations of mental health challenges inadvertently leads to increased rates of school suspensions, expulsions, and justice system involvement (Martinez, 2009; Schwarz, 2009). These practices disproportionately impact Black students (Irwin et al., 2013).

One of the most detrimental outcomes of mental health challenges is suicide and when a child or adolescent dies by suicide, it is an indicator that an underlying mental health concern was present. For students in Georgia between the ages of 6-24, suicide was the second leading cause of death (Voices for Georgia's Children, 2020). In their study, Sheftall et al., (2016) found that 33% of children and adolescents who died by suicide had a mental health problem. Nationally, the rate of suicide for Black youth is particularly alarming. In 2018, suicide was the second leading cause of death for Black adolescents between the ages of 10-14 and the third leading cause of death for Black adolescents between the ages of 15-19 (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019). Black youth as young as five are also disproportionately affected by suicide, as youth as young as five who die by suicide are more likely to be Black males (Sheftall et al., 2016). Given the prevalence and significant negative outcomes associated with mental health challenges, specifically among Black youth, it is critical

to identify barriers and facilitators to mental health service access and utilization for this population.

Bronfenbrenner Ecological Systems Theory

The current study is guided by Bronfenbrenner's Ecological Systems theory as a framework for examining barriers and facilitators to Black youth accessing and utilizing SMH services because it places the child at the center of complex and interacting systems and environments (Bronfenbrenner, 1979). Barriers to mental health service access and utilization are obstacles in place that directly or indirectly hinder an individual from accessing or receiving mental health services (Planey et al., 2019). Conversely, facilitators describe the individuals, mechanisms, and systems that support or make it easier for Black youth to pursue, receive, or complete mental health treatment (Planey et al., 2019). Barriers and facilitators are distinct constructs; however, depending on the individual, environments within systems can operate as a barrier for one individual and a facilitator for another in accessing and utilizing school mental health services.

The Ecological Systems framework consists of five levels of influence on the child and their development. The first system is the microsystem. The microsystem is the most proximal system in which a child has direct contact, which shapes their development. The direct contact within the microsystem is believed to have a more significant impact than indirect experiences within other systems (Crawford, 2020). For example, family, teachers, peers, religious organizations, health, etc., are all located within the microsystem and have an impact on child development and, subsequently, youths' decisions to access and utilize SMH services. The second layer of influence is the mesosystem. The mesosystem represents the interactions that

take place between microsystems. For example, family systems and religious organizations influence each other and create the mesosystem, which in turn impacts the child at the center. The third layer of influence is the exosystem. The exosystem represents the connections and actions that occur between other systems. The exosystem impacts the child indirectly through its influence on more proximal child-level systems. In relation to the current study, the exosystem consists of SMH policies and procedures that are largely created and influenced by state and district governmental agencies, which students are not members of but which have a profound impact on student access to and utilization of SMH services. Despite the apparent importance of the exosystem on school mental health service access and utilization, the majority of the literature has focused on the impact of individual and family-level factors on SMH service access and utilization. The current study hopes to fill this gap.

The fourth layer of influence is the macrosystem. The macrosystem represents societal and cultural beliefs that influence the perceptions and behaviors of the developing child. This includes socioeconomic status, which impacts child development as it directly impacts access to food, school quality, and mental healthcare. Finally, the fifth layer of influence in the chronosystem. As the most distal system, the chronosystem signifies natural changes that occur throughout one's life as well as unexpected occurrences, both of which have an impact on development (Guy-Evans, 2020).

Overall, the Ecological Systems Theory exemplifies the notion that children are often at the mercy of systems and adults, many of whom they have no direct interaction with who make decisions that impact their development. Black children and youth have been positioned within systems of oppression that affect their home and school environments. This ultimately threatens their success academically, socially, and emotionally and makes it imperative that the interacting

systems in which Black children and youth are placed are researched intently. There is much to be done within each system regarding the barriers and facilitators to accessing and utilizing SMH services, traditional models studying Black youth function from a deficit mindset. These models fail to approach research from a standpoint that recognizes the cycle of inequity that impacts Black youth and adolescents' access to mental health care while also uplifting the facilitators to Black youth mental health care access and utilization. Therefore, to counteract traditional approaches to research on Black youth that focus on the individual and family, this study focuses exclusively on the barriers and facilitators that occur within the *exosystem* and *microsystem* in relation to SMH services, as these systems are the closest in proximity to students. The interactions between the exosystem and microsystem will be examined through the perspective of Black youth and school mental health providers in relation to SMH service access and utilization. The mesosystem, while an important component of child development as it represents the interactions that occur between multiple microsystems, is not a primary focus of the current study. Additionally, the macrosystem and chronosystem also impact child access to and utilization of services due to their influence on other systems; however, they are the most distal to the child and fall outside the scope of this study.

Barriers and Facilitators Within the Exosystem

Mental Health Policies

The history of mental health awareness, prevention policies, and initiatives dates back over 75 years, with the enactment of the National Mental Health Act in 1946, which focused on mental illness prevention in the United States. Following the implementation of the Mental Health of School-Age Children and Youth initiative in 1995, an increase in research on the determinants of mental health, mental health utilization, mental health outcomes, protective

factors, and school interventions steadily increased. Laws such as the Americans with Disabilities Act, Individuals with Disability Education Act (IDEA), and the Rehabilitation Act provide protection against discrimination against individuals with mental health disorders in the community, for employment, and in the schools. Currently, no federal SMH law exists, so the onus is on states to develop SMH policies and practices based on the needs of their states (Mental Health America, n.d.). The absence of federal SMH laws leaves room for wide variability in how mental health is prioritized by states, which has implications for access and utilization of SMH services for students and may serve as a barrier or facilitator depending on the state. State systems (i.e., State Department of Education) located in the exosystem have the choice to enforce the basic standards put forth in laws regarding mental health systems or expand requirements to address areas of access, quality, and protection.

To offset barriers to accessing and utilizing SMH services, State-mandated SMH policies set the tone for comprehensive and accessible school mental health programs. State-mandated SMH policies function as facilitators and have been associated with lower rates of suicide and substance abuse for school-aged youth and adolescents (Spera & Monnat, 2020). Currently, only 22 states require school districts to establish SMH services or school-linked mental health services. Twenty-four states encourage districts to establish these services, four states have a non-codified policy, meaning that existing documents are not included on state websites, regulations, policy memos, etc., and three states have not addressed SMH services at all (National Association of State Boards of Education, n.d.). Georgia state law requires districts to establish school-based or school-linked mental health promotion and intervention programs, requires school counseling or guidance services in elementary grades (K-8), and requires state agencies to develop models and guidance for districts to support the implementation of

counseling, psychological, and social services (National Association of State Boards of Education, n.d.).

Variability in policy composition, mandates, and funding at the state and district is problematic and represents barriers to students' access to school mental health services (Adelman et al., 1999; Mental Health America, n.d.). Variability and incongruency in policies and practices impede on SMH services because it impacts all students, but particularly minoritized Black youth, who typically attend underfunded schools, as policies and practices dictate who gets *access* to comprehensive SMH services. Congruency in state mental health policies serves as a facilitator to access and utilization of school mental health services, is vital to supporting the mental well-being of all students, and supports the continual growth of school mental health initiatives at the federal, state, and local levels.

Mental Health Initiatives

Several initiatives, projects, and reports have been proposed and implemented at various levels to address the growing mental health concerns for youth and adolescents in the United States and increase access to school mental health professionals and increase access to SMH services through school and community partnerships. These initiatives serve as facilitators of SMH services. Federally, in September 2021, the Substance Abuse and Mental Health Services Administration awarded $825 million dollars in grants to support individuals with mental illness through community-based programs. Through these grants, community mental health centers created plans that focused on improving access and outcomes for under-resourced populations in the community and were granted permission to provide training opportunities for behavioral health providers assigned to support schools in addressing the needs of school-aged youth at-risk

for serious emotional disturbances (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021).

The Mental Health in Schools Excellence Program Act (2021) and the Increasing Access to Mental Health in School Act (2021) were legislative initiatives designed to facilitate partnerships between institutes of higher education and local education agencies to increase the presence of mental health professionals in low-income schools and provide tuition grants to graduate students pursuing a career as a school mental health professional. The Build Back Better Act (2021), passed in the House, was designed to make significant investments in the social determinants of health, including education, neighborhoods, and the economy, which all have an impact on mental health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). The bill allocated $165 million dollars to improve the National Suicide Prevention line and support Project Aware, a national program designed to increase awareness of mental health in school-aged populations. Although no federal law currently exists requiring all states to provide SMH services for students across the United States, the increase in legislative initiatives and fiscal commitment through grants depict facilitative components necessary for increasing access and utilization of SMH services targeting school-aged youth.

The Georgia Apex Program is a state initiative implemented to support the mental health needs of students in Georgia. It fosters relationships between community-based mental health organizations and schools to provide SMH services to students across grade levels. Through a multi-tiered support system, the Georgia Apex Program serves over 14,000 students in 565 schools and provides mental health awareness events, individual and group therapy, and behavior assessment services to students (Georgia Department of Behavioral Health and Developmental Disabilities, n.d.).

These national initiatives address key barriers to accessing and utilizing SMH services such as psychoeducation, fiscal investments, and building partnerships between universities and communities through programmatic efforts and providing state-level mental health data. These efforts have the potential to encourage states to evaluate their mental health services for both adults and youth in comparison to other states and may pave the way for collaboration, innovation, and adjustments (Stiffman et al., 2010). Despite an increase in mental health initiatives across all levels, there is currently a gap in research that examines the congruency between policies and practices to identify potential areas of improvement in the exosystem that support the access and utilization of SMH for Black youth within the microsystem.

Barriers and Facilitators within the Microsystem

Schools

At the district and school levels, several initiatives act as facilitators supporting the mental well-being of students. The Regional Educational Service Agencies (RESA) supports school districts throughout Georgia with various services and supports. For example, the Northeast Georgia RESA supports a positive school climate by providing easily accessible links to resources on mental health, trauma, suicide, and social-emotional learning (Northeast Georgia Regional Educational Service Agency, n.d.). At the community level, Mental Health First Aid provides adults working with adolescents between the ages of 12-18 with training on how to recognize, interact with, and support youth with internalizing and externalizing mental health challenges (National Council for Mental Wellbeing, n.d.b).

SMH services can offset the systemic and individual-level barriers to community-based mental health services and fill the gap in treatment by providing access to mental health services in schools (Ali et al., 2019; Allison et al., 2007; Bains et al., 2017; Duong et al., 2021; Farmer et

al., 2003; Snowden & Yamada, 2005). Despite the popularity of SMH services, data on access and utilization by race and ethnicity is scarce, and less is known about its effectiveness due to state and district variability in laws, policies, and practices (Atkins et al., 2010). Studies and meta-analyses have documented that between 20-37%, with some as high as 54.8%, of Black youth in educational settings utilized SMH services (Ali et al., 2019; Allison et al., 2007; Bains et al., 2017; Duong et al., 2021; Parasuraman & Shi, 2015; Slade, 2002; Whitaker et al., 2018). The variability in utilization rates of SMH services should not be attributed to Black youth or interpreted from a deficit mindset but should be understood from a systems perspective (e.g., exosystem and microsystem), which have an immense degree of power on Black youth's mental health access and utilization and their perceptions of mental health. When considering race and ethnicity, minoritized student groups face similar barriers to accessing SMH services as they do in community settings (Lindsey et al., 2013). These barriers include teachers' subjective interpretation of mental health challenges, parental consent, family engagement, adult gatekeeping, and referral processes (Guo et al., 2014; Murry et al., 2011; Splett et al., 2019; Twymon et al., 2020). For example, Black students are primarily referred for SMH services for externalizing or behavioral concerns in the early grades and are less likely to receive mental health services for internalizing concerns such as anxiety or depression (Bramlett et al., 2002; Foster et al., 2005; Ghandour et al., 2019; Lindsey et al., 2013).

Students with severe emotional or behavioral disturbances that interfere with their academic performance are typically referred for psychoeducational evaluations to determine qualification for special education services. Qualified students receive an Individualized Education Program (IEP), a legal document that outlines individualized supports and services needed to be successful in the schools (Murry et al., 2011). SMH services such as counseling can

be required as a component of a student's IEP. This process facilitates the access and utilization of SMH services as families may be more agreeable to their child receiving these services if they are part of the IEP. Despite this process, many youth and adolescents are not referred for evaluations for mental health disorders until after involvement with the juvenile justice system, signifying a reactive instead of proactive approach to mental health well-being (Murry et al., 2011).

Family

"It takes a village," an African proverb, symbolizes the value and importance of the extended family and community in child rearing as sources of emotional, financial, and social support to both the parent and child (Jones, 2007b; Sue & Sue, 2012). The reliance on and support of Black families and the Black community contributes to the high value youth and adults place on the perceptions and opinions of elders in the community (e.g., extended family, clergy) in navigating mental health challenges and mental health service utilization (Murry et al., 2011; Planey et al., 2019; Ward et al., 2009). However, this value has the propensity to dissuade Black youth from seeking out mental health services or continuing treatment and instead encourage them to "pray about it" (Breland-Noble et al., 2011).

Black youth and adolescents value the perceptions and wisdom of their parents and often seek them out for guidance and understanding, largely due to racial socialization as a parenting style (Brown & Krishnakumar, 2007; Prout & Fedewa, 2015). Through this protective parenting style, Black parents educate their children on surviving in a racist and discriminatory society and seek to protect them from any potentially racist or discriminatory treatment. For instance, research indicates that the Black community (adolescents and adults) traditionally underutilize community-based mental health treatment options due to historical and present-day experiences

with racism (e.g., Tuskegee Airmen experiment; Mishra et al., 2009) and cultural mistrust. Cultural mistrust also impacts the degree of youth engagement for Black youth once receiving treatment (Breland-Noble et al., 2011).

Another potential barrier to Black youth accessing and utilizing SMH services involves parental perception of mental health challenges. Given federal and state requirements for parental consent for youth under the age of 18 to receive SMH services, parental perception of the presence and severity of mental health issues has implications and operates as a barrier to Black youth mental health help-seeking behaviors and has been found to lead to premature termination of mental health services (Mukolo & Heflinger, 2011; Planey et al., 2019). Black youth identified their parents as a barrier to mental health treatment as the negative parental perception of treatment and medication dictated the availability of transportation (Samuel, 2015). For instance, Black caregivers who questioned the effectiveness of treatment did not increase mental health utilization for their children despite recognizing the presence and severity of a mental health challenge (Mukolo & Heflinger, 2011). However, other Black parents of adolescents, particularly those in rural areas, believed that mental health professionals in their community could support their child's needs (Murry et al., 2011). Overall, despite conflicting research findings, the results indicate that parents play a pivotal role in their child's access to and utilization of mental health services.

Peers

Peer relationships increase in importance and are instrumental to youth as they navigate early adolescence and become more autonomous (Helsen et al., 2000; Roach, 2018; Rubin et al., 2005; Williams & Anthony, 2015). Positive and negative peer relationships play a major role in supporting or deterring youth from seeking out and utilizing mental health services (Roach,

2018; Wang et al., 2019). Existing peer relationship research suggests that Black peer relationships increase in importance due to family dysfunction, poverty, or living in a single-parent household (Silverstein & Krate, 1975); however, other research findings contradict this notion (Giordano et al., 1993). Black youth and adolescents reported that they value their close friends as confidants, protectors, and financial safe-keepers and view their friendships as reciprocal and intertwined through familial relationships (Way et al., 2005). Considering the importance of and reliance on peer relationships, many youth bear first witness to peer mental health challenges. As a facilitator that taps into the value of peer relationships at the community level, Teen Mental Health First Aid training is available to train high school youth grades 10-12 on how to detect, relate to, and respond to peer mental health warning signs and serve as a level of support to their peers (National Council for Mental Wellbeing, n.d.a); however, this training is not geared towards middle school students and serves as a barrier to the availability of psychoeducation programs and peer support programs for middle school populations.

In a study conducted by Samuel (2015), Black youth indicated that their peers were a source of encouragement to seek out and utilize mental health services. Conversely, other Black male youth shared that their peers made them feel embarrassed and ashamed for receiving mental health treatment (Samuel, 2015). Peer perceptions of mental health utilization are a critical factor in mental health service utilization and continuation of treatment; this is no different for Black youth. Despite this notion, positive characteristics of peer relationships are insufficiently researched overall and for Black youth. Existing research focuses primarily on the impact of negative peer relationships on an expansive range of educational, social, and mental health outcomes (Williams & Anthony, 2015). In an integrative review, Roach (2018) identified fifteen studies that met the inclusion criteria for examining the impact of peer relationships on mental

health outcomes. Although a significant portion of studies found that peer relationships led to improved mental health outcomes, no studies examined the impact of peer relationships on SMH access, utilization, or interventions, highlighting peer-led mental health interventions as a critical future direction for research (Roach, 2018).

Spirituality

Spirituality, while distinctively different from person to person, refers to the belief in something greater than the individual (Koenig, 2010; Swinton, 2001). As a more tangible set of established beliefs, rules, and traditions by which an individual lives, religion is synonymous with and presumed to encompass spirituality and is used as a measurable construct (Swinton, 2001). The Black church, including the pastor, represents a source of strength, providing spiritual grounding and guidance in navigating life and challenges (Neighbors et al., 1998). As an institution, the Black church influences decisions both within the individual, the family, and the greater community, including schools. Literature examining the relationship between religion and mental health has found that individuals reporting higher levels of religion and spirituality endorsed lower levels of psychological distress, such as depression, anxiety, and suicide (Koenig, 2009). Black adults and Black youth frequently referenced prayer as a coping mechanism for mental health challenges and life stressors (Chatters et al., 2008; Planey et al., 2019; Samuel, 2015; Snowden, 2001; Ward et al., 2013; Ward et al., 2009a; Ward & Heidrich, 2009). The reliance on religious coping or self-help in lieu of professional help conceivably exacerbates challenges to mental health service utilization in the Black community and overall mental health well-being (Breland-Noble et al., 2011). This is not suggestive that prayer should be eliminated; instead, considering the prominence of religious coping in the Black community,

prayer must co-exist with professional mental health services for Black youth and adolescents (Murry et al., 2011; Wachholtz et al., 2013).

Current Study

The benefits of SMH services are well documented for reducing gaps in access to mental health services and improving academic success and mental health outcomes (Hoover & Mayworm, 2017; Walrath et al., 2004); however, variability in utilization rates of SMH services for Black youth suggests that a deeper analysis of policies, and practices at the district and school level is warranted. Although previous research has included analyses on the utilization of SMH services for Black youth (Schwarz, 2009), the literature base is limited in its focus on systemic policies and practices that impact Black youth's access and utilization of SMH services. The present study seeks to fill this gap by achieving two aims that examine how exosystem (i.e., district school mental health policies) and microsystem (i.e., school practices) systemic factors impact Black youth's access and utilization of SMH services (Lindsey et al., 2013; Office of the Surgeon General [US] et al., 2001).

Aim 1 focuses on understanding the systemic barriers and facilitators to accessing SMH services from the perspective of Black middle school youth and SMH providers. Aim 1 seeks to answer the following research questions:

1) What are the systemic barriers and facilitators to SMH access and utilization for Black youth?
2) What are the perceptions of Black students and SMH providers of school mental health services?

Aim 2 contributes to the literature by exploring the importance of peer relationships for Black middle school youth using qualitative methodology while also investigating Black youth and

school mental health professionals' perspectives on the desirability, barriers, and facilitators of a peer-to-peer mediated school mental health intervention. Aim 2 seeks to answer the following research questions:

1) What are Black youth and SMH providers' perspectives on the development of a universal peer-to-peer intervention program aimed towards expanding the reach of SMH services to Black youth?

Positionality Statement

Having grown up in a Baptist church, with a God-fearing prayer warrior as my grandmother and a spiritually led mother, God has always been in the forefront of my life. I accepted Christ at a young age, sang in the church choir, attended Bible study, and participated in church programs. Yolanda Adams was a staple in our household. One of her most prominent songs, "Just a Prayer Away," still resonates with my spirit. Being raised in a Black spiritual family meant two things: 1) "What goes on in this house stays in this house," and 2) When you experience difficult times, pray about it. This is by no means an attempt to discredit or disparage my upbringing; however, it highlights the thought processes and behaviors that permeate many Black homes. I learned firsthand the power of prayer in times of adversity, but my family never discussed mental health challenges and therapy. In my community, therapy was and remains associated with "crazy"; furthermore, it went against "keeping it in the family." When I expressed the challenges and stressors of life, I was encouraged to pray and directed to God. It felt like praying and seeking mental health services were considered opposites, and if you needed therapy, that was a negative reflection of your faith and relationship with God.

I tip-toed in and out of therapy for several years. I knew it was helping me—helping me process and make sense of relationships, work, and who I was—but I struggled with accepting

that it was okay for me to see a therapist. The strain of being separated from my family in the Deep South and the grueling nature of navigating a PhD program as one of two Black women made me feel like I needed something in addition to prayer to survive. While my mother encouraged me to pray and seek God (which I did), I was grateful that my Black female therapist and sessions centered my faith.

Following several unsuccessful attempts to find a community therapist, the world began facing the immeasurable disruption of a global pandemic, and everything was at a standstill. As a Black woman, I watched COVID-19's disproportionate impact on the Black community while also navigating the emotions I felt witnessing George Floyd's murder and the racial unrest that unfolded. This led to the birth of my dissertation topic. My interest in SMH services blossomed during that time of isolation. I tried to envision the impact of these events on student peer relationships and access and use of mental health services in a community with considerable distrust of these services. I prayed, cried, and dove deeply into the school mental health literature and learned how Black youth were disproportionately negatively affected by unaddressed mental health needs.

Consistent with traditional research studies focusing on Black populations, SMH literature frequently highlighted the underutilization of services by Black youth; however, no one asked "why?" Yet another key element was missing: the voice of Black youth. What I also found lacking was research on Black youth's access to these services and the consistently obvious presumption that the presence of services equates to access. Studies primarily used quantitative methodology and occasionally mixed methods, leaving little room for context and explanation of results from the data sources themselves. To avoid falling into similar research pitfalls, I knew my study would be more powerful if I centered Black youth voices through qualitative research.

Taking a closer look at SMH services through the lens of youth and from their voices would assist in the identification of opportunities for improvement in how mental health conversations take place in schools and how students access and utilize these services. My committee and I believed that the best way to change how we think about SMH services for Black youth was to hear from them via surveys and focus groups. Also of importance was the perspective of school mental health providers, who have direct insight into the policies and procedures that govern SMH services, to identify opportunities for improvement and areas of strength in the provision of SMH services for Black youth.

CHAPTER 2

SEALING THE CRACKS: BLACK MIDDLE SCHOOL YOUTH AND SCHOOL MENTAL HEALTH PROVIDERS PERSPECTIVES ON SCHOOL MENTAL HEALTH ACCESS AND UTILIZATION[1]

[1] S.S. To be submitted to a peer-reviewed journal.

Abstract

The suicide rates for Black youth have increased exponentially. School mental health services have garnered much attention for mediating challenges to accessing community-based mental health and improving the academic, behavioral, and mental health of students. However, the growing rate of death by suicide within the Black youth community and wide variability in the utilization rates of school mental health services by Black youth indicates a need for an exploration of barriers and facilitators to accessing school mental health services. The current study examined Black middle school youth (n = 20) and school mental health providers (n = 6) perspectives on the barriers and facilitators of accessing and utilizing school mental health services using focus groups and interviews. Black youth completed the Strengths and Difficulties Questionnaire and an additional survey examining their level of knowledge of school mental health providers. Black youth and school mental health providers participated in focus group discussions on barriers and facilitators, in addition to their perspectives on school mental health services. Findings indicate that all students knew their school counselor, with fewer knowing their school social worker and school psychologist. Students in the eighth grade reported higher levels of overall stress compared to 6th and 7th graders. Qualitative findings identified six themes: access, utilization, promoting positive mental health, hindering mental health promotion, conflicting roles within the school system, and feelings of isolation. Across grade levels, Black youth and school mental health providers discussed positive adult-student relationships as key factors to accessing and utilizing school mental health services while also identifying referral processes as a major barrier to accessing and utilizing school mental health services. Black youth passionately voiced their interest in being part of the solution to addressing access and utilization concerns for this population. Implications for practice and future research are discussed.

Keywords: School mental health, Black youth, middle school, accessing school mental health services, utilizing school mental health services.

Introduction

According to the National Healthcare Qualities and Disparities Report (2022), current estimates of mental health disorders indicate that the most common mental health disorder diagnoses for children and youth between the ages of 3-17 years old include attention-deficit/hyperactivity disorder, anxiety, behavior problems, and depression. Rates of ADHD, anxiety, and depression diagnoses more commonly increase as students get older. While representing the lowest estimate, approximately 4.4.% or 2.7 million students between the ages of 3-17 years old were diagnosed with depression between 2016-2019. For adolescents in middle and high school, between 2018-2019, 36.7% of students who experienced a major depressive disorder reported experiencing feeling sad or hopeless, and 18.8% seriously considered attempting suicide. Data from 2016-2019 examining the mental and behavioral health disorders for children within the United States indicate that the prevalence rates of ADHD (10.5%) and behavior/conduct (10.1%) were higher for Black children and adolescents compared to their peers. Black children and adolescents between the ages of 3-17 also had higher self-report rates of depression compared to their Hispanic and Asian peers 6% vs. 5.3% and 3.6%). With regard to anxiety, with the exception of their Asian peers, Black children and youth had a lower prevalence rate compared to their peers (Bitsko, et al., 2022).

Many children and adolescents diagnosed with mental health disorders do not receive mental health services in the community and rely heavily on receiving mental health services in school (Ali et al., 2019; Allison et al., 2007). Community based mental health services are well documented as being underutilized in the Black community among adults and adolescents due to

systemic (e.g., scheduling challenges, child care availability, access, transportation, quality, insurance costs) and individual (e.g., stigma, mistrust, psychoeducation, perceptions regarding need, misdiagnosis) level barriers (Kazdin & Wassell, 2000; Lindsey et al., 2013; Mishra et al., 2009; Owens et al., 2002; Snowden, 2001, 2003; Thompson et al., 2004). Even though schools are relied on heavily to provide mental health supports and services, particularly for Black youth, little is known about what factors contribute to access and utilization of these supports. Thus, the current study uses the Ecological systems model (Bronfenbrenner, 1979) to understand Black youth access and utilization of school mental health services.

Theoretical Framework

Bronfenbrenner Ecological Systems Model (Bronfenbrenner, 1979) provides a framework for understanding the various environments and individuals within systems that influence child development. The model exemplifies the notion that children are surrounded by and at the mercy of systems and adults, many of which they have no direct interaction. Applying the Bronfenbrenner ecological model, we conceptualize schools as an environment within the microsystem that creates and implements school mental health policies and procedures, which have a profound impact on student access to and utilization of school mental health services. This is consistent with research that connects schools to child development through its influence on structural, instructional, and peer factors (Farmer & Farmer, 1999). Black children and youth have been positioned within systems of oppression that impact their school and home environments. Schools serving youth from urban communities are more likely to have fewer resources and less qualified teachers, which ultimately threatens their success academically, behaviorally, socially, and emotionally and makes it imperative that the interacting systems in which Black children and youth are placed are researched intently. Traditional models studying

Black youth function from a deficit mindset and fail to approach research from a standpoint that recognizes the cycle of inequity that impacts Black youth and adolescent's access to mental health care while also uplifting the facilitators to Black youth mental health care access and utilization. Therefore, to counteract traditional approaches to research on Black youth that focus on the individual and family, this study focuses exclusively on the barriers and facilitators that occur within the school (microsystem) in relation to school mental health services, as this system is the closest in proximity to students.

School Mental Health Services

For the purposes of this study, the term school mental health is defined and conceptualized as "any program, intervention, or strategy applied in a school setting specifically designed to influence students' emotional, behavioral, or social functioning" (Rones & Hoagwood, 2000 pg. 224). Various terms are used to describe services consistent with mental health being provided in the schools. These terms, school-based mental health services, expanded school mental health services, and comprehensive school mental health services, all provide some continuum of services dedicated to the promotion of mental health well-being, prevention of mental health disorders, and early intervention to reduce the prevalence of mental health challenges. While the purpose of this study is not to highlight similarities or differences between the services provided under these terms, it is important to mention as it provides context into the complexity of mental health services in the schools, which further complicates researchers' ability to understand student and provider experiences and work towards improvements.

Schools are viewed as the optimal setting for SMH services due to the ease of access to students, existing relationships between parents and schools, and school mental health providers

and SMH services are viewed as a mediator, offsetting the systemic and individual-level barriers to community-based mental health services and filling the gap in treatment by providing mental health services in the schools (Ali et al., 2019; Allison et al., 2007; Bains et al., 2017; Duong et al., 2021; Farmer et al., 2003; Snowden & Yamada, 2005). However, the autonomy of states, districts, and schools leads to inconsistencies in the conceptualization of SMH services, services available to students, identification of SMH providers, and the implementation of these services. In addition to the impact of autonomy in the development of SMH services and state prioritization of addressing children and youth mental health needs, which have direct implications for access and utilization of SMH services, the nature of schools as the primary setting for mental health services for children and adolescents has called into question the true accessibility, quality, sustainability, and effectiveness of SMH services (Atkins et al., 2017; Foster et al., 2005; Kazdin, 1993; Verlaan et al., 2018).

Currently, no federal SMH law exists, so states have the responsibility to develop and implement SMH policies and practices according to the needs of their student population (Mental Health America, n.d.). For example, in Georgia, the Georgia Apex Program is a state initiative implemented to support the mental health needs of students in Georgia. The program facilitates relationships between community-based mental health organizations and schools to provide SMH services to students across grade levels. Through a multi-tiered support system, the Georgia Apex Program serves over 14,000 students in 565 schools and provides mental health awareness events, individual and group therapy, and behavior assessment services to students (Georgia Department of Behavioral Health and Developmental Disabilities, n.d.).

As a result of SMH services, increased student academic success, improved mental health outcomes, decreased suspension rates, and increased attendance have been identified as positive

impacts (Ballard et al., 2014; Hoover & Mayworm, 2017; Walrath et al., 2004). In addition to individual student benefits, SMH services have also been associated with benefits for the entire school community, such as improved mental health awareness and school climate (Walrath et al., 2004). Taking into account both the individual and school community benefits of SMH services, it is alarming to witness steady increases in mental health challenges experienced by youth in general and Black youth specifically. Despite these well-documented benefits, less is known about factors impacting *access* to and *utilization* of school mental health services for Black adolescents (Lindsey et al., 2013; Office of the Surgeon General [US] et al., 2001).

Access and Utilization

While wide variability exists in the provision of SMH services by state, district, and school level, many mental health providers, including school counselors, social workers, and school psychologists, work as multidisciplinary team members to provide services that support the academic, emotional, and behavioral functioning of children and adolescents. Increased *access* to mental health services is a highly referenced benefit of SMH services (Allison et al., 2007). In the school mental health literature, "*access*" is undefined operationally and is often referred to as the mere presence of services, presumed availability of services, or open to interpretation. Utilization as it relates to SMH services follows similar patterns. Many research studies operationalize utilization of SMH services from standpoints that place emphasis on culture, school-related factors, the type of problem behavior, the severity of behavior, the actual delivering of services, frequency of contact, and retention (Bains et al., 2017; Evans, 1999; Verlaan et al., 2018;) while also adjoining (or interconnecting) the terms and characteristics of the processes and steps that determine access and utilization (Bains et al., 2017; Lindsey et al., 2012.)

Access and Utilization of SMH Services for Black Youth

Data on access and utilization of SMH services by race and ethnicity is scarce, with less being known about its effectiveness due to the general autonomous nature of schools (Atkins et al., 2010). Studies and meta-analyses have documented that anywhere between 20-54.8% of Black youth in educational settings utilized SMH services (Ali et al., 2019; Allison et al., 2007; Bains et al., 2017; Duong et al., 2021; Parasuraman & Shi, 2015; Slade, 2002; Whitaker et al., 2018). The variability in utilization rates of SMH services should not be attributed to Black youth or interpreted from a deficit mindset that emphasizes individual, familial relationships, and neighborhood factors. It should be viewed from a systems perspective as the academic stressors of school, negative school climate, state testing, prevalence of bullying, shortage of mental health professionals, and limited capacity of school personnel emit an immense degree of power over youth's access and utilization of SMH services and are contributing factors in the increased rates of mental health challenges for all youth, particularly Black youth (Barksdale & Thomas, 2000; Greene & Winters, 2006).

In addition, Black students are primarily referred to, access, and utilize SMH services for externalizing or behavioral concerns and are less likely to receive mental health services for internalizing concerns such as anxiety or depression (Bramlett et al., 2002; Foster et al., 2005; Ghandour et al., 2019; Lindsey et al., 2013). Further, Black youth typically are not referred for evaluations for mental health disorders until after involvement with the juvenile justice system, signifying a reactive instead of a proactive approach to mental health well-being (Chow et al., 2003; Murry et al., 2011). Using the term "*access*" lends itself to the assumption that mental health service availability in schools translates to an opportunity for the "utilization of services." Despite the increasing discussion and prevalence of provided SMH services documented in

research, mental health challenges experienced by Black youth are increasing nationally (Bringewatt & Gershoff, 2010). It has become increasingly more apparent that minoritized student groups, such as Black youth, face similar barriers to accessing SMH services as they do in community settings, including subjective interpretation of mental health challenges by teachers, parental consent, competing responsibilities of SMH providers, family engagement, and adult gatekeeping and referral processes, which highlights the need for the continual examination of SMH systems (Guo et al., 2014; Lindsey et al., 2013; Murry et al., 2011; Splett et al., 2019; Twymon et al., 2020).

Current Study

The benefits of SMH services are well documented for reducing gaps in access and improving academic success and mental health outcomes (Hoover & Mayworm, 2017; Walrath et al., 2004); however, variability in utilization rates of SMH services for Black youth suggests that a deeper analysis of policies and practices at the school level is warranted. Although previous research has included analyses on the utilization of school mental health services for Black youth (Schwarz, 2009), the literature base is limited in its focus on systemic policies and practices that impact Black youth's access to and utilization of SMH services. The present study seeks to fill this gap by examining how systemic exosystem (school district school mental health policies and practices) and microsystem (i.e., school mental health policies and practices) factors impact Black youth's access and utilization of school mental health services and seeks to answer the following research questions:

1) What are the systemic barriers and facilitators to school mental health access and utilization for Black youth?

2) What are the perceptions of Black students and school mental health professionals of school mental health services?

Methods

Participants and Procedures

Participants in this study were drawn from an urban school district in the Southeastern United States. This school district was selected based on proximity, familiarity, and the high percentage of Black students served (48%; Georgia Office of Student Achievement, 2019). A non-random purposive sampling strategy was used to select two middle schools that did not participate in the Georgia Apex. Following the IRB process and approval at the university, district, and school level, one school declined to participate in the study due to the inability to fully provide the resources needed to successfully implement the study. At the beginning of the 2022-2023 school year, the remaining school commenced its relationship with a community mental health provider as part of the Georgia Apex program. The researcher selected an additional middle school (School B) where a previous working professional relationship existed to increase participation rates. School A had four school counselors, one school social worker, and one school psychologist. School B had two school counselors, one school social worker, and one school psychologist.

The study proposal was sent for review at the researcher's institution following district and school-level approval. The study was approved by the University Institutional Review Boards (IRBs) and the school district in December 2022. At schools A and B, recruitment began with selected teachers receiving and disseminating parental consent forms to students, which included an overview of the study, purpose, study requirements (i.e., brief questionnaires and focus groups), time commitment, and compensation. At school B, the researcher provided a brief

5-minute presentation of the study to students in selected classrooms. Interested students were provided consent forms for their parent's review. Consent forms required parents to provide demographic information, including whether their child received special education services. Students with an IEP receiving counseling services as part of their IEP were excluded from the study. The researcher conferred with the school counselor (School A) and behavioral specialist (School B) to ensure accurate reporting of special education services.

A purposive sampling strategy was utilized to recruit and select participants (Kilgus et al., 2015). The sample population for this study included middle school youth in 6th, 7th, and 8th grade who self-identified as Black and did not have an Individualized Education Plan (IEP) requiring counseling services as part of their IEP. The sample size for this study was 19 Black middle school youth. To offset age differences and personal experiences and to ensure a balance of responses and opinions to facilitate richer conversations, student participants were split by grade level and *not* grouped based on their gender (Hall, 2020). However, due to small sample sizes for 6th and 7th grade levels at each school, students were placed in a combined group (e.g., 6th and 7th or 7th and 8th) or interviewed individually.

School mental health providers were recruited using purposive sampling based on occupation and employment at the selected schools and included school counselors, school psychologists, school social workers, and mental health counselors. School mental health providers were recruited through the dissemination of fliers and consent forms explaining the study. The fliers outlined that school mental health providers were being recruited for a research study. The flier also indicated that school mental health providers would be involved in a one-to-one interview that would last between 60-90 minutes discussing school mental health policies and procedures related to student access and utilization of SMH services. Each provider was

compensated $50 for their time. The intended sample of 10 was selected based on the number of SMH provider positions at each school. A total of six school mental health providers expressed interest in the study, completed the questionnaires, and participated in both interviews. One school mental health provider declined to participate in the study. Two providers did not respond. Another school provider could not identify a time to participate in the study within the data collection period. The participation rate for school mental health providers was 60%.

Measures

Demographic Questionnaire

SMH providers provided demographic information such as race and ethnicity, position/title, degree, special certifications, and years of experience at that school. Demographic information for students was obtained in the consent form, and parents provided birthdate, race, ethnicity, grade level, and special education status.

Knowledge of School Mental Health Providers and Services

A 10-item researcher-developed self-report measure was used to evaluate students' knowledge and awareness of available SMH services and providers and engagement with SMH providers. Three questions assessed students' knowledge of SMH services(e.g., "Do you know what school mental health services are available?"), three questions assessed knowledge of mental health service providers at their school (e.g., "Do you know who your school counselor is?"), and four questions assessed student engagement with SMH providers and the likelihood of help-seeking (e.g., "Have you ever been seen by a school counselor?"). Students answered "*yes*" or "*no*" when asked about their knowledge of available SMH services at their school, knowledge of employed school mental health providers at their school, and if they have ever been seen by a school mental health provider. Students also rated their level of agreement with a statement

about their knowledge of mental health, mental health services, and help-seeking behavior. Responses ranged from "*disagree* to *agree."*

Mental Health Symptoms

The Strengths and Difficulties Questionnaire (SDQ; Bourdon et al., 2005) is a 25-item brief validated behavioral screening tool to provide an overview of 3-16-year-old children's overall stress, behavior, emotions, prosocial behaviors, and peer relationships. Responses were rated on a three-point Likert scale from *not true* to *certainly true*; sample items include *I am often unhappy, depressed, or tearful* and *I try to be nice to people. I care about their feelings.* The total difficulties score (TDS) is generated by adding the scores from items included in the first four scales (Emotional problems, Conduct problems, Hyperactivity scale, and Peer problems scale). TDS ranges from 0 to 40, with scores between 0-14 considered close to normal, 15-17 considered slightly raised, 18-19 considered high, and scores above 20 very high. The Prosocial scale measures positive behavior with scores ranging from 0 to 10. The SDQ has been normed on British and U.S. children between 4 and 17 years old and has been found to have good acceptability and internal consistency (Bourdon et al., 2005).

Procedure

The focus group and interview protocols were reviewed by four university faculty members and one doctoral graduate candidate. The process of reviewing questions led to changes in the position of questions as well as modifications to initial and follow-up questions. For example, a reviewer noted that it would be imperative to incorporate "low stakes questions" such as "Can you describe the mental health services at your school?" to ease students into the focus group discussion, set the stage for a natural progression of questions, and start on a positive note. Following a participant's difficulty understanding two questions, the SMH provider interview

protocol was reviewed and revised by the researcher and one university faculty member. No other participants expressed difficulty with understanding the questions following revisions.

Focus Group Procedures

Focus groups occurred in-person during the students' lunch period and were conducted in private locations on school grounds (e.g., conference room, unused classroom), which were pre-determined by school administrators and teachers as the least disruptive to the educational environment and student's learning. Focus groups lasted approximately 50 minutes. At the start of each focus group, participants were welcomed, reminded of the study purpose and goals, that they may opt-out at any time with no impact on grades, extracurricular activities, or school relationships, and that their opinions and beliefs are highly valued. Verbal consent from all students was received prior to the start of focus group discussions. Students also provided verbal consent to audio record focus group discussions for transcription purposes. Confidentiality and anonymity, the associated limitations within a focus group setting, and the attempts to reduce these limitations (i.e., pseudonyms, storing recorders in a locked space, ground rules, etc.) were discussed with participants. Additional efforts were made to facilitate comfortable discussions that did not solely rely on or require students to draw from their personal experiences. Participants received $25 for their participation. The audio recordings from the focus groups were transcribed using a third-party transcription service. Member checking was utilized during focus group discussions as it allowed participants to validate the researcher's interpretation of responses (Birt et al., 2016).

Interview Procedures

Interviews with SMH providers occurred via Zoom based on participant availability, which accommodated work and personal responsibilities and facilitated open discussions. At the

start of each interview, SMH providers were welcomed, reminded of the study purpose and goals, that they may opt out at any time with no impact on their relationships with colleagues or employment with the school or district, and that their opinions and beliefs were highly valued. Verbal consent to participate and audio-record the session was also received prior to the start of each interview. Participants were given the opportunity to participate in the interview with their camera off. SMH providers participated in one 60-minute interview. Interviews followed procedures outlined for focus groups, such as audio recording transcription through third-party transcription services, member checking, and summarizing responses. SMH providers received $50 for their participation.

Analysis

Black youth and SMH providers were key informants in understanding processes, barriers, and facilitators to accessing and utilizing SMH services. To achieve this, the present study applied thematic analysis (TA), developed by Victoria Clarke and Virginia Braun in 2006, as an approach to identify Black students' perceptions of their access to and use of SMH services, as well as school mental health providers' perceptions of SMH services provided. TA is a pliable tool to assist researchers with uncovering and analyzing data using qualitative methods, such as interviews and focus group data (Braun & Clarke, 2006).

As the core of data analysis, becoming familiar with the data set the stage for engagement in formal coding processes. Data from the focus groups and interviews were transcribed through Otter.ai services, and to ensure accuracy and familiarity with the data, the researcher repeatedly reviewed the data (i.e., audio recording transcripts) for meaning. The transcripts were then compared to the original audio recordings to make changes as necessary. After becoming familiar with the data and establishing a general idea of what the data entails, the researcher and

a trained graduate student engaged on a deeper level with the data to construct initial codes. The coding process, which the researcher and graduate student approached as data-driven, entailed identifying interesting data components and systematically grouping data based on these components. While all data was thoroughly examined to identify recurring patterns, specific pieces went through multiple coding revisions and ultimately fell under more than one potential theme.

Following familiarization of the data and generation of initial codes, development began. The researcher analyzed the codes developed during phase 2 and determined how they related to and shaped comprehensive themes. At the culmination of this phase, the researcher established a preliminary list of themes and subthemes of importance, which were reviewed in the next phase to determine the strength of themes to make appropriate modifications. After establishing a preliminary list of themes, the researcher fine-tuned the identified themes. At this stage, it became apparent that previously identified themes no longer had sufficient data to support that specific theme, two or more themes were better suitable under one theme, or one theme should be separated. Reviewing and fine-tuning themes involved two steps. In the first step, all data that fell under each theme was reviewed to ensure that, collectively, a clear pattern was apparent. In the second step, the researcher reviewed all themes in relation to the entire dataset to determine validity and ensure that the dataset was accurately represented.

Additional defining and refining of themes during data analysis also took place. Each theme underwent a rigorous analysis to highlight the story of each theme within the context of the broader data set and as it related to the research questions and was reviewed in isolation and together to determine if subthemes or a theme existed under a broader theme fits better under a different theme or independently.

Results

Descriptives

A total of 494 parental consent forms were disseminated to potential Black youth participants, and 20 students (School A = 7 students, School B = 13 students) returned signed consent forms and participated in focus groups. Twenty students met all inclusion criteria and were invited to participate in the study. Female participants comprised the majority of student participants (n = 15; 75%), while male participants (n = 5) represented 25% of the sample. All participants self-identified as Black (100%). Participants' ages ranged from 10.74 to 14.87, with all students currently enrolled in middle school. Eighth grade students represented the highest percentage of student participants. Participants did not have an IEP requiring counseling services. Table 1 represents student demographic information. With regard to school mental health providers, the majority were female (n = 5; 83%), White (n = 5; 83%), and school counselors (n = 3; 50%). The average years of experience was (7.8 years), and SMH providers served their school on average for 4.7 years. Table 2 provides demographic data for school mental health providers, and to maintain confidentiality, the position/title of school mental health providers is not included.

Table 1

Student Demographic Information

Gender	Ethnicity	Grade
Male	Black	6th
Female	Black	6th
Male	Black	6th
Male	Black	7th

Female	Black	8th
Female	Black	8th
Female	Black	8th
Female	Black	6th
Male	Black	6th
Female	Black	7th
Female	Black	7th
Female	Black	7th
Female	Black	7th
Female	Black	7th
Male	Black	8th
Female	Black	8th
Female	Black	8th
Female	Black	8th
Female	Black	8th
Female	Black	8th

Table 2

School Mental Health Provider Demographic Information

Gender	Ethnicity	Years of Experience	Years at School
Female	White	8	8
Female	White	8	4
Female	White	5	3 months
Female	Black	7	7
Female	White	13	7
Male	White	6	2

Knowledge of School Mental Health Providers and Services

Table 3 shows responses to the researcher-developed questionnaire about students' knowledge of SMH providers and services. While all students indicated that they knew their assigned school counselor, only 35% of students knew their school social worker and only 20% knew who the school psychologist was at their school.

Table 3

Knowledge of School Mental Health Providers and Services

Question	Yes		No		Not Applicable	
	n	%	n	%	n	%
School Counselor						
6th	5	100%	0	0%	0	0%
7th	6	100%	0	0%	0	0%
8th	9	100%	0	0%	0	0%
All	20	100%	0	0	0	0
School Social Worker						
6th	1	20%	4	20%	0	0%
7th	2	33%	3	15%	0	0%
8th	3	33%	6	30%	0	0%
All	6	30%	13	65%	1	5%
School Psychologist						
6th	0	0%	5	25%	0	0%
7th	1	5%	4	20%	1	5%
8th	1	5%	7	35%	1	5%
All	2	10%	16	80%	2	10%

Question	Agree		Disagree		Neither	
	n	%	n	%	n	%
Know What SMH services Are						
6th	3	15%	2	10%	0	0%
7th	5	33%	1	5%	0	0%
8th	6	30%	2	10%	1	5%
All	14	70%	5	25%	1	5%
SMH SERVICES						
6th	3	60%	2	40%	0	0%
7th	5	83%	0	0%	1	17%
8th	8	89%	1	11%	0	0%
All	16	80%	3	15%	1	5%
Know What Mental Illness Is						
6th	4	20%	0	0%	1	5%
7th	5	25%	1	5%	0	0%
8th	9	45%	0	0%	0	0%
All	18	90%	1	5%	1	5%
Providers						
6th	5	25%	0	0%	0	0%
7th	2	10%	0	0%	4	20%

8th	4	20%	2	10%	3	15%
All	11	55%	2	10%	7	35%

When asked to rate the degree to which they agreed or disagreed with statements pertaining to their overall knowledge of SMH services at their school, almost all participants (90%) indicated knowing what mental illness is, 80% reported knowing what SMH services were available at their school; however, only 70% knew what SMH services are. Interestingly, when asked if students would confide in a SMH provider if faced with challenges, student responses were mixed. Slightly over half of students agreed that they would talk with a provider, while 35% were unsure, and 10% disagreed.

Strengths and Difficulties Questionnaire

Based on SDQ norms, TDS scores range from 0 to 40, with scores between 0-14 considered close to normal, 15-17 considered slightly raised, 18-19 considered high, and scores above 20 very high. The average overall TDS score, a measure of overall stress, for all students was approximately 14.8 and considered close to normal ($\bar{x} = 14.8$); [1-24]; ($\sigma = 6.6$). Data disaggregated by grade level highlight different outcomes. A higher percentage of students in the 8th grade (17.8%) reported higher levels of overall stress compared to 6th graders (13.7%) and 7th graders (12.7%). Examining data from the individual scales, such as the emotional distress scale, indicates that 42% (n = 8) of all participants scored within the high or very high range on this scale and suggests that these students are experiencing significant emotional distress.

Summary of Identified Themes

Black middle school youth and SMH providers highlighted various facilitators and barriers that influence their perceptions of available SMH services as well as their perceptions of authorities within the school setting who have an impact on their mental health (e.g., teachers, school counselors, administrative staff). These factors were classified into six themes: access,

utilization, promoting positive mental health, hindering mental health promotion, conflicting roles within the school system, and feelings of isolation. Access to SMH services was broken down into two additional categories: student definition of access to SMH services and SMH provider definition of access to SMH services. Promoting positive mental health was further categorized into continued education, action-oriented behaviors, practices and environment, and trust between students and providers. Hindering mental health promotion incorporated four sub-categories and included challenges with internal and external referral processes, judgment, challenges with community-based agencies and parents. Conflicting roles within the school system represented conflict with the system and bandwidth as sub-categories. Lastly, feelings of isolation included self-sufficiency and internal or external pressures.

Theme #1: Access to SMH Services

The term "*access*" lacks an operational definition in the SMH literature, which lends itself to open interpretation. However, it is frequently conceptualized as a representation of services or the presumed availability of services to students. Using the term "access" also suggests that mental health service availability in schools translates to an opportunity to utilize services. Black youth and SMH providers were asked to provide their own definitions of access to school mental health services.

Theme #1a: Student Definition of Access to SMH Services

Students defined access to SMH services as an opportunity to discuss challenges with adults without judgment. For instance, an 8th grade student defined access as, "To be able to get, be able to have, [like] being able to get something knowing that you can get to it easily. You know, just knowing that someone, something is always there that you can get to." Other students were more specific and stated, "Being able to have the help that you need if you experience

mental health problems." Another conveyed, "[access means] being able to have someone that you know you can talk to and express your feelings to without, you know, like getting judged or criticized." Sixth grade students discussed access to SMH services as open to everybody and services that are easy to get connected with. A seventh-grade student defined access from a more complex standpoint, considering race and ethnicity as considerations for student's access and elaborated by saying,

> "Sometimes it can be limited… and sometimes there isn't limits to it because I feel we have our eighth grade counselor [], she's a really good counselor, but then you have like the other counselors, and I feel like sometimes they don't understand like where we're coming from, especially as a African American student."

Theme #1b: SMH Provider Definition of Access to SMH Services

School mental health providers defined access in relation to processes in which students typically receive services. Several providers noted that students access SMH services based on the severity and frequency of disruptive behaviors that are brought to the attention of administrative staff. One provider stated, "…They access mental health because their behavior is disruptive. Unfortunately, that's usually how they end up accessing…it's almost like asking for help without directly asking for help, essentially." Despite the traditional disciplinary trajectory to accessing SMH services that providers reflected on, others highlighted their opinions on the multi-step process of accessing SMH services and how failure to provide or engage in all steps constitutes a lack of access. They stated,

> "So I see [access] as referrals but then also ensuring that the referrals can and are followed up on. And so, if you make a referral and there is not an intake completed, that child has not accessed mental health service. If you make a referral and it's for an agency that is, you know, unattainable, whether it be transportation or time, or family commitment, and this is not going to be sustainable, that is also not access. So, I think [access] is referrals and then ensuring that there's no barriers to that referral being following up on."

Theme #2: Utilization of SMH Services

Consistent with research on access to SMH services, many studies that focus on the utilization of SMH services lack a clear definition of the meaning behind "utilization." Both providers and students struggled with articulating their perception of utilization.

Theme #2a: Student Definition of Utilization of SMH Services

Students described utilization of SMH services as opportunities to seek out SMH providers to discuss problems and stated,

"It's easy because if you tell your teacher why you need to talk to them, they'll let you out" while another reflected on the process, saying "you can always fill out the form that's like on our [inaudible], like, it's a counseling form where you can fill out and you could have like a specific day and she'll pull you and you could talk to her and stuff."

Theme #2b: SMH Providers Definition of Utilization of SMH Services

Providers equated utilization of SMH services with observable changes in behavior, while other providers discussed utilization within the context of tiered supports and services, frequency of completed referral forms by students, active engagement in sessions, and sessions attended. Several providers defined utilization from an outcome perspective, with one provider stating,

> "They would be attending the sessions, they would be actively participating in the sessions, you would see progress throughout the sessions of them being able to emotionally regulate themselves, you would get reports from teachers…[And] that would indicate to me that the student was not only utilizing and accessing the care, but then incorporating it into their behavior."

Theme #3: Promoting Positive Mental Health

Promoting positive mental health represented actions, training, and trust that were interpreted as participants' views of what the school and mental health providers have control over, as well as facilitators that support the access and utilization of SMH services. Across participants, the promotion of positive mental health as it relates to access and utilization of

SMH services was tied primarily to trust and communication. Both students and providers discussed at length the importance of a bi-directional relationship between adults in the school and the students.

Theme #3a: Trust

SMH providers discussed the importance of mentorship in the school building to facilitate SMH services. Students discussed the supportive adults or authoritative figures in the schools as their primary confidants in times of need. Interestingly, several students vocalized trusting their teachers, coaches, or other professionals in the school more and preferring to speak with them over school counselors. One student elaborated on their trust in teachers by saying that teachers make accessing SMH services easier based on how they present themselves. She stated, "I feel like how the teachers display themselves, like, you know, you can branch out and find somebody that you really attached to, and therefore you can like, express your feelings and what you thinking."

Theme #3b: Action-oriented Behaviors

Providers also shared the importance of diffusing their sense of authority both within the counseling space and school building to facilitate trusting relationships that cultivate honesty, openness, and safety. One counselor stated,

> "It is a constant sort of trying to be reflective as a mental health professional around how I am portraying myself and trying to defuse that sense of authority within my office space and how I am utilized within the building."

She also reflected on her race in a school that serves predominately Black students, and indicated,

> "I think myself and some other white adults in the building, make it a point, you know, especially with a lot of the things going on nationally [to] make it a point to express beliefs and support of the value of Black lives vocally and outwardly."

Related to diffusing their sense of authority, many providers reflected on action-oriented measures that they take to create safe environments. When mentioning their current practices, one school counselor shared,

> "I think having a welcoming environment in my office has been really helpful… I met with all my kids at the beginning of the year. And so they all had an opportunity to be in my office space, and to see the fidgets and the games and trying to make it a comfortable meeting space for them."

A school social worker explained that after meeting with the student support team she reaches out to students to begin building rapport and stated,

> "I'm putting those kids into those discussions and then also having follow-up discussions with them [students] around attendance. Attendance is often sort of the symptom of other stuff that's going on and so using that as an opportunity to not just connect with that student, but also make sure that they're got their adults in the building that they can go to if there are concerns that come up… you know, who are your people that you can go to, and trying to build that social capacity within the building so that it isn't just the counselors. There may be a teacher that they're going to feel more comfortable going to and getting that child to identify who their advocates and preferred adults are within the building to report to if there are problems."

She also described taking it a step further and informing the student's teacher to provide an additional layer of support and to facilitate additional relationship building, saying,

> "So, if I have talked to the student and had them identify a particular teacher that they feel like they're really comfortable with and would like to go to if something comes up, I let that teacher know. What I have found is they're [teacher] going to be more responsive to that student when they come to them if I kind of bridge that gap a little bit to say, you know this is something that I asked my students when they're coming back into the building and you're [teacher] sort of who they identified and that like a warm fuzzy feeling for teachers and sort of builds that capacity."

Theme #3c: Continued Education

Several providers highlighted the importance of continued education, including training or continued education that promotes mental health and well-being. They expressed the necessity of evidence-based practices at Tier 1, psychoeducation geared towards students and school staff on referral processes, mental health warning signs, and SMH provider roles. One school

counselor called out the need for school district leaders to provide counselors with access to more evidence-based curriculum resources to support the growing need for counseling groups. When talking about student's knowledge of mental health, one provider shared,

> "I feel like there's probably just a large group of kids who don't know what they don't know. So, they don't know that they need to ask for help regulating their emotions, or they don't know what depression or anxiety feels like or is it that they just know that they don't feel right, and they don't know who to ask for help." They continued to say, "They might not necessarily understand that that's what a counselor does. Educating them on the fact that there is someone out there that can help them, I think then they would be able to utilize mental health services."

Theme #4: Hindering Mental Health Promotion

Factors that make it harder or impede Black youth's ability to access and utilize SMH services were identified as challenges with internal and external referral processes, judgment, challenges with community-based agencies, parents, conflicting roles within the school system, and feelings of pressure and isolation. The review of transcripts uncovered systems level, interpersonal, and youth-adult relationship factors as barriers to accessing and utilizing SMH services.

Theme #4a: Challenges with Internal and External Referral Processes

While all providers discussed to some capacity the referral process, including an established referral form, a student review team, data-based decision-making, and intervention selection, several providers and students emphasized issues that frequently occur prior to the beginning of the referral process or mid-process with the school's ability to identify students in need of SMH services swiftly and accurately. Several providers made a point to emphasize current access points to SMH services as disciplinary focused and stated, "…the way that they [students] access mental health services is [that] their behavior has gotten unmanageable [and] they're disruptive in the school environment. They can't sit still; they have a hard time paying

attention…" with other providers identifying administrative differences between disciplinary approaches compared to mental health approaches as potential barriers to being referred for school mental health services by stating,

> "Administrators who are getting a referral for a student's fighting, you know, if that administrator sort of acknowledges or is parsing out, like this was an interpersonal peer issue that may be best addressed from like a mental health standpoint or from a skills standpoint versus a disciplinary standpoint, like that is another I think, access barrier, depending on who those are and depending on sort of the outlook of that administrative team."

Providers at one school spoke in detail about the cracks in the referral process, with one commenting,

> "[The] vast majority of referrals are student request and we do not get a lot of referrals from teachers, basically none from parents…teachers do not make a lot of referrals. So, unless the student remembers that the form exists, remembers that we're here to support them, then we might not get referrals for something."

Providers pointed out that when schools and administrators primarily focus on decreasing disruptive or externalizing behaviors in the classroom, other students in need of SMH services are overlooked, with one stating, "A lot of kids fly under the radar because of internalizing problems." Students also talked about giving up seeking out mental health help due to complications with their school's referral form and finding alternative means,

> "We usually just do forms, but I don't like the form format…its certain questions that you have answer in that certain way. And like sometimes you don't feel the way and you don't want to answer the way the question is being stated…I don't know maybe you just need to express yourself to different people, and then find the right person to get you to where you need to get to."

Another student continued the discussion saying, "and then the formula…I feel like you can fill out the form if you just want to get out of class, and sometimes it's not always for that, some people are actually struggling, you actually need the help."

Theme #4b: Judgement

Although Black youth and providers discussed trust as a key factor in mental health promotion, Black youth spoke at length about negative experiences with authority figures in schools, which symbolized to them that adults are out of touch with students and functioned as barriers to their access and utilization of SMH services. Some discussed concerns that adults do not maintain confidentiality after expressing personal problems with one voicing,

> "A lot of these people just say that you can to them, and this and that and that it'll stay between y'all. But it somehow gets out and that's just like, I don't know, it just makes you like, never mind, I should [have] just been quiet the whole entire time."

While another discussed feeling judgment directed towards youth from adults who diminish youth mental health needs,

> "Adults downplay mental health for teens and they don't think it's a big deal when, like, it really is a big deal, especially like in this age, like going into ninth grade going to high school, like it is a big deal. Some students can be affected by that, they can, you know, suicidal thoughts, that come into play and stuff like that, and they downplay it into thinking, oh, its social media or its your friends you're hanging around."

One 7th grade student captured judgment from a different perspective, highlighting instances in which students who perform academically well are often overlooked with regard to the need for mental health services and stated,

> "They [counselors] only view students as like their good student and that they don't go through anything so they don't need a therapist or no one to talk to and I feel like they need to stop judging people about like how they act and stuff because they actually don't know what a person going through."

Even when students sought out providers, they spoke about the efficacy of the services, with one expressing,

> "It [talking with a provider] don't really help as much as it should because you tell stuff and it might be something regarding bullying or something and all they do is just like talk to the person like 'hey don't do this' and you know nothing really happens after that. You know, talking to a teacher I feel is more helpful."

Theme #4c: Challenges with Community-Based Agencies

Both schools reported having established partnerships with multiple community-based agencies and relying heavily on them to provide SMH services to their students; however, they identified various factors such as limited capacity of school and community-based agencies, high turnover rates, early career professionals as providers, and insurance as cracks in SMH delivery model The social worker captured several of those cracks and noted,

> "So, one of our major mental health agencies in this community, you know, has closed referrals to the entire country, you know for months at a time. At any given time, they've got a capacity within any one individual school. And then those positions have had high turnover."

Speaking about the experience of quality of providers employed by community-based agencies, one provider stated,

> "There are some things that lower that barrier, but then like, it's not necessarily equitable, you know. For a lot of the mental health agencies that can provide school based, right, they are likely to employ younger clinicians that may not be licensed at an independent level, and so [they] don't have as many years of clinical experience. So, they're newer, they're greener. You know, and higher turnover rates. So, if you're referring a student to the most accessible mental health option available, but it means that they cycle through three clinicians in one academic school year, is that better?"

Insurance, one of the frequently mentioned barriers to accessing community-based mental health care, was also referenced during discussions around SMH services. This appeared to be mainly because many schools do not have the capacity or SMH providers on staff to provide SMH services, so they contract with community agencies who receive payment through insurance companies, with one provider saying, "Only students that have Medicaid can access school-based [mental health services.]" and another stating "I would say insurance is probably also a barrier. However, the majority of the students I work with, have Medicaid of some variety and it's much easier to access services with that than with private insurance."

Theme #4d: Parents

Parents were brought up by students and providers as potential barriers to accessing and utilizing school mental health services. Students discussed their parents as barriers from the perspective of not feeling like parents understand the struggles that Black youth experience, with one student stating, "Parents don't really understand." Interestingly, very few providers discussed parents as barriers in relation to students accessing SMH services due to challenges obtaining consent but spoke in depth about parents as potential barriers due to systemic level factors and their relationship with schools. For example, one provider stated,

> "I think that the discussion with black families and black parents around accessing mental health supports, you know, that there is often a lot of trepidation around what that looks like within some communities, and you know worrying if they're sending their child to speak with a white woman."

Relatedly, another provider spoke about the mistrust and strained relationships between schools and parents and called for more collaboration with outside providers to talk with parents in order to move the needle forward in getting students access to SMH services by expressing, "I think that sometimes somebody else other than the school need to educate the parents because I think they feel like, I don't know, sometimes like we have a hidden agenda for some of the parents." Another mental health provider discussed how she navigates potential concerns about parental stigma towards mental health at the direction of school administrators when discussing consent with parents and described,

> "Every time someone's referred to my caseload, I call the parent and I have a conversation. Because I was coached not to use the word mental health, I say, 'I'm on site, I'm part of the counseling team and I am here to offer additional support by meeting with your student."

Providers who did discuss parents as barriers to accessing SMH services in relation to paperwork and utilizing SMH services shared,

> "Often we'll have a student that is reaching out for help and support and the parent, for a variety of reasons, the parent is not able or willing to follow-up, whether it's initiating the intake or consistently having contact with the clinician."

Another discussed the potential relationship ramifications by stating, "Occasionally I'll have a parent who maybe doesn't want their child to be receiving certain services and so that could create somewhat of a barrier in terms of a child feeling comfortable opening up or sharing information with me" while another stated "Children are afraid to even let us know what their experience is… children feel like they may be in trouble if they do [by] their parents or something if they reach out for help."

Theme #5: Conflicting Roles Within the School System

When discussing existing SMH services, each provider detailed their role in the delivery of SMH services to some compacity and the internal conflict or tension they experienced while working within the system and also trying to support the needs of students as a provider. All providers elaborated on their goals and responsibilities in the school as it relates to SMH services, highlighting many differences between their training and how their skills are utilized in the school. As described earlier, all providers had a master's level education, some were licensed, and some had an additional specialist degree in school counseling or were a licensed specialist in school psychology. Despite these advanced degrees, a school counselor expressed frustration saying, "although I'm a licensed professional counselor, we can't do therapy in the schools." Another explained,

> "…since our role as school counselors is, you know, we might provide kind of low-level mental health support. But again, it would not be appropriate for us to be promising any student, any type of therapy services. That's not our role."

One provider compared their role as a school counselor to a position of triage by saying,

> "Due to the volume of students on our caseload, it is not possible to ever consider that therapy. And then, in the event that, you know, there is a crisis, or a student needs a

> deeper level of support that falls more under a clinical or therapeutic scope, that is when we would refer out and so basically our role is, I liken it to triage. But our role is never to be their primary, clinical, or therapeutic mental health provider."

Another counselor painted a picture of how she is utilized in the school and detailed a frequently experienced situation of the expectations that have been set by the school administration,

> "So let's say if I have a student in here who's actually going through a crisis and we're talking it through and I'm assessing a student…well as the bell rings I'm supposed to say 'Excuse me' and get up and go and stand in the hallway while the children transition from class to class and I'm leaving my crisis student. I try to let them know 'hey, I got a crisis kid' but sometimes they don't the email in time. So, to me, that's like inhuman, like, I'm trying to show this child 100% that I'm listening that I care, and I'm here for him. But then the bell ring, and they just take everything away."

Only one provider discussed their role as designed and utilized as someone who can provide therapy if students need mental health services. She commented,

> "So if the kids are unable to connect with therapy in the community because of parent schedules or they don't have good insurance or whatever, those kids are placed on my caseload so that I can see them in school and its so that they're actually able to receive some sort of mental health care."

On the other hand, a school social worker discussed their role, goals, and views SMH services as intertwined with access to educational curriculum and stated,

> "…When I think of school-based mental health, what the counselor's goals are or what my goal is, within a session that's being conducted by school staff, it's to address an immediate concern and try to get that kid to transition back to class in a better space so that they're able to access their educational curriculum. I see that as a different role than ongoing counseling that may be looking to address broader issues for students."

Many providers expressed internal conflicts of wanting to support the mental health needs of students while working in a school system that they believe plays a part in the decline of mental health for students. The mental health provider passionately said,

> "I feel like it's putting a Band-Aid on a gunshot wound. Personally, I feel like we're there and I'm able to help a few kids…it feels gross sometimes getting paid to do this, because I do provide a safe space for kids to come and talk through whatever's frustrating them, but then you send them right back out into the system that's [expletive] up and causing mental health problems to begin with."

A school counselor also shared their frustration with the lack of emphasis schools and district place on mental health compared to academics and extracurricular activities,

> "I mean schools are talking about the whole child and talking about educating, it should not be just academics. I mean, provided you truly care about children, provide transportation, a bus. It's not like it's a lot of children going to counseling, but that [bus] will take them from school to that therapy session and back. Just like you would take them from here to a football game or wherever else they need to go. You could take them to what they really need, which is therapy."

Students also noted the responsibilities added onto teachers and providers that impact their ability to receive SMH services. One student, referring to the adults in the building, stated,

> "I'm pretty sure every teacher got at least one type of duty they gotta be on. So, like it's two counselors and they got something to do all day. Then like, where we gonna go? Like I said, you got to let them [counselors] know ahead of time and like what if you told them ahead of time and they can't even do it then."

They continued by saying, "they [schools] putting too much on the counselors because we got to email them just for us to talk to them about a situation and they not going to see it until like a couple days later."

Theme #6: Feelings of Pressure and Isolation

Students expressed a variety of feelings related to isolation, resilience, and school pressure, which impacted their desire to seek out and utilize SMH services. Many students commented on the stress they encounter juggling school requirements and friendships while trying to maintain positive mental health. Students detailed the pressure they feel to be successful saying, "Imma be on top of everything, but I'm not gonna say nothing, like feeling like a lone wolf that don't have nobody and then when they go home, they parents be wondering like, what's wrong?" Students in different grades offered similar sentiments and elaborated on a pattern where students recognize that they need to get mental health support, while also

highlighting school responsibilities and their own feelings of self-sufficiency as barriers to accessing and utilizing SMH and shared,

> "Maybe myself, because like I said, I need this [mental health support], but then sometimes you just like, I gotta put in the work to actually be able to focus on doing this. And it's like sometimes you don't have the time because you still got school and stuff like that. So sometimes you're like I'll be fine, I'll be able to get through this and I'll be able to push through."

Speaking to the pressure that they feel in school and at home, students conferred with each other when one expressed,

> "It's hard for me to say no, and so it's like everybody what me to do this, do this, do this and I'm constantly saying yes, yes, yes. It's hard for me to say no and when I do say no, I feel it's something a part of me that it breaks me down a little bit… I do like sports and stuff like that and other activities outside of school and I feel like I'm just doing too much on top of school as well and that's why I don't take time for me."

Discussion

This study offers key insight into the perspectives of Black middle school youth and SMH providers and the impact of various systemic, personal, and interpersonal factors that influence or hinder Black youth's access and utilization of SMH services. The exploration of these perspectives helps shape the SMH literature about the various factors contributing to the wide variability in Black middle school youth's access and utilization of SMH services. This study also contributes to the literature by adding data that will help drive future research, school mental health system analysis, and SMH service delivery models.

This research offers a unique perspective on the role of systems as it relates to Black middle school youth's use of SMH services. Few prior studies have focused on the middle school population (Chandra & Minkovitz, 2007), and fewer studies have examined SMH policies and procedures or sought out the voices of Black middle school youth as key stakeholders. Existing research on SMH access and utilization primarily focuses on high school students as opposed to middle school students. Data from focus groups highlight that Black adolescents can articulate their perceptions about SMH services, are in tune with what is happening on their campuses, and desire to be involved in SMH decision-making processes. At the same time, younger students, particularly 6th-grade students, were less vocal and offered less information about their perspectives on services, which could have reflected their comfortability. Their lack of responses could be explained by the novelty of their transition into middle school or their lack of experience or interaction with SMH services.

Student responses on surveys outlined their level of knowledge of SMH services provided at their school, knowledge of SMH providers, and willingness to seek help from an SMH provider. Almost all students reported knowing what mental illness is and what SMH

services were available at their school; however, few students indicated knowing what SMH services entail in general. Students overwhelmingly identified SMH providers as counselors, with fewer indicating that they knew the school social worker and even fewer knowing the school psychologist. Surprisingly, across grades, student responses varied, with more than 50% agreeing that they would talk with a SMH provider, 35% were unsure, and 10% disagreed.

Access. Students and providers alike outlined their views on the definition of access and utilization of SMH services, which serves as a guiding point to assist researchers and practitioners in conceptualizing these terms in future research studies. Overall, participants identified multiple factors they considered important components to conceptualizing access to SMH services. They viewed access as a multilayered and bi-directional process that aims to meet the mental health needs of students and families. Access to SMH services meant ensuring that providers educate students on what SMH services are available, have the language to express their needs, and that students have positive relationships with teachers who are knowledgeable of mental health challenges that will assist in the identification of students needing referrals. Access also requires the integration of broad screenings for the entire student population, that SMH providers respond timely to referrals and complete intake processes, provide services in the school setting by school personnel or community providers, consider the level of care required and needed for students, and have the physical school space to provide services. Responses highlight the complexity of the term access and the variability that exists among providers and students, which rejects the notion within the SMH literature that the presence or advertisement of SMH services equates to access as they fail to account for the various steps that must take place first. This complexity should be considered when researching topics such as this and with diverse student populations before arriving at conclusions suggesting that access means availability.

Utilization. The concept of utilization was difficult for participants to convey, symbolizing future opportunities for additional conversations surrounding the meaning of SMH utilization. While difficult to articulate, there appeared to be some consensus of ideas surrounding the term, with many equating utilization to help-seeking behaviors, observable changes in behaviors, referral form completion, and session attendance and engagement. Overall, many providers spoke to access and utilization of SMH services from a behavioral standpoint, noting that many students who access and utilize SMH services do so due to their externalizing behaviors and/or attendance issues, which is consistent with existing literature that highlights the historical tendency for students with disruptive or aggressive behaviors to be targeted first for SMH services (Armbruster & Lichtman, 1999). This also aligns with what providers stated in interviews: the goal of SMH services is to get students back into the classroom to access their curriculum. This approach makes it easier for other students experiencing internalizing symptoms to slip through the cracks. Taken together, the wide range of conceptualization signifies a need to engage in further dialogue and deeper examination of the terms access and utilization and how they intersect and differ in meaning.

Understanding of SMH Services. During qualitative focus groups, most students expressed their understanding of SMH services as opportunities to speak with a school counselor. One group of students referenced disseminated surveys as attempts by their school to assess school climate and student well-being. Providers spoke more in-depth about the implemented SMH services, such as providing psychoeducation to students, school events, and brief counseling to assist in increasing student's access to education. However, they also mentioned their limited capacity to provide individual and group therapy services to students due to other school-related responsibilities and roles within the school designated by the district and

school while also speaking to community partnerships and referrals to community mental health agencies to alleviate these challenges.

SMH Facilitators. Participant descriptions of the key variables that impact access and utilization stemmed from trusting and supportive relationships with adults at school as the foundation and shed light on the emphasis of these relationships when Black youth consider seeking out and utilizing SMH services. Identifying trusting adults, particularly teachers, whom they sought out and found the most support from when dealing with mental health challenges were facilitators for Black youth. While partnering with community mental health agencies fills a need for providers, considering the frequency in which students and providers mentioned trust as a key factor to students' help-seeking behaviors and willingness to discuss problems, partnering with community agencies may weaken students' interest in participating in services provided by an outsider. Although providers and students spoke to the challenges of seeing SMH providers, once connected, SMH providers vocal support of Black lives and purposeful environmental configurations played key parts in diffusing authority and creating safe spaces, which in turn facilitated openness and comfortability discussing mental health challenges. Alternatively, students also referenced feelings of judgment from parents and adults as barriers to seeking help. The study findings indicate the importance of positive adult-student relationships within the school building and call for adults to intentionally cultivate meaningful and trusting relationships with students.

SMH Barriers. The results from the study also highlighted various systemic challenges that influence Black middle school youths' access to and utilization of SMH services. Aligned with research indicating similar barriers found in accessing community mental health services and SMH services, the study findings highlight failure points in the referral system (Guo et al.,

2014; Lindsey et al., 2013; Murry et al., 2011; Splett et al., 2019; Twymon et al., 2020). Particularly, students and providers alluded to many referrals for SMH services stemming from behavioral concerns and fewer referrals coming from teachers, placing a greater responsibility on students with internalizing concerns to refer themselves for services. The study findings support continued calls for changes in the conceptualization of behavior as solely disruptive and encourages school personnel to consider other contextual and mental health factors that may provide better explanations of behaviors given the increasing prevalence of mental health challenges experienced by youth. This could be accomplished through additional training in the signs of mental health distress and continued education on the SMH referral process.

While not an indicator that data-driven decision-making occurs in the absence of community mental health providers, in this study, when discussing the external referral process, SMH providers did not discuss community mental health providers as members of the student review team, part of the referral process, nor did they mention their role in determining student level of support, which has been a longstanding practice documented in existing literature (Armbruster & Lichtman, 1999). Community mental health providers' participation in the process was only discussed in terms of when the needs of the student exceeded the capacity of school providers, which occurred frequently and who were the primary source of SMH services. Therefore, additional work is needed to elucidate the role that community mental health providers play in the overall mental health and well-being of youth in schools. This study contributes to the limited body of literature centered on the perspectives of Black youth as it relates to access and utilization of SMH services; however, more work must be done to help eradicate differences in the mental health outcomes of Black youth through access and utilization of these services.

Limitations & Future Directions

While this study contributes significantly to the literature on Black middle school youth's access and utilization of SMH services and represents a step forward in understanding the barriers and facilitators Black youth experience accessing and utilizing SMH services, there are limitations that must be acknowledged. First, this study had a small sample size. This study was conducted within one school district and two middle schools. While the combined student population of both schools was over 1,300, only 20 students volunteered to participate. To address the difficulty with recruitment, the study inclusion criteria differed from the original study's intent. Initially, students who scored above the SDQ cutoff score of 14 would be invited to participate in the study; however, this inclusion criteria was eliminated. Altering the cutoff score for inclusion criteria potentially decreased the number of students with self-reported emotional or behavioral concerns and may have obscured the severity of internalizing concerns experienced by Black youth. In addition, while student participants were Black, the results of the study do not represent the experiences of all Black middle school youth as ethnicity, cultures, within-group differences, states, districts, and schools account for extensive variability to the lived experiences of this population and provide potential explanations for access and service utilization or underutilization of SMH services for the Black youth (Assari & Caldwell, 2017).

Due to challenges with recruitment, focus groups for the 7th and 8th grades at School A were combined, and two 6th-grade students were interviewed at School B, which could have impacted the comfortability of discussing the topic. Due to combining focus groups and interviews with students, the study did not lend itself to individual or in-depth grade-level comparison of responses or the ability to connect student survey responses to focus group data collected.

Implications for Research

The results of this study has several implications for future research. First, and most importantly, based on the low response rate of Black middle youth, it is apparent that mistrust and the relationship between school districts and universities must be strengthened, and future researchers must recognize the importance of relationship-building in diverse communities. It is imperative that researchers entering these spaces dedicate time, resources, and knowledge to supporting these communities prior to engaging in research. Not only will this begin to rebuild the trust that communities of color have in researchers, but it will also serve as a catalyst for more participants to engage and be part of the research process. Relatedly, when conducting research with youth populations, it is vital that youth are an integral part of the process. Youth Participatory Action Research (YPAR) lends itself to integrating youth in the research process towards change and development within their community. Derived from participatory action research, YPAR, uplifts the intersecting experiences of youth and recognizes them as integral change agents to identify problems and solutions to cultivate well-being and success (Cammarato & Fine, 2010). The current study did not seek to explore the potential moderating effects of school climate on student's access and utilization of school mental health services; however, many students alluded to challenges they experienced with feeling like their voices were not heard or valued when school personnel make decisions for the greater school community (Mori et al., 2021). This highlighted the youth's desire to be involved in decision-making processes as well as activities and events related to school mental health.

Implications for Practice

The autonomy of states, districts, and schools cultivates widespread variation in the resources, manpower, and directed roles and responsibilities toward improving the mental health outcomes of our nation's youth. This autonomy also impacts how SMH providers are utilized within the school. Despite Georgia state law requiring districts to establish school-based or school-linked mental health promotion and intervention programs, requiring school counseling or guidance services in elementary grades (K-8), and requiring state agencies to develop models and guidance for districts to support implementation of counseling, psychological, and social services (National Association of State Boards of Education, n.d.) counselors strongly indicated that in their role they were not providing individual counseling to students nor was that the goal of their position. Despite being licensed, the additional school responsibilities outlined by providers in interviews appeared to take precedence over therapeutic counseling and crisis intervention, leaving vulnerable students to fend for themselves and imprinting the idea that schools do not care, which in turn may impact future help-seeking behaviors. As outlined by a provider, districts, and schools must hire additional providers and provide clear differentiation in the role and responsibility of clinical mental health providers and school counselors to ensure that the mental health needs of students can be met in the school.

School psychologists have extensive knowledge and training on various factors that impact the service delivery of SMH services, including but not limited to the influence of mental health on learning and academic success, evidence-based interventions, and strategies for mental health promotion (NASP, 2020). Although considered providers of SMH services and despite vocalizing interest in being active participants in the delivery of SMH services, many districts do

not utilize their knowledge and skills in this capacity, and many school psychologists within the school setting are primarily used for psychological testing and special education eligibility assessments (Reschly, 2000; Splett et al., 2013). While there are many efforts at the federal and state level to increase the number of school psychologists; increasing the number of school psychologists may not have its intended impact if districts and schools choose to utilize their skill set in limited capacities. Therefore, it is imperative for states and districts to set a precedence and implement protected time for school psychologists to engage in the delivery of SMH services.

Considering the high frequency at which students receive SMH services from community mental health agencies, it will be important for community providers to be members of the student review teams when discussions on potential referrals take place. This strengthens communication between community and school providers, prioritizes the relationship, and fosters future collaboration opportunities, such as educating parents on mental health challenges middle school youth face (Villarreal, 2018; Bryan, 2009).

Few providers discussed providing teacher training on the warning signs of mental health challenges, and many disclosed receiving few referral forms from teachers. Providers also described infrequently presenting mental health curricula in the classroom, and most Black youth expressed limited knowledge of available SMH services and providers. Students discussed completing surveys geared towards school safety; however, they noted a lack of honesty in answering questions on the forms, which hinders school efforts to create safe and supportive school environments and also represents the need for school personnel to foster positive relationships with students where they feel like their opinions are important. Given the increasing prevalence of mental health challenges experienced by youth, it is critical for schools to provide

psychoeducation to school personnel and students on mental health and mental health warning signs and inform them of SMH services available and the referral process multiple times in the school year to increase help-seeking behaviors of youth (Splett et al., 2019; Reinke et al., 2011).

This research emphasizes the need for continual examination of SMH systems and the SMH delivery model as integral components of Black youth's access and utilization of SMH services and to recognize the systemic influence on student and provider perspectives on mental health and help-seeking behaviors. The insight acquired from focus groups with Black youth and interviews with SMH providers highlights the importance of centering the voices of those directly impacted and involved with SMH efforts and signals the need for future research to identify preventative measures to minimize potential negative mental health outcomes for students of color.

Chapter 3

FOR THEM, BY THEM: LETTING YOUTH TAKE THE LEAD IN CREATING MENTAL HEALTH PREVENTION PROGRAMS [2]

[2] S.S. To be submitted to a peer-reviewed journal.

Abstract

Many Black youth have fallen between the cracks, and suicide as the second leading cause of death for Black youth between the ages of 10-14 highlights the unfortunate and avoidable trajectory that occurs when mental health needs go unaddressed. Continued calls to leverage peer relationships to facilitate access and utilization of school mental health services are widely documented in the research but are not widely implemented. This study explored the importance of peer relationships within the context of school mental health for Black middle school youth (n = 20) and Black middle school youth and school mental health providers (n = 6) perspectives on the desirability, feasibility, and required components of a peer-to-peer medicated intervention program to expand the reach of school mental health services. Black youth completed the Strengths and Difficulties Questionnaire (SDQ) and completed an additional survey exploring their peer relationships and mental health. Findings indicated that more than half of Black youth scored within the high or very high range on the peer relationships scale, suggesting peer relationship problems. Contrary to SDQ results, the majority of Black youth reported having supportive peer relationships and indicated that they believe youth play a role in supporting other youth's mental health challenges. However, fewer Black youth reported confiding in peers about their mental health challenges. Qualitative findings identified five themes: qualities and logistics of a peer-to-peer mediated intervention program, supportive relationships, buy-in, perceived responsibility, and "friends." Black youth envisioned a peer-to-peer mediated intervention program that would protect anonymity and described it similarly to a church confessional. Black youth responses highlighted the complexities of peer relationships that encompassed a desire to

avoid burdensomeness, maintain loyalty, and provide support simultaneously. Implications for practice and future research are discussed.

Keywords: School mental health, Black youth, middle school, peer intervention, peers, intervention

Introduction

One of the most detrimental outcomes of mental health challenges is suicide. When a child or adolescent dies by suicide, it is an indicator that an underlying mental health concern was present and unaddressed. The rate of suicide for Black youth is particularly alarming and represents a public health crisis. In 2018, suicide was the second leading cause of death for Black adolescents between the ages of 10-14 and the third leading cause of death for Black adolescents between the ages of 15-19 (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019). This frightening trajectory has continuously increased over the past decade. Unfortunately, data on the mental health challenges experienced by Black adolescents is rarely collected, disseminated widely, or viewed as a public health crisis, leaving many unaware of the challenges Black adolescents face and results in Black youth increasingly suffering silently. Guided by Bronfenbrenner's Ecological Systems Theory, the current study explores the importance of Black youth peer relationships in addition to examining Black youth and school mental health (SMH) providers perspectives on a peer-to-peer mediated intervention designed to increase Black youth's access and utilization of SMH services.

Existing mental health prevention programs scarcely include the middle school population as the target population. Even more concerning is the lack of focus on prevention and intervention programs designed specifically to increase student access and utilization of SMH services, considering the alarming increasing rates of suicide and mental health challenges experienced by Black youth. Traditionally, prevention and intervention programs are largely created and influenced by national, state, and district governmental agencies, which students are not members of but have a profound impact on their access to and utilization of SMH services. Despite the apparent importance of the exosystem in relation to SMH prevention and

intervention programs, the majority of the literature has focused on the impact of individual and family-level factors. Furthermore, despite the proximity of peers in the microsystem and the continual calls for future research to consider youth as potential leverage points, few research studies have answered that call and anchored or explored peers as core components of SMH delivery service models. Therefore, to counteract traditional approaches to prevention and intervention, this study attempts to answer the call of previous researchers by exploring the importance of Black peer relationships in middle school youth while gaining insight into the desirability, barriers, and facilitators related to the development of a peer-to-peer mediated SMH program aimed towards expanding the reach of SMH services to Black middle school youth.

School Mental Health Services

SMH services have garnered increasing attention and popularity as the optimal setting in which to provide mental health services to student populations experiencing difficulties accessing mental health services in the community. However, it is well documented that Black youth underutilize school mental health services (SMH), with estimates ranging from 20-54.8% compared to the high percentage of Black youth experiencing mental health challenges (Ali et al., 2019; Allison et al., 2007; Bains et al., 2017; Duong et al., 2021; Parasuraman & Shi, 2015; Slade, 2002; Whitaker et al., 2018). Given the prevalence of mental health challenges, wide variability in the utilization rates, and significant negative personal and societal outcomes associated with mental health challenges (National Alliance on Mental Illness, 2021), specifically among Black youth, the creation and implementation of prevention and intervention programs targeting this population is imperative.

In addition to creating and implementing prevention and intervention programs for Black youth, considering school budget constraints, it is also critical to identify existing resources

within the school that may facilitate this process. One important resource and leverage point for youth is their peers. For the purposes of this study, peers refer to any individual a student shares a common background, interest, culture, race, ethnicity, gender, etc. Peers play an important role in adolescent development as youth often identify social norms regarding mental health and service utilization from their peers (Helsen et al., 2000; Lombardi et al., 2019; Roach, 2018). In addition, adolescents primarily confide in their peers about their mental health struggles (Hasking et al., 2015). Leveraging peers as support may be a potential way to connect Black youth with SMH services. Despite this fact, little research has examined the use of peers in increasing the access to and use of SMH services, specifically for Black youth.

Peers

The importance of peer relationships increases as youth navigate adolescence and become more autonomous (Helsen et al., 2000; Roach, 2018; Rubin et al., 2005; Williams & Anthony, 2015). Peer relationships play a major role in supporting or deterring youth from seeking out and utilizing mental health services (Roach, 2018; Wang et al., 2019). Existing peer relationship research suggests that Black peer relationships increase in importance due to family dysfunction, poverty, or living in a single-parent household (Silverstein & Krate, 1975); however, this notion has been consistently contradicted (Giordano et al., 1993; Samuel 2015, Way et al., 2005). Black youth value their close friends as confidants, protectors, and financial safekeepers, and they view their friendships as reciprocal and intertwined through familial relationships (Way et al., 2005). Considering the importance of and reliance on peer relationships, many youth bear first witness to peer mental health challenges. In a study conducted by Samuel (2015), Black youth indicated that their peers were a source of encouragement to seek out and utilize mental health services. Conversely, Black males also

shared that their peers made them feel embarrassed and ashamed for receiving mental health treatment (Samuel, 2015). Peer perceptions of mental health utilization are a critical factor in mental health service utilization and continuation of treatment; this is no different for Black youth. Despite this notion, positive characteristics of peer relationships are insufficiently researched overall and for Black youth. Existing research focuses primarily on the impact of negative peer relationships on an expansive range of educational, social, and mental health outcomes (Williams & Anthony, 2015). In an integrative review, Roach (2018) identified fifteen studies that met the inclusion criteria for examining the impact of peer relationships on mental health outcomes. Although a significant portion of studies found that peer relationships led to improved mental health outcomes, no studies examined the impact of peer relationships on mental health service access, utilization, or intervention, highlighting peer-led mental health interventions as a critical future direction for research (Roach, 2018).

Prevention and Intervention

Taking into account the onset of mental health challenges during adolescence, researchers are taking a more direct approach to prevention and treatment to reach a broad range of students from diverse racial and ethnic backgrounds across school and community settings. The Integrative Model for Linking Prevention and Treatment Research (Weisz et al., 2005) synthesizes prevention and treatment programs and interprets them as emphasizing the strengths of youth, families, communities, and their cultures with effective interventions across settings. The model represents a spectrum of populations with and without serious diagnosed and long-term conditions and settings where these interventions are implemented, noting that more than one intervention (health promotion/positive development and universal prevention) can be delivered across settings (i.e., school; neighborhood agency). While using a brief mental health

literacy intervention for economically disadvantaged middle and high school students in a community setting, Mumbauer-Pisano & Barden (2020) found positive increases in student knowledge of mental health and help-seeking behaviors and a decrease in mental health stigma, which were sustained one-month post-intervention. An increasing number of studies emphasizing the importance of culture and individual strengths of participants in interventions and evaluating the outcomes of racially and ethnically diverse student populations led to an increase in resiliency for school-aged youth (Chandrasekhar et al., 2023). Focusing on economically disadvantaged student groups, which typically include Black/African American and Hispanic/Latinx populations, emphasizes the need for implementation of mental health promotion, prevention, and early intervention programs across race, settings, and socioeconomic status. Despite yielding positive results, study results lacked data disaggregated by middle and high school, which dilutes potential grade level differences and suggests an overall effectiveness for all adolescents. Consistently absent from research are the voices of youth to identify areas of strength and weaknesses of existing SMH services and selected intervention programs to help inform future intervention development and implementation. These findings also suggest that schools lacking strong models focused on mental health promotion, prevention, and culture may be unable to identify students with internalizing concerns and who may, therefore, slip through the cracks.

Peer Support Programs

Peer support programs have a longstanding history of providing validation, mentorship, support, information sharing, and observational learning for adults in need of mental health services. In community-based settings, peer support services pair youth with mental health challenges with another youth with a personal experience with mental illness or substance use

who provides a variety of supports (Shalaby & Agyapong, 2020). While the components of these programs are becoming more frequently implemented as peer-to-peer mediated interventions spanning intervention settings such as schools, target populations, treatment modalities, and mental health concerns and outcomes (Ali et al., 2015;) most of these studies target high school or young adult populations (i.e., over 18) (Fortuna et al., 2020; O'Leary et al., 2018), fewer take place in school settings, target middle school populations, or focus on Black youth.

With the increased prevalence of mental health concerns in the youth population, Teen Mental Health First Aid was designed to train high school youth to identify and understand mental health warning signs and serve as a level of support to their peers. Other peer programs such as Hope Squad and Sources of Strength utilize school-aged peers to implement a suicide prevention program in the schools, and research has shown that these programs have led to reductions in stigmatizing beliefs about mental health that serve as barriers to help-seeking behaviors (Wright-Berryman et al., 2022). Few school-based programs, such as The Sky Center's Natural Helpers, utilize peer relationships to connect susceptible peers to adults in the schools in order to receive help or resources. These community and school programs have recognized a need to support the growing mental health concerns of the nation's youth and utilized existing peer relationships to design prevention and early intervention programs.

The Current Study

Several studies have called for the increased incorporation of youth to facilitate access and utilization of SMH services. Despite this, little research has examined the use of peer programs in increasing the access to and use of school mental health services, specifically for Black middle school youth. Many existing prevention and intervention programs target high school students, and to the knowledge of the researcher, few prevention and intervention

programs are designed for middle school-aged students and fewer for Black middle school youth. Considering the high rates of suicide among Black youth, it is important to consider youth voices and peers as opportunities to increase access to and utilization of SMH services. This study contributes to the literature by exploring the importance of peer relationships for Black middle school youth within the context of SMH. This study will also gain perspectives of Black youth and school mental health providers' desirability, feasibility, and required components of a peer-to-peer mediated school mental health intervention program aimed towards expanding the reach of SMH services to Black youth. The study explores these factors in part because of the (a) rising suicide rates in the Black youth community, (b) variability in the utilization rates of SMH services, and (c) increased call to leverage youth in prevention and intervention programs. The current study seeks to answer the following research question:

1) What are Black youth and SMH provider perspectives on the development of a universal peer-to-peer intervention program aimed towards expanding the reach of SMH services to Black youth?

Methods

Participants and Procedures

Participants in this study were drawn from an urban school district in the Southeastern United States. This school district was selected based on proximity, familiarity, and the high percentage of Black students served (48%; Georgia Office of Student Achievement, 2019). A non-random purposive sampling strategy was used to select two middle schools that did not participate in the Georgia Apex. Following the IRB process and approval at the university, district, and school level, one school declined to participate in the study due to the inability to fully provide the resources needed to implement the study successfully. At the beginning of the

2022-2023 school year, the remaining school commenced its relationship with a community mental health provider as part of the Georgia Apex program. The researcher selected an additional middle school (School B) where a previous working professional relationship existed to increase participation rates. School A had four school counselors, one school social worker, and one school psychologist. School B had two school counselors, one school social worker, one on-site therapist, and one school psychologist.

The study proposal was sent for review at the researcher's institution following district and school-level approval. The study was approved by University Institutional Review Boards (IRBs) and the school district in December 2022. At schools A and B, recruitment began with selected teachers receiving and disseminating parental consent forms to students, which included an overview of the study, purpose, study requirements (i.e., brief questionnaires and focus groups), time commitment, and compensation. At school B, the researcher provided a brief 5-minute presentation of the study to students in selected classrooms. Interested students were provided consent forms for their parent's review. Consent forms required parents to provide demographic information, including whether their child received special education services. Students with an IEP receiving counseling services as part of their IEP were excluded from the study. The researcher conferred with the school counselor (School A) and behavioral specialist (School B) to ensure accurate reporting of special education services.

A purposive sampling strategy was utilized to recruit and select participants (Kilgus et al., 2015). The sample population for this study included middle school youth in 6th, 7th, and 8th grade who self-identified as Black and did not have an Individualized Education Plan (IEP) requiring counseling services as part of their IEP. The sample size for this study was 20 Black middle school youth. To offset age differences and personal experiences and to ensure a balance

of responses and opinions to facilitate richer conversations, student participants were split by grade level and *not* grouped based on their gender (Hall, 2020). However, due to small sample sizes for 6th and 7th grade levels at each school, students were placed in a combined group (e.g., 6th and 7th or 7th and 8th) or interviewed individually.

School mental health providers were recruited using purposive sampling based on occupation and employment at the selected schools and included school counselors, school psychologists, school social workers, and mental health counselors. School mental health providers were recruited through the dissemination of fliers and consent forms explaining the study. The fliers outlined that school mental health providers were being recruited for a research study. The flier also indicated that school mental health providers would be involved in a one-to-one interview that would last between 60-90 minutes discussing school mental health policies and procedures related to student access and utilization of SMH services. Each provider was compensated $50 for their time. The intended sample of 10 was selected based on the number of SMH provider positions at each school. A total of six school mental health providers expressed interest in the study, completed the questionnaires, and participated in both interviews. One school mental health provider declined to participate in the study. Two providers did not respond. Another school provider could not identify a time to participate in the study within the data collection period. The participation rate for school mental health providers was 60%.

Measures

Demographic Questionnaire.

SMH providers provided demographic information such as race and ethnicity, position/title, degree, special certifications, and years of experience. Students' demographic

information was obtained in the consent form, and parents provided birthdate, race, ethnicity, grade level, and special education status.

Peer Relationships and Mental Health

Students completed an 8-item researcher-developed measure to evaluate their perceptions of mental health challenges within the Black middle school community and the role of peers. Using a 3-point Likert scale, students rated their level of agreement with statements with responses ranging from *disagree* to *agree*. Seven questions assessed student's peer relationships (e.g., "I have supportive peer relationships"; "I confide in my peers about mental health challenges"), and one question assessed their perception of mental health challenges in the Black youth community (e.g., "There is a mental health issue in the Black youth community").

Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ; Bourdon et al., 2005) is a 25-item brief validated behavioral screening tool to provide an overview of 3-16-year-old children's overall stress, behavior, emotions, prosocial behaviors, and peer relationships. Responses were rated on a three-point Likert scale from *not true* to *certainly true*; sample items include "*I am often unhappy, depressed, or tearful"* and "*I try to be nice to people. I care about their feelings."* The total difficulties score (TDS) is generated by adding the scores from items included in the first four scales (Emotional problems, Conduct problems, Hyperactivity scale, and Peer problems scale). TDS ranges from 0 to 40 with scores between 0-14 considered close to normal, 15-17 considered slightly raised, 18-19 considered high, and scores above 20 very high. The Prosocial scale is a measure of positive behavior with scores ranging from 0 to 10. The SDQ has been normed on British and U.S. children between 4 to 17 years old and has been found to have good acceptability and internal consistency (Bourdon et al., 2005).

Procedures

Four university faculty members and one doctoral graduate candidate reviewed the focus group and interview protocols. After one participant had difficulty understanding two questions, revisions were made. No other participants expressed difficulty understanding the questions following the revisions.

Focus Groups Procedures

Focus groups occurred during students' lunch periods and were conducted privately on school grounds (i.e., conference rooms or unused classrooms). These groups were pre-determined by school administrators and teachers as the least disruptive to the educational environment. Focus groups lasted approximately 50 minutes. At the start of each focus group, participants were welcomed, reminded of the study purpose and goals, that they may opt out at any time without impacting grades, extracurricular activities, or school relationships, and that their opinions and beliefs are highly valued. Verbal consent to audio record and participate in the study was received prior to the start of focus group discussions. Confidentiality and anonymity, the associated limitations within a focus group setting, and the attempts to reduce these limitations (i.e., pseudonym, storing recorders in a locked space, or ground rules, etc.) were discussed. The audio recordings from the focus groups were transcribed using a third-party transcription service. Member checking was utilized during focus group discussions as it allowed participants to validate the researcher's interpretation of responses in real time (Birt et al., 2016).

Interview Procedures

Interviews with SMH providers occurred via Zoom based on participant availability, which accommodated work and personal responsibilities and facilitated open discussions. At the start of each interview, SMH providers were welcomed, reminded of the study purpose and

goals, that they may opt out at any time with no impact on their relationships with colleagues or employment with the school or district, and that their opinions and beliefs were highly valued. Verbal consent to participate and audio-record the session was also received prior to the start of each interview. Participants were given the opportunity to participate in the interview with their camera off. SMH providers participated in one 60-minute interview. Interviews followed similar procedures as those outlined for focus groups, such as audio recording transcription through third-party transcription services, member checking, and summarizing responses.

Analysis

The current study aimed to investigate the importance of peer relationships for Black middle school youth and explore the potential development of a peer-to-peer mediated school mental health intervention program to assist in expanding the reach of SMH services to Black youth. Black youth and SMH providers are key stakeholders in understanding the importance of peer relationships as they relate to access and utilization of SMH services. Thematic analysis (TA) was applied as an approach due to its flexibility and easy integration with theoretical frameworks, as it assists with distinguishing, inspecting, and describing patterns within the data acquired through qualitative methods (Braun & Clarke, 2006). As an iterative process, TA allowed the researcher to revisit previous phases to make adjustments as needed. The present study utilized focus groups and interviews. Familiarity with the data through reviewing audio recordings and transcripts occurred before selecting initial codes, identifying coinciding data, and transitioning into themes.

Data from the focus groups and interviews were transcribed through Otter.ai services and then compared to the original audio recordings to make necessary edits. Following familiarity with the data and establishing a general idea of what the data entails, the researcher and a trained

graduate student engaged on a deeper level with the data to construct initial codes. The coding process, which the researcher and graduate student approached as data-driven, entailed identifying interesting components of the data and systematically grouping data based on these components. While all data was thoroughly examined to identify recurring patterns, specific pieces of data went through multiple revisions of coding.

Following the generation of initial codes, the researcher analyzed codes developed during the previous stage and determined their relationship to shape comprehensive themes. It was anticipated that all codes would not fit neatly within all themes; thus, a transient miscellaneous theme was created. A preliminary list of themes and subthemes was created and reviewed to make appropriate modifications, determine the strength of themes, and begin the process of fine-tuning themes. At this stage, it became apparent that two or more themes were better suited under one theme and that one theme should be separated. As a two-step process, the researcher and graduate student reviewed data under each theme to ensure that a clear pattern was present within each theme and reviewed all themes in relation to the entire dataset to determine validity. After undergoing a rigorous analysis, each theme highlighted the story of the broader data set as it related to the proposed research questions. Each theme was reviewed again in isolation and together to determine if subthemes or a theme that exists under a broader theme would exist better independently or under a different theme.

Results

Descriptives

A total of 494 parental consent forms were disseminated to potential Black youth participants, and 20 students (School A = 7 students, School B = 13 students) returned signed consent forms and participated in focus groups. Twenty students met all inclusion criteria and

were invited to participate in the study. Female participants comprised the majority of student participants (n = 15; 75%), while male participants (n = 5) represented 25% of the sample. All participants self-identified as Black (100%). Participants' ages ranged from 10.74 to 14.87, with all students currently enrolled in middle school. Eighth-grade students represented the highest percentage of student participants (n = 9). Participants did not have an IEP requiring counseling services. Table 1 represents student demographic information. The majority of school mental health providers were female (n = 5; 83%), White (n = 5; 83%), and school counselors (n = 3; 50%). The average years of experience was (7.8 years), and SMH providers served their school on average for 4.7 years. Table 2 provides demographic data for school mental health providers, and to maintain the confidentiality of the school mental health providers, position/title is not included in the table.

Table 1

Student Demographic Information

Gender	Ethnicity	Grade
Male	Black	6th
Female	Black	6th
Male	Black	6th
Male	Black	7th
Female	Black	8th
Female	Black	8th
Female	Black	8th
Female	Black	6th
Male	Black	6th
Female	Black	7th
Female	Black	7th
Female	Black	7th
Female	Black	7th
Female	Black	7th
Male	Black	8th
Female	Black	8th
Female	Black	8th
Female	Black	8th

Female	Black	8th
Female	Black	8th

Table 2

School Mental Health Provider Participant Demographic Information

Gender	Ethnicity	Years of Experience	Years at School
Female	White	8	8
Female	White	8	4
Female	White	5	3 months
Female	Black	7	7
Female	White	13	7
Male	White	6	2

Table 3 represents student responses to the researcher-developed questionnaire measuring their peer relationships within the context of mental health. Student responses showed wide variability when asked if they believe that there is a mental health issue in the Black youth community. While the majority (55%) of participants agreed with the statement, one student in each grade level (15%) disagreed with this statement, and 30% of participants neither agreed nor disagreed. Seventy-five percent of Black youth indicated that they have a supportive peer relationship in school. Sixty percent of participants agreed that their friends were knowledgeable of mental health issues and agreed that youth play a role in supporting the mental health of other youth.

Participant responses showed wide variability on questions pertaining to their level or their peer's level of comfort confiding in one another. Fifty-five percent of Black youth reported that they confide in their peers about their personal problems, while 30% disagreed with the

statement. The percentage of students in agreement decreased, and the percentage of students in disagreement increased when participants were asked if they confided in their peers about their mental health problems. Only 40% of students agreed that they would confide in their peers about their mental health problems, whereas 45% disagreed. Almost all (75%) participants agreed that their friends confide in them about their personal problems; however, only 55% agreed that their friends confide in them about mental health issues. (See Table 3).

Table 3

Peer Relationships and Mental Health

Question	Agree		Disagree		Neither	
	n	%	n	%	n	%
Mental Health Issue in the Black Youth Community						
6th	1	5%	1	5%	3	15%
7th	3	15%	1	5%	2	10%
8th	7	35%	1	5%	1	5%
All	11	55%	3	15%	6	30%
Supportive Peer Relationships						
6th	4	20%	0	0%	1	5%
7th	4	20%	0	0%	2	10%
8th	7	35%	0	0%	2	10%
All	15	75%	0	0%	5	25%
Peer Knowledge of Mental Health Issues						
6th	4	20%	0	0%	1	5%
7th	3	15%	2	10%	1	5%
8th	5	25%	1	5%	3	15%
All	12	60%	3	15%	5	25%
Youth Supporting Other Youth's Mental Health						
6th	3	15%	0	0%	2	10%
7th	1	5%	1	5%	4	20%
8th	8	40%	0	0%	1	5%
All	12	60%	1	5%	7	35%
Confiding in Peers - Personal						
6th	3	15%	1	5%	1	5%

7th	2	10%	2	10%	2	10%
8th	6	30%	3	15%	0	0%
All	11	55%	6	30%	3	15%
Confiding in Peers – Mental Health						
6th	1	5%	2	10%	2	10%
7th	1	5%	4	20%	1	5%
8th	6	30%	3	15%	0	0%
All	8	40%	9	45%	3	15%
Peers Confiding in Participants - Personal						
6th	3	15%	1	5%	1	5%
7th	4	20%	0	0%	2	10%
8th	8	40%	0	0%	1	5%
All	15	75%	1	5%	4	20%
Peers Confiding in Participants – Mental Health						
6th	2	10%	0	0%	3	15%
7th	2	10%	1	5%	3	15%
8th	7	35%	2	10%	0	0%
All	11	55%	3	15%	6	30%

Strengths and Difficulties Questionnaire

Based on SDQ norms, TDS scores range from 0 to 40, with scores between 0-14 considered close to normal, 15-17 considered slightly raised, 18-19 considered high, and scores above 20 very high. The average overall TDS score, a measure of overall stress, for all students was approximately 14.8 and considered close to normal ($\bar{x} = 14.8$); [1-24]; ($\sigma = 6.6$). One student's scores were not included in the SDQ data due to their young age. Data disaggregated by grade level highlight different outcomes across grade levels. Students in 8th grade reported higher levels of overall stress compared to 6th and 7th graders (17.8% vs. 13.7% and 12.7%). Examining data from the individual scales, such as the emotional distress scale, indicates that 42% (n = 8) of all participants scored within the high or very high range on this scale, suggesting that students are experiencing significant emotional distress. Almost 60% (n = 11) of participants

scored within the high or very high range on the peer relationships scale, suggesting peer relationship problems. Fifteen students (78.9%) rated their prosocial behaviors as average or close to average.

Themes

Black middle school youth and SMH providers discussed peer relationships as they relate to mental health and their perceptions on the desirability, feasibility, and required components of a peer-to-peer mediated SMH intervention program. The statements discussed in focus groups and interviews were classified into five themes: qualities and logistics of a peer-to-peer mediated intervention program, supportive relationships, buy-in, perceived responsibility, and "friends." The theme of supportive relationships was further categorized into adults as supportive and trusting peers as subcategories. Perceived responsibility included "I might tell" and "It's not my place." "Friends" comprised the subcategories cautious and judgment.

Theme #1: Qualities and Logistics of a Peer-to-Peer Mediated Program

Black youth and providers were asked about important characteristics of a peer-to-peer mediated program targeting Black youth's access and utilization of SMH services. Personal characteristics were key factors mentioned by students. Overall, students expressed wanting peers who were "caring," "understanding," "kind," "trustworthy," "honest," and a "good listener." Students frequently referenced the need for anonymity if they were allowed to create a peer-to-peer mediated program. One described it similarly to a blind date, where peers would not know who the peer disclosing information was ahead of time. They further elaborated on their desire to create an environment where peers come into the room and are separated from the peer helper. One peer described the prospective environment sharing,

> "You get in the room, but there's like a split. So. you don't know you just hear they voices, and you understand and you can get into they mind, and then if you feel comfortable enough, like after knowing that person for a long time, you want to reveal your identity and start getting closer and closer."

Black youth were adamant about the importance of building rapport with the peer helper prior to informing an adult and were in agreement when a female student stated,

> "When it comes to tryna help that person and stuff, I feel like it shouldn't always be like, 'Oh, we've talked, now let's go talk to an adult about it.' I feel like it should be like, like a couple of meetings with that person and see if that changes like when you meet with that person, like, if the problem that you have, like changes when you meet with that person and then after a certain amount of time nothing really changes then, okay, like go to an adult, but like you know, like you know, since it's like youth talking to youth, I just feel we should use it to the full extent."

Students also expressed their desire to design a mental health program that was open to all students and would like for the program to take place after school to increase participation. To get the word out about the program, students thought creatively and suggested podcasts, school announcements, posters, and social media as potential advertising options.

Theme #2: Supportive Relationships

Black youth frequently outlined positive relationships in their lives and how those relationships either supported their existing mental health needs or that people pointed out changes in their behaviors and suggested additional help. Supportive relationships peers discussed were primarily familial relationships. Many reflected on talking to their older brother, sister, cousin, mother, uncle, etc., when navigating their mental health challenges. Students stated that they chose those family members to discuss challenges due to their previous experiences or challenges with mental health or similarities in current lived experiences. As the conversation shifted towards friends at school, many youth shared that their friends would encourage and support them with their mental health needs, with one stating, "I would say my

friend because it's the things that they have been through, they would also recommend like 'you should definitely go get help' and all of that." Other students were in agreement with a statement posed by one student that identified the level of support they receive from parents, friends, and teachers as related to their networks overall goal of success for them and stated, "Because it's the best for me and it could also help me a lot for my future." Providers also spoke about recognizing the importance of peers supporting peer's mental health problems, declaring,

> "I feel like so many grownups forget what it's like to be that age and so we get into our adulthood and a lot of the times, we forget it's a natural part of growing up for kids at this age to start relying more on peer interaction."

When thinking about their supportive relationships with adults in the school building, many students discussed teachers and counselors as people who would support them in receiving mental health services. Most students discussed the level of care they feel from their teachers, with one sharing, "I feel as though [teacher] understands and tries to understand like how much school can take a toll on you and stuff as well as like home issues. I think he kind of understands." Another student commented "They care about you because they have like the same like feelings that you had, like adults they went to school and they had like the same pressures that we have."

Theme #3: *Buy-In*

When discussing key components of a prevention program for Black youth, Black youth and providers spoke in detail about the importance of having support from administrators and buy-in from the school community. SMH providers discussed the importance of administrative buy-in as a key component to creating prevention programs for Black youth. One provider stated,

> "If there's not support from the leadership as to the value of mental health support, I think that could be a really big problem. So, I think getting buy-in as to the critical nature of mental health support from principals and administrators is also really important."

Another provider identified ways to increase administrative buy-in by integrating a potential peer-to-peer mental health prevention program into existing programs and commented,

> "Administrative buy-in, just as far as like, I think there at any given point in time, are a lot of different programs that we're trying to initiate or pilot and they're all viewed as sort of discrete programs. So, I feel like my hope, and I think that when things are created, that are sustainable, they're integrated. So, if there was a way to integrate a peer-to-peer program into either an existing program or structure within the building, that is likely to be more manageable and more sustainable as opposed to like an additional thing."

Students also reflected on buy-in from youth and recognized the importance of mental health issues within the youth community. Many students shared that students who participate must demonstrate that they care about students with one sharing,

> "It would have to be a program where like the people, like they actually care about being there and they actually want to be there with people. It's not just something where like random people can come in and do as they please."

Theme #4: Perceived Responsibility

While discussing the logistics of a potential peer-to-peer mental health program, both Black youth and SMH providers spoke about the level of responsibility to communicate challenges to adults. For Black youth, this level of responsibility was discussed within the context of who is responsible for communicating a peer's admission of mental health needs. Their responses varied considerably depending on whether their admission or their peer's disclosure was personal or mental health-related. When discussing personal problems, many Black youth freely shared that they discussed their personal problems openly with peers.

However, when the conversation shifted towards mental health concerns, many youth broke down situations in which they would or would not inform an adult of a peer dealing with a mental health issue. Overwhelmingly, Black youth referred to the necessity of consent to share information with adults. One student passionately stated, "That ain't my place to be telling they business." With another confirming, "If they don't want the adults to know, I feel like you

shouldn't tell them because, like, that's their choice to let the adult know if they want. Like if they're going through stuff." One student placed the responsibility of seeking help on the peer expressing challenges and explained,

> "I'm not finna sit here and tell somebody like, if you're ready to tell somebody about your problems, like a professional help, then you go ahead. I'm not finna sit there and do it for you, you know. I'm saying that's not my place to do something like that… even if I do think you're like, you know, going through it or whatever, I feel like you would still be able to do it on your own if you really wanted to, you know what I'm saying, like if you really want to, like get help, you would do it."

Providers echoed these comments by reporting, "I've had kids sitting in my office and saying 'Well, if I, if I, you know tell about what's going on [with] my friend, that's snitching. You know, my momma said you ain't supposed to be no snitch.'" Student opinions slightly altered when discussing serious mental health concerns such as suicidal ideation ,with one 8th grader stating, "That's what I'm talking about. It depends on like, if they're trying to like, if it's like self-harm related, then that's different" and another stating "It depends what it's about. If it's something like a problem and he just can't get over it, I might tell the counselor."

Alternatively, other students reported comfortability telling trusted adults, including parents, about their peer's mental health concerns while acknowledging their limited skills to support the student. One 6th grader stated, "Because they're like their parents and like telling them that it's something wrong with them or their friend, like my friend. So that us two don't have to be like looking like, we don't know what to do." Another reported, "I said yes because like if they need help and they're not talking to anyone besides me like, I have to do something about that because they weren't." An 8th grader shared, "If my friend need help and I can help her, then we can go talk to somebody who can help her." Some students also expressed submitting a referral to the counselor as a course of action to support their peers by revealing, "I'll tell the counselor like 'maybe you should talk to them'…if they don't want to talk, I mean

there's nothing else she [counselor] can do but I'm gonna put in a referral that you [friend] probably should talk to them."

Theme #5: "Friends"

Focus group discussions around the topic of friendship responsibilities and the level of trust they have in their peers when expressing mental health challenges varied immensely. While peers shared having positive existing peer relationships at school, several Black youth, particularly those in higher grades, provided comments that indicate that they navigate peer relationships cautiously as an attempt to avoid feelings of judgment as it relates to mental health concerns. Several responses captured the youth's desire to retain information to avoid being a burden to their friends by discussing their mental health problems. One 7th grade student expressed,

> "I just don't like to overshare and you know I feel as though some people, they be like, 'oh, well she trauma dumped her problems.' So, I just don't really like to talk to people about stuff because I don't want to, I don't want it to like add a burden onto what they might be going through or something so I don't want to add to anything, so I just don't."

Students also questioned the authenticity of friendships and potential judgment when identifying peers who would or would not support them receiving mental health support, commenting, "Some of your friends who like not your friend forreal, they would not, they would disapprove because they'll think like you at them or they would judge you because that you need help." Students also expressed concerns about peers in this community being able to maintain confidentiality when disclosing mental health or personal problems, which caused them to question their peers. Some reflected on situations in which they confided in a peer, and the resulting outcome caused them to cautiously consider how much and to whom they should confide. She stated,

> "I would probably say no, because, like that's happened to me where I told a friend and you know they went off and told like a counselor or something when I didn't want that. I didn't want [that] because it's like, I just didn't want many people to know so I thought I could trust them with that and then they told somebody else and then that kind of led them to a whole different thing that happened."

Discussion

The current study offers a glimpse into the perspectives of Black middle school youth and SMH providers on peer relationships while also exploring the feasibility, desirability, barriers, and facilitators related to the development of a peer-to-peer mediated SMH program that would expand the reach of SMH services to Black youth. The investigation into these relationships and perspectives helps shape information about Black youth relationships and potential future mental health interventions targeting this population. Many interventions and studies exist that target various aspects of mental health; however, mental health interventions are traditionally created by adults for youth, and an inadequate number of studies and interventions include the voices of the population directly targeted. Considering the high variability in SMH utilization rates for Black youth, it is time to reflect on key components missing in existing interventions and studies to help inform future studies and interventions which lie with youth.

Peer-to-Peer Intervention. Black youth were vocal, transparent, inspired, and forthcoming with their desire to have a peer-to-peer mental health intervention program designed and operated by them to increase access to and utilization of SMH services. They envisioned their programs as open to the entire student body and available after school to increase participation. They selected brilliant ideas to support advertising efforts to increase awareness and participation by using different modalities such as social media, podcasts, and morning announcements. They also identified ideal peer personal characteristics, including trustworthiness, honesty, humor, and loyalty. Because confidentiality and anonymity were

frequently discussed as the standard, peers described the optimal conceptualization of a peer-to-peer mediated program as one that allows students seeking help to conceal their identity until they are comfortable, likening it to a confessional in the church. While not ideal for the student supporting the confiding peer if adult intervention is needed, it remains a critical step forward in understanding the components of a peer-to-peer intervention program deemed necessary by Black youth. In addition to their desire to ensure confidentiality and anonymity, Black youth were vocal about their weariness of incorporating adults into the intervention program until necessary, suggesting that students feel a sense of self-sufficiency in addressing low-level personal and mental health problems independently (Ijadi-Maghsoodi et al., 2018); however, they also recognized which situations warranted an adult intervening, such as suicidal ideation.

Peer Relationships and Mental Health. When asked to rate their agreement with statements about mental health within the Black youth community, students were split on their agreement. Students primarily agreed that Black youth are dealing with mental health issues, while 30% were indecisive about their agreement or disagreement. This variability in responses may represent Black youth's lack of knowledge of challenges their peers experience or fearfulness of admitting their true thoughts, which is reflective of the opportunities provided to youth to authentically express their opinions without concern for backlash. Questions related to peer relationships indicated that most Black youth had a supportive peer relationship in school. Youth viewed their friend's knowledge of mental health illness as lower than their knowledge but believed that youth play a role in supporting other youth experiencing mental health challenges. When it came to questions pertaining to sharing personal and mental health challenges with peers, youth indicated being more comfortable with sharing personal problems with their peers as opposed to mental health problems.

Qualitative focus groups exposed differences in how Black youth felt about confiding in their peers about their personal and mental health challenges. While many took pride in feeling like they were considered trustworthy when their peers confided in them, many also described their sharing of information with a peer as a cautious venture. They often referred to their friends as "friends for the drama," "fake friends," or similar variations exemplifying levels of their friendship and suggesting the absence of true authentic friendships. Youth also expressed differences in confiding in their peers because they were cognizant of the challenges their friends experienced and wanted to avoid adding another burden or load for them to carry by expressing their challenges. This is not surprising as middle school is a period where the exploration and confirmation of friend groups increases in importance while students simultaneously navigate a key developmental timeframe (Samuel, 2015; Roach, 2018; Wang et al., 2019).

Supportive Relationships. Students spoke at length about the supportive people in their lives, which offers a closer look at the various influences that may impact Black youth's access and utilization of SMH services. Family members were considered supporters of students receiving SMH services, which pushes back on the repeated implications that Black parents are a hindrance to their child's receipt of SMH services (Murry et al., 2011; Reardon et al., 2017). Black youth also considered their peers supportive; however, this varied by grade level as several students framed their responses within the notion that if they were my friend, they would support me receiving SMH services.

Buy-In. Consistent with existing research, Black youth and SMH providers mentioned buy-in from school administrators, teachers, and youth when discussing the feasibility of a peer-to-peer mental health intervention program (Langley et al., 2010). SMH providers recognized the challenges of implementing an additional program in school communities already struggling to

sustain the various implemented school programs and suggested integrating the proposed peer-to-peer mental health program into an existing program to offset potential concerns with administrative buy-in and competing work responsibilities. Youth talked about obtaining buy-in from prospective participants to ensure the sustainability and credibility of the peer-to-peer program. Further, even though many participants were in a program focused on service to the school community, their opinions were not valued, and opportunities to meet with school administrators to discuss problems within the school were non-existent.

Conversations around perceived responsibility to communicate a peer's difficulty with an adult sparked debate within focus groups, with responses ranging from "that's not my place" to "I'm telling" to students submitting mental health referral forms to SMH providers to request help for their friends. While wide variation existed, students approached these topics with careful consideration of the impact that disclosing information would have on their relationship and appeared to struggle to balance loyalty with connecting their friends to trusted adults or SMH providers. Provider's discussed responsibility within the context of adults designated to support program development and implementation.

The results from this study highlighted Black youth peer relationships within the context of SMH service use as well as their perceptions of peer-to-peer mediated intervention program. These findings push the needle forward in helping researchers, states, and districts understand the complexities of peer relationships at this age while also highlighting the maturity, perseverance, and dedication to the success of Black middle school youth. Not unexpectedly, several barriers across levels and stakeholders were identified in the creation of a peer-to-peer mediated intervention program; however, that must not silence the voices and ideas of Black youth who want to be part of the solution to support the mental health needs of their peers.

Although it may not be considered a formal therapeutic technique, Black youth recognized themselves as important supporters of their peer's mental health challenges, which must symbolize a step forward.

Limitations & Future Directions

Although this study contributes significantly to the literature on Black middle school youth's peer relationships and perceptions of a peer-to-peer intervention to increase the access and utilization of SMH services, it is imperative to acknowledge limitations. First, this study had a small sample size. This study was conducted within two middle schools with a combined student population was over 1,300; however, only 20 students participated in the study. The original inclusion criteria of an SDQ score of at least 14 was eliminated to address difficulty with recruitment. Altering the cutoff score for inclusion criteria potentially decreased the number of participants with self-reported emotional or behavioral concerns and may have obscured the severity of concerns experienced by Black youth. While student participants self-identified as Black, the study's results do not represent the experiences of all Black middle school youth as ethnicity, cultures, within-group differences, geographic locations, and school climate represents the extensive variability in the lived experiences of this population.

Additionally, focus groups for 7th and 8th graders at School A were combined, and 6th graders at School B were interviewed to address low participation rates. By combining focus groups and a small sample size, the study did not lend itself to individual or in-depth grade-level comparisons of responses or the ability to connect student survey responses to focus group data collected.

Implications for Research

This study contributes to the limited body of literature centered on the perspectives of Black youth as it relates to the importance of peer relationships and provides insight into the desirability, barriers, and facilitators related to the development of peer-to-peer mediated school mental health intervention programs. The relationship between the Black community and the research community is marred by racism, discrimination, and cultural mistrust (Mishra et al., 2009; Breland-Noble et al., 2011). Future studies and researchers working with this population must recognize this mistrust and approach their research from the lived experiences and perspectives of those directly impacted. Equally important is identifying, through the community's lens, the problems they wish to address (Baum et al., 2006; Cammarato & Fine, 2008). Black voices have been absent from research studies. These practices are even more evident with Black youth, who are often under the direction of adult figures across settings. Thus, future research should continue to elevate Black youth's voices to explain the presence or absence of help-seeking behaviors. New interventions are developed yearly; however, very few incorporate Black youth voices or their opinions on matters directly impacting them. Considering the increased rates of mental health challenges and suicide for this population, future researchers are encouraged to support and expand on the innovative ideas youth possess. These actions will begin the process of repairing the fragmented relationship between communities of color and researchers while also generating intervention programs created or co-created with target populations. However, researchers must also recognize the insufficiency and harm created when they engage in research practices that consistently take information from the Black community without providing anything in return for their knowledge, ideas, and lived experiences. These

investments catapult researcher's careers but leave the community vulnerable and without solutions.

This research emphasizes the need for continual examination of existing mental health interventions and the creation of culturally relevant peer-to-peer programs that create spaces in which Black youth feel supported and safe. The insight acquired from focus groups with Black youth highlights their eagerness and desire to be academically successful and support the needs of their peers, even if it is to the detriment of their own mental health. This study offered a glimpse into the question of what Black youth want when it comes to addressing their mental health needs. Future research must occur to discover their needs and the feasibility of prevention programs for Black middle school youth.

CHAPTER 4
CONCLUSIONS

Guided by Bronfenbrenner's Ecological Systems Theory, the proposed two-fold study first examined systemic policies and practices within the exosystem and microsystem (i.e., school and district school mental health policies and practices) that facilitate or hinder Black youth's access and utilization of school mental health services. The second study explored the importance of Black youth's peer relationships that exist within the microsystem and investigated Black youth and school mental health professionals' perspectives on the desirability, barriers, and facilitators of a culturally relevant peer-to-peer mediated school mental health intervention.

The first study sought to further conceptualize access to and utilization of SMH services. A definitive definition of access and utilization remains a topic of exploration; however, the current study contributed to existing research by taking a deeper look into the multi-layered and bi-directional process of access and utilization. It would be beneficial for future research to consider the seven key components outlined as integral to determining the level of access Black youth have to SMH services. These components include (1) student acquisition of language to express need, (2) positive relationships with teachers knowledgeable of mental health issues, (3) universal screening, (4) timely response to referrals and intake procedures, (5) quality of services provided by SMH providers or community mental health providers, (6) accurately identifying the level of care or intervention necessary for students, and (7) having the physical space with the school to provide identified services. The absence of these components represented a weakened SMH system from the viewpoint of Black youth and SMH providers. Participant responses highlighted the complexity of access and the variability that exists among providers and students and rejected the notion that the presence or advertisement of SMH services equates to access.

Utilization of SMH services was conceptualized from a standpoint that placed emphasis on measurable and observable changes in Black youth's behaviors, and participants exposed the trajectory of student's utilization of SMH services as one stemming from disruptive and externalizing behaviors, leaving a population of students struggling internally to sustain themselves.

Findings from both studies emphasized the importance of trusting relationships between adults and peers. While a key factor, the results of the studies exemplified the intricacies of these relationships and underscored the magnitude in which these relationships determine Black youth's access to and utilization of SMH services. This resulted in SMH providers calling for increased efforts to target mentorship within the school to facilitate the identification of students in need of mental health services. Not surprisingly, spaces that physically exemplified safety and trust were facilitative factors employed by SMH providers to ensure access and utilization of SMH services and identified in discussion on a peer-to-peer mediated program. There is still significant progress to be made, especially within the context of Black youth's variable relationships with adults and administrators in the building. Only a few SMH providers discussed efforts to diffuse their sense of authority when interacting with youth. While it would be impossible to ensure that all adults within the school building positively interact with youth, making this an administrative priority can set the tone for the school community and foster change within the school climate.

Providers outlined available SMH services at their schools, including mental health curriculum presentations and individual and group therapy sessions; however, the frequency in which these services were available to Black youth varied by school, which is consistent with the autonomous nature of schools even within the same school district and signifies the necessity of

examining SMH services across districts and schools. Across studies, psychoeducation or continued education for SMH providers and Black youth was considered an essential variable necessary for the promotion of mental health well-being as well as an opportunity to increase comfortability for Black youth to express needs to their peers within a peer-to-peer mediated intervention program.

A host of barriers to access and utilization of SMH services were detected by Black youth and SMH providers, which included fragmented and complicated referral processes, judgmental adults within the school, efficacy of services, limited capacity of SMH providers and community agencies, insurance, parents, and competing roles and responsibilities. The barriers identified within this study contribute to the existing body of research that has drawn attention to the challenges youth experience accessing SMH services and disputes the notion of access being frequently associated with availability (Guo et al., 2014; Lindsey et al., 2013; Murry et al., 2011; Splett et al., 2019; Twymon et al., 2020). Specific to Black youth was their admission of feeling pressure and isolation in order to succeed in school instead of addressing underlying mental health challenges. They were transparent with their thoughts and, in the absence of seeking help, expressed self-sufficiency and long-suffering as effective means to persevere when experiencing stressors to succeed. This method of coping, frequently reflected within the African American community and referred to as "John Henyrism" in the literature, highlights the mental, physical, and emotional well-being African Americans sacrifice to be productive (James, 1983; James, 1994). Within this study, we view self-reported self-sufficiency as rooted in the historical experiences and survival tactics employed by the Black community to navigate systems of oppression, racism, and discrimination. This is unlike stigma, as students not only recognize and

want to get help but actively seek help but find it challenging or unfruitful due to circumstances outside of their control.

Across studies, Black youth voiced their desire to be included in matters of their school community. They envisioned a peer-to-peer mediated intervention program that would be available after school to the school community on a weekly basis as a space for Black youth to discuss their problems. The major concerns Black youth endorsed with discussing their problems were related to experiences with breached confidentiality and judgment directed towards them by adults and peers, and not the inability or desire to talk about their mental health problems. The findings also reinforce the calls for changes in the conceptualization of behavior as solely disruptive and draws attention to the consideration of contextual and mental health explanations.

The additional responsibilities of SMH providers outside their positions impede their ability to be present and available for students, which increases the school's reliance on outside providers to address student needs. The existing competing responsibilities also threaten the endorsement and implementation of a peer-to-peer mediated intervention, as it would require an intentional level of commitment from an adult within the building to facilitate the program. Future studies targeting the creation of interventions should take note of the facilitators and barriers to implementation for both SMH providers and youth. Instruments such as the Usage Rating Profile (URP) and Children's Usage Rating Profile (CURP) are questionnaires developed by the University of Connecticut to inform decision-making processes regarding assessments and interventions implemented within school settings. Factors such as the acceptability, understanding, home-school collaboration, feasibility, system climate, and system support of assessments and interventions are incorporated into the questionnaire and helps guide researchers

understanding of barriers and facilitators and helps them detect and make the necessary adjustments to increase success (Briesch & Chafouleas, 2009; Chafouleas et al., 2011)

While all providers possessed advanced degrees, their therapeutic skills or training to impact the SMH service delivery model positively were often unused. Continued calls to increase the number of SMH providers, particularly school psychologists, may alleviate the student-to-provider ratio but may not address the concerns communicated by these providers that their skill sets are not used to their full capacity (Splett et al., 2013). Many providers called into question the authenticity and sincerity of statements frequently made, such as "serving the whole child," and shared their internal conflicts of working within the school system that does not put in place and sustain supports and services for all students. The reality for many providers and Black youth is the apparent disconnect between the school's portrayal of serving the whole child and their actions, particularly when externalizing behaviors are disproportionately the golden ticket to SMH services and students with good grades, and attendance are perceived as less in need.

The growing mental health concerns within the Black youth population is a public health crisis and must be treated as such if we are to address the alarming rates of suicidality for this population. Too many Black youth are falling between the cracks in favor of addressing disruptive classroom behaviors. While I am not suggesting that we decrease the attention, support, and services for students with externalizing behaviors, we are pleading for the improvement in the delivery of SMH services, practices, and procedures to more intentionally identify students struggling with internalizing mental health concerns and the deliberate creation of spaces that include seats at the table for youth to be part of decision-making discussions and

implementation of programs targeting Black youth. In the words of Black youth, "We have the rights to talk and speak up on what we want to change."

References

Abram, K. M., Paskar, L. D., Washburn, J. J., & Teplin, L. A. (2008). Perceived Barriers to Mental Health Services Among Youth in Detention. *Journal of the American Academy of Child and Adolescent Psychiatry*, *47*(3), 301–308. https://doi.org/10.1097/CHI.0b013e318160b3bb

Adelman, H. S., Taylor, L., Weist, M. D., Adelsheim, S., Freeman, B., Kapp, L., Lahti, M., & Mawn, D. (1999). Mental Health in Schools: A Federal Initiative. *Children's Services*, *2*(2), 95–115. https://doi.org/10.1207/s15326918cs0202_3

Agency for Healthcare Research and Quality. (2022). National healthcare quality and disparities Report. Rockville (MD): Oct. Child and Adolescent Mental Health. https://www.ncbi.nlm.nih.gov/books/NBK587174/

Ali K., Farrer L., Gulliver A., & Griffiths K. (2015). Online Peer-to-Peer Support for Young People With Mental Health Problems: A Systematic Review. JMIR Ment Health 2015;2(2):e19 https://doi.org/10.2196/mental.4418

Ali, M. M., West, K., Teich, J. L., Lynch, S., Mutter, R., & Dubenitz, J. (2019). Utilization of Mental Health Services in Educational Setting by Adolescents in the United States. *Journal of School Health*, *89*(5), 393–401. https://doi.org/10.1111/josh.12753

Allison, M. A., Crane, L. A., Beaty, B. L., Davidson, A. J., Melinkovich, P., & Kempe, A. (2007). School-Based Health Centers: Improving Access and Quality of Care for Low-Income Adolescents. *Pediatrics*, *120*(4), e887–e894. https://doi.org/10.1542/peds.2006-2314

Anglin, D. M., Alberti, P. M., Link, B. G., & Phelan, J. C. (2008). Racial differences in beliefs about the effectiveness and necessity of mental health treatment. *American Journal of Community Psychology*, *42*(1–2), 17–24. https://doi.org/10.1007/s10464-008-9189-5

Armbruster, P & Lichtman, J. (1999). Are School Based Mental Health Services Effective? Evidence from 36 Inner City Schools. *Journal of Community Mental Health,* 35(6), 493–504.

Assari, S., & Caldwell, C. H. (2017). Mental health service utilization among black youth; psychosocial determinants in a national sample. *Children*, *4*(5), 40.

Atkins, M.S., Cappella, E., Shernoff E.S., Mehta, T.G., & Gustafson, E.L. (2017). Schooling and Children's Mental Health: Realigning Resources to Reduce Disparities and Advance Public Health.

Atkins, M. S., Hoagwood, K. E., Kutash, K., & Seidman, E. (2010). Toward the Integration of Education and Mental Health in Schools. *Administration and Policy in Mental Health*, *37*(1–2), 40–47. https://doi.org/10.1007/s10488-010-0299-7

Bains, R. M., Cusson, R., White-Frese, J., & Walsh, S. (2017). Utilization of Mental Health Services in School-Based Health Centers. *Journal of School Health*, *87*(8), 584–592. https://doi.org/10.1111/josh.12528

Ballard, K. L., Sander, M. A., & Klimes-Dougan, B. (2014). School-related and social–emotional outcomes of providing mental health services in schools. *Community mental health journal*, *50*, 145-149.

Barksdale, M., & Thomas, K. (2000). What's at Stake in High-Stakes Testing: Teachers and Parents Speak Out. *Journal of Teacher Education - J TEACH EDUC*, *51*, 384–397. https://doi.org/10.1177/0022487100051005006

Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of*

epidemiology and community health, *60*(10), 854–857. https://doi.org/10.1136/jech.2004.028662

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bitsko RH, Claussen AH, Lichtstein J, Black LJ, Everett Jones S, Danielson MD, Hoenig JM, Davis Jack SP, Brody DJ, Gyawali S, Maenner MM, Warner M, Holland KM, Perou R, Crosby AE, Blumberg SJ, Avenevoli S, Kaminski JW, Ghandour RM. Mental health surveillance among children – United States, 2013-2019. MMWR Suppl. 2022 Feb 25;71(2); 1–42. DOI: http://dx.doi.org/10.15585/mmwr.su7102a1.

Bourdon, K. H., Goodman, R., Rae, D. S., Simpson, G., & Koretz, D. S. (2005). The Strengths and Difficulties Questionnaire: U.S. normative data and psychometric properties. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(6), 557–564. https://doi.org/10.1097/01.chi.0000159157.57075.c8

Bramlett, R., Murphy, J., Johnson, J., Wallingsford, L., & Hall, J. (2002). Contemporary practices in school psychology: A national survey of roles and referral problems. *Psychology in the Schools*, *39*, 327–335. https://doi.org/10.1002/pits.10022

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2012). Thematic analysis. In *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Breland-Noble, A. M., Bell, C. C., Burriss, A., & AAKOMA Project Adult Advisory Board. (2011). "Mama just won't accept this": Adult perspectives on engaging depressed African American teens in clinical research and treatment. *Journal of Clinical Psychology in Medical Settings*, *18*(3), 225–234. https://doi.org/10.1007/s10880-011-9235-6

Briesch, A. M., & Chafouleas, S. M. (2009). *Children's Usage Rating Profile (Actual)*. Storrs, CT: University of Connecticut.

Bringewatt, E. H., & Gershoff, E. T. (2010). Falling through the cracks: Gaps and barriers in the mental health system for America's disadvantaged children. *Children and youth services review*, *32*(10), 1291–1299. https://doi.org/10.1016/j.childyouth.2010.04.021

Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34*(10), 844–850. https://doi.org/10.1037/0003-066X.34.10.844

Brown, T. L., & Krishnakumar, A. (2007). Development and Validation of the Adolescent Racial and Ethnic Socialization Scale (ARESS) in African American Families. *Journal of Youth and Adolescence*, *36*(8), 1072–1085. https://doi.org/10.1007/s10964-007-9197-z

Bryan, J. (2009). Engaging clients, families, and communities as partners in mental health. *Journal of Counseling & Development, 87*(4), 507–511. https://doi.org/10.1002/j.1556-6678.2009.tb00138.x

Build Back Better Act. (2021, November 19). *Build Back Better Act* (2021/2022) [Legislation]. H.R.5376 - 117th Congress (2021-2022). https://www.congress.gov/bill/117th-congress/house-bill/5376

Burkett, C. A. (2017). Obstructed Use: Reconceptualizing the Mental Health (Help-Seeking) Experiences of Black Americans. Journal of Black Psychology, 43(8), 813-835. https://doi.org/10.1177/0095798417691381

Cammarota, J., & Fine, M. (2010). Youth participatory action research: A pedagogy for transformational resistance. In Revolutionizing education (pp. 9-20). Routledge.

Center for Behavioral Health Statistics and Quality. (2021). *Racial/Ethnic Differences in Mental Health Service Use among Adults and Adolescents (2015-2019)* ((Publication No. PEP21-07-01-002).; p. 207). Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/

Center for Disease Control and Prevention. (2021, December 8). *Mental Health*. National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. https://www.cdc.gov/mentalhealth/index.htm

Chafouleas, S. M., Briesch, A. M., Neugebauer, S. R., & Riley-Tillman, T. C. (2011). *Usage Rating Profile – Intervention (Revised)*. Storrs, CT: University of Connecticut.

Chandra, A., & Minkovitz, C. S. (2007). Factors that influence mental health stigma among 8th grade adolescents. *Journal of Youth and Adolescence*, *36*, 763-774.

Chandrasekhar, J. L., Bowen, A. E., Heberlein, E., Pyle, E., Studts, C. R., Simon, S. L., & Kaar, J. L. (2023). Universal, school-based mental health program implemented among racially and ethnically diverse youth yields equitable outcomes: Building resilience for healthy kids. *Community mental health journal*, *59*(6), 1109-1117.

Chatters, L. M., Taylor, R. J., Jackson, J. S., & Lincoln, K. D. (2008). Religious Coping Among African Americans, Caribbean Blacks and Non-Hispanic Whites. *Journal of Community Psychology*, *36*(3), 371–386. https://doi.org/10.1002/jcop.20202

Chow, J. C. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American journal of public health*, *93*(5), 792-797.

Clark, T. T. (2014). Perceived discrimination, depressive symptoms, and substance use in young adulthood. *Addictive Behaviors*, *39*(6), 1021–1025. https://doi.org/10.1016/j.addbeh.2014.01.013

Crawford, M. (2020). Ecological Systems Theory: Exploring the Development of the Theoretical Framework as Conceived by Bronfenbrenner. *Journal of Public Health Issues and Practices*, *4*(2). https://doi.org/10.33790/jphip1100170

Crocker, L., Schmitt, A., & Tang, L. (1988). Test Anxiety and Standardized Achievement Test Performance in the Middle School Years. *Measurement and Evaluation in Counseling and Development*, *20*(4), 149–157. https://doi.org/10.1080/07481756.1988.12022865

Dept. of Health and Human Services, & U.S. Public Health Service. (1999). *Mental health: A report of the Surgeon General*. Dept. of Health and Human Services, U.S. Public Health Service. https://search.ebscohost.com/login.aspx?direct=true&AuthType=ip,shib&db=cat06564a&AN=uga.9910017384402931&site=eds-live&custid=uga1

Duong, M. T., Bruns, E. J., Lee, K., Cox, S., Coifman, J., Mayworm, A., & Lyon, A. R. (2021). Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis. *Administration and Policy in Mental Health and Mental Health Services Research*, *48*(3), 420–439. https://doi.org/10.1007/s10488-020-01080-9

Dupéré, V., Dion, E., Nault-Brière, F., Archambault, I., Leventhal, T., & Lesage, A. (2018). Revisiting the Link Between Depression Symptoms and High School Dropout: Timing of Exposure Matters. *Journal of Adolescent Health*, *62*(2), 205–211. https://doi.org/10.1016/j.jadohealth.2017.09.024

Emergency Taskforce on Black Youth Suicide and Mental Health. (2019). *Emergency Taskforce on Black Youth Suicide and Mental Health report: Ring the alarm: The crisis of Black youth suicide in America*. U.S. Congresswoman Bonnie Watson Coleman. https://watsoncoleman.house.gov/suicidetaskforce/

Evans, S.W. (1999). Mental Health Services in Schools: Utilization, Effectiveness, and Consent.

Farmer, E. M. Z., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services (Washington, D.C.)*, *54*(1), 60–66. https://doi.org/10.1176/appi.ps.54.1.60

Farmer, E. M., & Farmer, T. W. (1999). The role of schools in outcomes for youth: Implications for children's mental health services research. *Journal of Child and Family Studies*, *8*, 377-396.

Fortuna K.L., Naslund J.A., LaCroix J.M., Bianco C.L., Brooks J.M., Zisman-Ilani Y., Muralidharan A, & Deegan, P. (2020). Digital Peer Support Mental Health Interventions for People With a Lived Experience of a Serious Mental Illness: Systematic Review. JMIR Ment Health2020;7(4):e16460. https://doi.org/10.2196/16460

Foster, S., Rollefson, M., Doksum, T., Noonan, D., Robinson, G., & Teich, J. (2005). School Mental Health Services in the United States, 2002-2003. In *Substance Abuse and Mental Health Services Administration*. SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI). https://eric.ed.gov/?id=ED499056

Georgia Department of Behavioral Health and Developmental Disabilities. (n.d.). *Georgia Apex Program*. https://dbhdd.georgia.gov/georgia-apex-program

Georgia Office of Student Achievement. (2019). Enrollment by grade level. Retrieved by https://gosa.georgia.gov/dashboards-data-report-card/downloadable-data

Ghandour, R. M., Sherman, L. J., Vladutiu, C. J., Ali, M. M., Lynch, S. E., Bitsko, R. H., & Blumberg, S. J. (2019). Prevalence and Treatment of Depression, Anxiety, and Conduct Problems in US Children. *The Journal of Pediatrics*, *206*, 256-267.e3. https://doi.org/10.1016/j.jpeds.2018.09.021

Giordano, P. C., Cernkovich, S. A., & DeMaris, A. (1993). The Family and Peer Relations of Black Adolescents. *Journal of Marriage and Family*, *55*(2), 277–287. https://doi.org/10.2307/352801

Greene, J. P., & Winters, M. A. (2006). Getting ahead by staying behind: An evaluation of Florida's program to end social promotion. *Education Next*, *6*(2), 65–70.

Guo, S., Kataoka, S. H., Bear, L., & Lau, A. S. (2014). Differences in school-based referrals for mental health care: Understanding racial/ethnic disparities between Asian American and Latino youth. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *6*(1), 27–39. https://doi.org/10.1007/s12310-013-9108-2

Guy-Evans, O. (2020). *Bronfenbrenner's Ecological Systems Theory*. https://www.simplypsychology.org/Bronfenbrenner.html

Hall, J. N. (2020). *Focus groups: culturally responsive approaches for qualitative inquiry and program evaluation.* Myers Education Press

Hasking, P., Rees, C. S., Martin, G., & Quigley, J. (2015). What happens when you tell someone you self-injure? The effects of disclosing NSSI to adults and peers. *BMC Public Health*, *15*(1), 1039. https://doi.org/10.1186/s12889-015-2383-0

Helsen, M., Vollebergh, W., & Meeus, W. (2000). Social Support from Parents and Friends and Emotional Problems in Adolescence. *Journal of Youth and Adolescence*, *29*(3), 319–335. https://doi.org/10.1023/A:1005147708827

Hoover, S. A., & Mayworm, A. M. (2017). The Benefits of School Mental Health. In K. D. Michael & J. P. Jameson (Eds.), *Handbook of Rural School Mental Health* (pp. 3–16). Springer International Publishing. https://doi.org/10.1007/978-3-319-64735-7_1

Ijadi-Maghsoodi, R., Bonnet, K., Feller, S., Nagaran, K., Puffer, M., & Kataoka, S. (2018). Voices from minority youth on help-seeking and barriers to mental health services: partnering with school-based health centers. *Ethnicity & disease*, *28*(Suppl 2), 437.

Increasing Access to Mental Health in Schools Act, no. H.R.3572, 117th Congress (2021). https://www.congress.gov/bill/117th-congress/house-bill/3572

Irwin, K., Davidson, J., & Hall-Sanchez, A. (2013). The Race to Punish in American Schools: Class and Race Predictors of Punitive School-Crime Control. *Critical Criminology*, *21*(1), 47–71. https://doi.org/10.1007/s10612-012-9171-2

James, S. A., Hartnett, S. A., & Kalsbeek, W. D. (1983). John Henryism and blood pressure differences among Black men. *Journal of Behavioral Medicine, 6(3), 259–278. https://doi.org/10.1007/BF01315113*

James S. A. (1994). John Henryism and the health of African-Americans. *Culture, medicine and psychiatry*, *18*(2), 163–182. https://doi.org/10.1007/BF01379448

Jennifer L Wright-Berryman, Devyn Thompson, Robert J Cramer, Reducing Suicide-Related Stigma through Peer-to-Peer School-Based Suicide Prevention Programming, *Children & Schools*, Volume 44, Issue 4, October 2022, Pages 216 223, https://doi.org/10.1093/cs/cdac015

Jones. (2007a). The Unintended Outcomes of High-Stakes Testing. *Journal of Applied School Psychology*, *23*(2), 65–86. https://doi.org/10.1300/J370v23n02_05

Jones, J. M. (2007b). Exposure to Chronic Community Violence: Resilience in African American Children. *Journal of Black Psychology*, *33*(2), 125–149. https://doi.org/10.1177/0095798407299511

Kazdin, A. E., & Wassell, G. (2000). *Predictors of Barriers to Treatment and Therapeutic Change in Outpatient Therapy for Antisocial Children and Their Families*. *2*(1), 14.

Kazdin, A. E. (1993). Adolescent mental health: Prevention and treatment programs. *American Psychologist, 48*(2), 127–141. https://doi.org/10.1037/0003-066X.48.2.127

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B. (2007). Age of onset of mental disorders: A review of recent literature. *Current Opinion in Psychiatry*, *20*(4), 359–364. https://doi.org/10.1097/YCO.0b013e32816ebc8c

Keyes, C. L. M. (2006). Mental Health in Adolescence: Is America's Youth Flourishing? *American Journal of Orthopsychiatry*, *76*(3), 395–402. https://doi.org/10.1037/0002-9432.76.3.395

Kilgus, S. P., Reinke, W. M., & Jimerson, S. R. (2015). Understanding mental health intervention and assessment within a multi-tiered framework: Contemporary science, practice, and policy. *School Psychology Quarterly*, *30*(2), 159.

Koenig, H. G. (2009). Research on Religion, Spirituality, and Mental Health: A Review. *The Canadian Journal of Psychiatry*, *54*(5), 283–291. https://doi.org/10.1177/070674370905400502

Koenig, H. G. (2010). Spirituality and mental health. *International Journal of Applied Psychoanalytic Studies*, *7*(2), 116–122. https://doi.org/10.1002/aps.239

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence based mental health programs in schools: Barriers and facilitators of successful implementation. *School mental health, 2*, 105-113.

Leeb, R. T. (2020). Mental Health–Related Emergency Department Visits Among Children Aged 18 Years During the COVID-19 Pandemic—United States, January 1–October 17, 2020. *MMWR. Morbidity and Mortality Weekly Report*, *69*. https://doi.org/10.15585/mmwr.mm6945a3

Leger, R. R., Wagner, L. D., & Odesina, V. (2018). Stigma in adults with sickle cell disease and family members: Scale development and pilot study in the USA and Nigeria. *International Journal of Africa Nursing Sciences*, *9*, 23–29. https://doi.org/10.1016/j.ijans.2018.06.003

Lindsey, M. A., Chambers, K., Pohle, C., Beall, P., & Lucksted, A. (2013). Understanding the Behavioral Determinants of Mental Health Service Use by Urban, Under-Resourced Black Youth: Adolescent and Caregiver Perspectives. *Journal of Child and Family Studies*, *22*(1), 107–121. https://doi.org/10.1007/s10826-012-9668-z

Lombardi, C. M., Coley, R. L., Sims, J., Lynch, A. D., & Mahalik, J. R. (2019). Social Norms, Social Connections, and Sex Differences in Adolescent Mental and Behavioral Health. *Journal of Child and Family Studies*, *28*(1), 91–104. https://doi.org/10.1007/s10826-018-1253-7

Mumbauer-Pisano, J., & Barden, S. M. (2020). Examining a mental health literacy intervention among economically disadvantaged youth. *Journal of Mental Health Counseling*, *42*(4), 339-355.

Martinez, S. (2009). A System Gone Berserk: How Are Zero-Tolerance Policies Really Affecting Schools? *Preventing School Failure: Alternative Education for Children and Youth*, *53*(3), 153–158. https://doi.org/10.3200/PSFL.53.3.153-158

Mental Health America. (n.d.). *The Federal and State Role in Mental Health*. Mental Health America. Retrieved December 11, 2021, from https://www.mhanational.org/issues/federal-and-state-role-mental-health

Mental Health in Schools Excellence Program Act, no. H.R.4198, 117th Congress (2021). https://www.congress.gov/bill/117th-congress/house-bill/4198

Mishra, S. I., Lucksted, A., Gioia, D., Barnet, B., & Baquet, C. R. (2009). Needs and Preferences for Receiving Mental Health Information in an African American Focus Group Sample. *Community Mental Health Journal*, *45*(2), 117–126. https://doi.org/10.1007/s10597-008-9157-4

Mori, Y., Tiiri, E., Khanal, P., Khakurel, J., Mishina, K., & Sourander, A. (2021). Feeling Unsafe at School and Associated Mental Health Difficulties among Children and Adolescents: A Systematic Review. *Children (Basel, Switzerland)*, *8*(3), 232. https://doi.org/10.3390/children8030232

Mukolo, A., & Heflinger, C. A. (2011). Rurality and African American Perspectives on Children's Mental Health Services. *Journal of Emotional and Behavioral Disorders*, *19*(2), 83–97. https://doi.org/10.1177/1063426609344604

Murry, V. M., Heflinger, C. A., Suiter, S. V., & Brody, G. H. (2011). Examining perceptions about mental health care and help-seeking among rural African American families of adolescents. *Journal of Youth and Adolescence, 40*(9), 1118–1131. https://doi.org/10.1007/s10964-010-9627-1

National Alliance on Mental Illness. (n.d.a). *Mental Health in Schools*. Retrieved January 21, 2022, from https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-in-Schools

National Alliance on Mental Illness. (n.d.b). *Pledge to Be Stigma Free*. https://www.nami.org/Get-Involved/Pledge-to-Be-StigmaFree

National Alliance on Mental Illness. (2012). *Closing the Gap for Children's Mental Health*. https://nami.org/Blogs/NAMI-Blog/May-2012/Closing-the-Gap-for-Children-s-Mental-Health

National Association of School Psychologists. (2020). NASP practice model: Improving outcomes for students and schools. https://www.nasponline.org/standards-and-certification/nasp-practice-model.

National Association of School Psychologists. (2021). *Comprehensive School-Based Mental and Behavioral Health Services and School Psychologists* [handout]. Author.

National Association of State Boards of Education. (n.d.). *School-based or School-linked Mental Health Services | State Policy Database*. Retrieved December 11, 2021, from https://statepolicies.nasbe.org/health/categories/counseling-psychological-and-social-services/school-based-or-school-linked-mental-health-services

National Council for Mental Wellbeing. (n.d.a). *Mental Health First Aid for Teens*. Mental Health First Aid. https://www.mentalhealthfirstaid.org/population-focused-modules/teens/

National Council for Mental Wellbeing. (n.d.b). *Mental Health First Aid for Youth*. Mental Health First Aid. https://www.mentalhealthfirstaid.org/population-focused-modules/youth/

Neighbors, H. W., Musick, M. A., & Williams, D. R. (1998). The African American Minister as a Source of Help for Serious Personal Crises: Bridge or Barrier to Mental Health Care? *Health Education & Behavior*, *25*(6), 759–777. https://doi.org/10.1177/109019819802500606

Northeast Georgia Regional Educational Service Agency. (n.d.). *Mental Health*. Retrieved December 13, 2021, from https://sites.google.com/negaresa.org/negaresaclimatespecialists/home

Office of the Surgeon General [US], Center for Mental Health Services (US), & National Institute of Mental Health (US). (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Substance Abuse and Mental Health Services Administration (US). http://www.ncbi.nlm.nih.gov/books/NBK44243/

O'Leary, K., Bhattacharya, A., Munson, S.A., Wobbrock,J.O., & Pratt,W . (2017). Design opportunities for mental health peer support technologies. CHI '18: Proceedings of the 2018 CHI Conference on Human Factors in Computing Systems April 2018 Paper No.: 331 Pages 1–14 https://doi.org/10.1145/3173574.3173905

Opara, I., Weissinger, G. M., Lardier, D. T., Lanier, Y., Carter, S., & Brawner, B. M. (2021). Mental health burden among Black adolescents: The need for better assessment,

diagnosis and treatment engagement. *Social Work in Mental Health*, *19*(2), 88–104. https://doi.org/10.1080/15332985.2021.1879345

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to Children's Mental Health Services. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(6), 731–738. https://doi.org/10.1097/00004583-200206000-00013

Parasuraman, S. R., & Shi, L. (2015). Differences in Access to Care Among Students Using School-Based Health Centers. *The Journal of School Nursing*, *31*(4), 291–299. https://doi.org/10.1177/1059840514556180

Planey, A. M., Smith, S. M., Moore, S., & Walker, T. D. (2019). Barriers and facilitators to mental health help-seeking among African American youth and their families: A systematic review study. *Children and Youth Services Review*, *101*, 190–200. https://doi.org/10.1016/j.childyouth.2019.04.001

Prout, H. T., & Fedewa, A. L. (2015). *Counseling and Psychotherapy with Children and Adolescents: Theory and Practice for School and Clinical Settings*. John Wiley & Sons, Incorporated. http://ebookcentral.proquest.com/lib/ugalib/detail.action?docID=1889212

Reardon, T., Harvey, K., Baranowska, M., O'Brien, D., Smith, L., & Creswell, C. (2017). What do parents perceive are the barriers and facilitators to accessing psychological treatment for mental health problems in children and adolescents? A systematic review of qualitative and quantitative studies. *European child & adolescent psychiatry*, *26*(6), 623–647. https://doi.org/10.1007/s00787-016-0930-6

Reinert, M., Nguyen, T., & Fritze, D. (2021). *2021 State of Mental Health in America*. Mental Health America. https://www.mhanational.org/research-reports/2021-state-mental-health-america

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly*, *26*(1), 1–13. https://doi.org/10.1037/a0022714

Reschly, D.J. (2000). The Present and Future Status of School Psychology in the United States. *School Psychology Review*, 29, 507–522.

Roach, A. (2018). Supportive Peer Relationships and Mental Health in Adolescence: An Integrative Review. *Issues in Mental Health Nursing*, *39*(9), 723–737. https://doi.org/10.1080/01612840.2018.1496498

Rones, M., & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review*, *3*(4), 223–241. https://doi.org/10.1023/A:1026425104386

Rose, T., Lindsey, M. A., Xiao, Y., Finigan-Carr, N. M., & Joe, S. (2017). Mental Health and Educational Experiences Among Black Youth: A Latent Class Analysis. *Journal of Youth and Adolescence*, *46*(11), 2321–2340. https://doi.org/10.1007/s10964-017-0723-3

Rubin, K. H., Coplan, R., Chen, X., Buskirk, A. A., & Wojslawowicz, J. C. (2005). Peer Relationships in Childhood. In *Developmental science: An advanced textbook, 5th ed* (pp. 469–512). Lawrence Erlbaum Associates Publishers.

Samuel, I. A. (2015). Utilization of Mental Health Services Among African-American Male Adolescents Released from Juvenile Detention: Examining Reasons for Within-Group Disparities in Help-Seeking Behaviors. *Child and Adolescent Social Work Journal*, *32*(1), 33–43. https://doi.org/10.1007/s10560-014-0357-1

Schwarz, S. W. (2009). *Adolescent Mental Health in the United States*. https://doi.org/10.7916/D8D50WP6

Sen, S., Aguilar, J. P., & Petty, M. (2020). An ecological framework for understanding HIV- and AIDS-related stigma among Asian American and Pacific Islander men who have sex with men living in the USA. *Culture, Health & Sexuality*. https://www.tandfonline.com/doi/full/10.1080/13691058.2019.1690164

Shalaby, R. A. H., & Agyapong, V. I. (2020). Peer support in mental health: literature review. *JMIR mental health*, *7*(6), e15572.

Sheftall, A. H., Asti, L., Horowitz, L. M., Felts, A., Fontanella, C. A., Campo, J. V., & Bridge, J. A. (2016). Suicide in Elementary School-Aged Children and Early Adolescents. *PEDIATRICS*, *138*(4), e20160436–e20160436. https://doi.org/10.1542/peds.2016-0436

Silverstein, B., & Krate, R. (1975). *Children of the dark ghetto: A developmental psychology* (pp. xvi, 271). Praeger.

Slade, E. P. (2002). Effects of School-Based Mental Health Programs on Mental Health Service Use by Adolescents at School and in the Community. *Mental Health Services Research*, 16.

Snowden, L. R. (2001). Barriers to Effective Mental Health Services for African Americans. *Mental Health Services Research*, 7.

Snowden, L. R. (2003). Bias in Mental Health Assessment and Intervention: Theory and Evidence. *American Journal of Public Health*, *93*(2), 239–243.

Snowden, L. R., & Yamada, A.M. (2005). Cultural Differences in Access to Care. *Annual Review of Clinical Psychology*, *1*(1), 143–166. https://doi.org/10.1146/annurev.clinpsy.1.102803.143846

Spera, S., & Monnat, S. (2020). *Adolescent and Young Adult Mental Health is Better in States that Mandate More School Mental Health Policies*. *15*, 6.

Splett, J. W., Garzona, M., Gibson, N., Wojtalewicz, D., Raborn, A., & Reinke, W. M. (2019). Teacher recognition, concern, and referral of children's internalizing and externalizing behavior problems. *School Mental Health: A Multidisciplinary Research and Practice Journal, 11*(2), 228–239. https://doi.org/10.1007/s12310-018-09303-z

Splett, J. W., Fowler, J., Weist, M. D., McDaniel, H., & Dvorsky, M. (2013). The critical role of school psychology in the school mental health movement. *Psychology in the schools*, *50*(3), 245–258. https://doi.org/10.1002/pits.21677

Stiffman, A. R., Stelk, W., Horwitz, S. M., Evans, M. E., Outlaw, F. H., & Atkins, M. (2010). A public health approach to children's mental health services: possible solutions to current service inadequacies. *Administration and policy in mental health*, *37*(1-2), 120–124. https://doi.org/10.1007/s10488-009-0259-2

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2021). *SAMHSA Awards Record-Setting $825 Million in Grants to Strengthen Community Mental Health Centers, and Support Americans Living with Serious Emotional Disturbances, Mental Illnesses*. https://www.samhsa.gov/newsroom/press-announcements/202109281153

Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice, 6th ed* (pp. xvii, 629). John Wiley & Sons, Inc.

Swinton, J. (2001). *Spirituality and Mental Health Care: Rediscovering a "Forgotten" Dimension*. Jessica Kingsley Publishers.

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' Perceptions of Psychotherapy and Psychotherapists. *Professional Psychology: Research and Practice*, *35*(1), 19–26. https://doi.org/10.1037/0735-7028.35.1.19

Twymon, K., Dorsey, M., Hudson, N., Kane, J., Valleru, J., & Fristad, M. A. (2020). Improving Timely Access to School-Based Mental Health Services: Getting through the Referral Gate. *Evidence-Based Practice in Child and Adolescent Mental Health*, *5*(2), 118–127. https://doi.org/10.1080/23794925.2020.1784055

Verlaan, P., Déry, M., Temcheff, C. E., & Toupin, J. (2018). Longitudinal determinants of school-based mental health service use for girls and boys with externalizing behavior problems. *School Mental Health*, *10*, 322-337.

Villarreal, V. (2018). Mental Health Collaboration: A Survey of Practicing School Psychologists. *Journal of Applied School Psychology*, *34*(1), 1–17. https://doi.org/10.1080/15377903.2017.1328626

Voices for Georgia's Children. (2020). *Supporting Children's Mental Health in Georgia Schools: How Three School-Based Mental Health Providers Serve Students*. https://georgiavoices.org/supporting-childrens-mental-health-in-georgia-schools/

Wachholtz, A. B., Sambamthoori, U., & Morgantown, W. (2013). National Trends in Prayer Use as a Coping Mechanism for Depression: Changes from 2002 to 2007. *Journal of Religion and Health*, *52*(4), 1356–1368. https://doi.org/10.1007/s10943-012-9649-y

Walrath, C. M., Bruns, E. J., Anderson, K. L., Glass-Siegal, M., & Weist, M. D. (2004). Understanding Expanded School Mental Health Services in Baltimore City. *Behavior Modification*, *28*(4), 472–490. https://doi.org/10.1177/0145445503259501

Wang, C., La Salle, T. P., Do, K. A., Wu, C., & Sullivan, K. E. (2019). Does parental involvement matter for students' mental health in middle school? *School Psychology*, *34*(2), 222–232. https://doi.org/10.1037/spq0000300

Ward, E. C., Clark, L. O., & Heidrich, S. (2009a). African American Women's Beliefs, Coping Behaviors, and Barriers to Seeking Mental Health Services. *Qualitative Health Research*, *19*(11), 1589–1601. https://doi.org/10.1177/1049732309350686

Ward, E. C., Clark, L. O., & Heidrich, S. (2009b). African American Women's Beliefs, Coping Behaviors, and Barriers to Seeking Mental Health Services. *Qualitative Health Research*, *19*(11), 1589–1601. https://doi.org/10.1177/1049732309350686

Ward, E. C., & Heidrich, S. M. (2009). African American women's beliefs about mental illness, stigma, and preferred coping behaviors. *Research in Nursing & Health*, *32*(5), 480–492. https://doi.org/10.1002/nur.20344

Ward, E., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American Men and Women's Attitude Toward Mental Illness, Perceptions of Stigma, and Preferred Coping Behaviors. *Nursing Research*, *62*(3), 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533

Way, N., Gingold, R., Rotenberg, M., & Kuriakose, G. (2005). Close friendships among urban, ethnic-minority adolescents. *New Directions for Child and Adolescent Development*, *2005*(107), 41–59. https://doi.org/10.1002/cd.120

Weisz, J. R., Sandler, I. N., Durlak, J. A., & Anton, B. S. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American psychologist*, *60*(6), 628.

Whitaker, K., Nicodimos, S., Pullmann, M. D., Duong, M. T., Bruns, E. J., Wasse, J. K., & Lyon, A. R. (2018). Predictors of Disparities in Access and Retention in School-Based

Mental Health Services. *School Mental Health*, *10*(2), 111–121. https://doi.org/10.1007/s12310-017-9233-4

Williams, L. R., & Anthony, E. K. (2015). A Model of Positive Family and Peer Relationships on Adolescent Functioning. *Journal of Child and Family Studies*, *24*(3), 658–667. https://doi.org/10.1007/s10826-013-9876-1

World Health Organization. (2018). *Mental health: Strengthening our response*. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization. (2021). *One in 100 deaths is by suicide*. https://www.who.int/news/item/17-06-2021-one-in-100-deaths-is-by-suicide

Wright-Berryman, J., Hudnall, G., Hopkins, R., & Bledsoe, C. (2018). Hope squads: Peer-to-peer suicide prevention in schools. *Children & Schools*, *40*(2), 125-126.

Yard, E. (2021). Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic—United States, January 2019–May 2021. *MMWR. Morbidity and Mortality Weekly Report*, *70*. https://doi.org/10.15585/mmwr.mm7024e1

Appendix A: Definitions

Access: Access is defined as the opportunity for all students in a school community to be recipients of school mental health services, based on student needs identified through evidence-based mental health screening measures, self-report, teacher report or parent report. This is different from availability which is the presence of school mental health services within the school setting.

Utilization: Utilization is defined as a student's recurrent use of school mental health services based on student needs and completion of the school mental health professional's treatment plan.

School Mental Health Services: "Any program, intervention, or strategy applied in a school setting that was specifically designed to influence students' emotional, behavioral, and/or social functioning" (Rones & Hoagwood, 2000; p. 224).

Peer-to-Peer Intervention: A program that is led by students and student peers to help Black middle school youth in need of mental health support connect with school mental health professionals to receive mental health services at school or in the community.

Appendix B: Knowledge of School Mental Health Providers and Services Questionnaire

Student Questionnaire

Student ID:
Age: _____
Grade level: _____
Race: _____
Ethnicity: _____

Please answer "Yes" or "No" to the following questions

1) Do you know what mental health services are available at your school? Yes No

2) Do you know who your school counselor is? Yes No

3) Do you know who your school social worker is? Yes No

4) Do you know who your school psychologist is? Yes No

5) Have you ever been seen by a school counselor? Yes No

6) Have you ever been seen by a school social worker? Yes No

7) Have you ever been seen by a school psychologist? Yes No

Please rate your level of agreement to the following statements.

1= Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I know what school mental health services are.					
I would go talk to a school counselor, social worker, teacher, or school psychologist about any challenges I am having.					
I know what mental illness is.					

Appendix C: School Mental Health Provider Demographic Form

Race _____
Ethnicity _____
Gender _____
Position/Title _____
Degree _____
Certificates _____
Years of Experience _____
Number of Years at Current School _____
Current Caseload_____

Appendix D: Study 1 Focus Group Guide – Student

Before the focus group begins, the leader will conduct the informed consent process.

A. Introduction

1. Welcome participants and introduce facilitator
2. Explain the general purpose of the discussion and why the participants were chosen
3. Discuss the purpose and process of focus groups
4. Explain the presence and purpose of recording equipment and introduce recorder
5. Outline general ground rules **(e.g., the importance of everyone speaking up, talking one at a time, and being prepared for the facilitator to interrupt if needed).**
6. Address the issue of confidentiality and that participants' names will not be used in analyses, comments made during focus group should not be repeated outside of the session

Assent Script:
Hello, my name is Shlon Smith and I am the primary investigator of this study and will be leading the focus group today. Thank you for coming today. This is _____ (graduate assistant name) and they will be helping me by writing down notes as you all speak. You are one of about 30 students being asked to participate in focus groups around the topic of school-based mental health services. You have been asked to participate in the focus group because you self-identify as Black and are a Middle school student. Your parent/guardian/caregiver has given you permission to participate. Your participation is voluntary. Once the session starts, we ask that you stay the full 30 minutes to fully participate in the focus group discussion.

Our discussion will be audio-recorded today to ensure that we capture all of your comments and suggestions accurately, _____ and I will be present to take notes to help us later when we go to transcribe the audio recordings. Your names will be deleted from the transcript, but they will help us get to know each other while we are here. To protect your confidentiality, all data will be stored in locked and/or password protected files to which only authorized study staff have access. Risks to participation in the focus group are minimal and the primary benefit is the opportunity to provide essential feedback on school mental health services for Black youth and how to apply what we learn to future efforts to increase access and utilization of school mental health services for Black youth. Your names will be removed from any and all data. Your focus group comments will be combined with others for reports based only on your grade level (6th, 7th, and 8th). You have two copies of the informed consent. Please sign one and keep the extra one for your records.

This work was supported by the Health Policy Research Scholars, a program of the Robert Wood Johnson Foundation. *We appreciate your participation and time today. The goals for this focus group are to identify your thoughts regarding the following:*

1. School mental health services at your school

2. Defining "access" in regard to school mental health services

3. Accessing school mental health services
4. Barriers and facilitators to accessing school mental health services
5. Defining “utilization” in regard to school mental health services
6. Barriers and facilitators to accessing school mental health services

Facilitator: Let’s do a quick introduction. Can you share your first name?

B. Discussion Questions for student focus groups (to be followed with nondirective probes)

1. Can you describe the mental health services at your school?
2. If you had problems at school, with your friendships, relationships, or your family, who would talk at your school?
    1. **Probe:** Can you tell me more about that? Who?
3. Is there anything within your school that makes it easy for you to access school mental health services?
    1. **Probe:** How?
4. Is there someone at your school that makes it easy for you to access school mental health services?
    1. **Probe:** Who? How?
5. Is there anything that your school could do that would make it easier for you to access and utilize school mental health services?
    1. **Probe**: What?
6. What does access mean to you?
    1. **Probe:** How would you define access in regard to school mental health services?
7. Is there anything that prevents you from accessing school mental health services?
    1. **Probe:** What? How?
8. Is there anyone that prevents or discourages you from accessing school mental health services?
    1. **Probe:** Who? How?
9. What does utilization mean to you?
    1. **Probe:** How would you define access in regard to school mental health services?

10. Is there anything that prevents you from utilizing school mental health services?
    1. **Probe:** What? How?
11. Is there anyone that prevents or discourages you from utilizing school mental health services?
    1. **Probe:** Who? How?

C. Closing

- Closing remarks
- Thank the participants
- Reminder that the results will be compiled into aggregate form to maintain confidentiality of responses. If you have questions or comments after the session, please contact Shlon Smith:

Appendix E: Study 1 Interview Guide – School Mental Health Professionals

Before the focus group begins, the leader will conduct the informed consent process.

A. Introduction

1. Welcome participant and introduce facilitator
2. Explain the general purpose of the discussion and why the participant was chosen
3. Discuss the purpose and process of the interview
4. Explain the presence and purpose of recording equipment and introduce recorder
5. Address the issue of confidentiality and that participants' names will not be used in analyses, comments made during focus group should not be repeated outside of the session

Assent Script:
Hello, my name is Shlon Smith and I am the primary investigator of this study and will be leading the interview today. Thank you for coming today. This is _____ (graduate assistant name) and they will be helping me by writing down notes as you speak. You are one of about 12 school mental health professionals being asked to participate in interviews around the topic of school-based mental health services. You have been asked to participate in this interview because you have been identified as a school mental health professional at _____ Middle School. Your participation is voluntary. Once the session starts, I ask that you stay the full 90 minutes to fully participate in the interview.

Our discussion will be audio-recorded today to ensure that I capture all of your comments and suggestions accurately. _____ and I will be present to take notes to help us later when we go to transcribe the audio recordings. Your name will be deleted from the transcript. To protect your confidentiality, all data will be stored in locked and/or password protected files to which only authorized study staff have access. Risks to participation in the interview are minimal and the primary benefit is the opportunity to provide essential feedback on school mental health services for Black youth and how to apply what we learn to future efforts to increase access and utilization of school mental health services for Black youth. You names will be removed from any and all data. Your interview comments will be combined with other school mental health professionals for reports based only on your school. You were provided with two copies of the informed consent and asked to sign one and keep the extra one for your records. Please let us know if you need another copy.

This work is supported by the Health Policy Research Scholars, a program of the Robert Wood Johnson Foundation. *We appreciate your participation and time today. The goals for this focus group are to identify your thoughts regarding the following:*

1. *School mental health services at your school*
2. *Defining "access" in regard to school mental health services*
3. *Referral processes for school mental health services*
4. *Barriers and facilitators to accessing school mental health services*

5. *School and community partnerships*
6. *Defining "utilization" in regard to school mental health services*
7. *Barriers and facilitators to utilizing school mental health services*
8. *Communicating with parents about school mental health services*
9. *School mental health practices in regard to Black youth.*

B. Interview questions for school mental health professionals (to be followed with nondirective probes)

Policy Section

1. What state school mental health policies are you familiar with?
   - **Probe**: Does your school implement these policies? How?
2. How are laws, policies, and guidance on school mental health communicated from the district to the school?
   - **Probe**: Do you think these policies serve as a barrier or facilitator to school mental services for Black youth?

General School Mental Health Services Section

1. What types of mental health services does your school provide?
2. What does access mean to you?
   - Probe: How would you define access in regard to school mental health services?
3. What is the referral process for school mental health services (i.e., crisis, teacher, parent, student)?
   - **Probe**: Please also discuss processes and procedures for parental consent.
4. What are the some of the barriers you find in getting students to access school mental health services?
5. What are the some of the facilitators you find in getting students to access school mental health services?
6. What does utilization mean to you?
   - **Probe:** How would you define access in regard to school mental health services?
7. Do you believe that existing school mental health services can be improved?"
   - **Probe:** If so, what areas can be improved?
8. Does your school partner with community agencies or providers to make data-based decision on school mental health services?
9. How does your school communicate information about school mental health services to parents?

Black youth school mental health services

1. In what areas do you think your school does particularly well in ensuring Black youth can access and utilize school mental health services?
    - **Probe:** If so, can you elaborate more on what your school does?
    - **Probe:** Can you elaborate on any specific practices that you employ as a mental health professional at your school?
2. Is there anything at the school level that you believe prevents Black youth at your school from accessing school mental health services?
    - **Probe:** If so, what do you think prevents Black youth from accessing school mental health services?
3. Is there anything at the school level that prevents Black youth at your school from utilizing school mental health services?
    - **Probe:** If so, what do you think prevents Black youth from utilizing school mental health services?
4. Do you believe there is something that the school could do that would make it easier for Black youth to access school mental health services?
    - **Probe:** If so, what do you believe would make it easier for Black youth to access school mental health services?
    - **Probe:** If not, can you explain your answer?

C. Closing

- Closing remarks
- Thank the participant
- Reminder that the results will be compiled into aggregate form to maintain confidentiality of responses. If you have questions or comments after the session, please contact Shlon Smith:

Appendix F: Peer Relationships and Mental Health Questionnaire

ID Number:

Please rate your level of agreement to the following statements.

1= Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There is a mental health issue in the Black youth community					
I have supportive peer relationships.					
My peers know what mental illness is.					
Youth play a role in supporting other youth's mental health					
I confide in my peers about my personal challenges (romantic relationships, family, school)					
I confide in my peers about my mental health challenges (i.e., anxiety, depression, suicide, etc.)					
My peers confide in me about ***their personal*** challenges (romantic relationships, family, school)					
My peers confide in me about ***their mental health*** challenges (i.e., anxiety, depression, suicide, etc.)					

Appendix G: Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire S 11-17

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain . Please give your answers on the basis of how things have been for you over the last six months.

Your name..... Male/Female

Date of birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CD's, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

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?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress you?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	A medium amount	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

• Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	A medium amount	A great deal
☐	☐	☐	☐

Your Signature ..... Today's Date .....

Thank you very much for your help

Appendix H: Study 2 Focus Group Guide – Student

Before the focus group begins, the leader will conduct the informed consent process.

A. Introduction

1. Welcome participants back and re-introduce the facilitator
2. Explain the general purpose of the discussion and why the participants were chosen
3. Discuss the purpose and process of focus groups
4. Explain the presence and purpose of recording equipment and introduce recorder
5. Outline general ground rules **(e.g., the importance of everyone speaking up, talking one at a time, and being prepared for the facilitator to interrupt if needed).**
6. Address the issue of confidentiality and that participants' names will not be used in analyses, comments made during focus group should not be repeated outside of the session

Assent Script:
Hello, my name is Shlon Smith and I am the primary investigator of this study and will be leading the focus group today. Thank you for coming today. This is _____ (graduate assistant name) and they will be helping me by writing down notes as you all speak. You are one of about 30 students being asked to participate in focus groups around the topic of school-based mental health services. You have been asked to participate in the focus group because you self-identify as Black and are a Middle school student. Your parent/guardian/caregiver has given you permission to participate. Your participation is voluntary. Once the session starts, we ask that you stay the full 30 minutes to fully participate in the focus group discussion.

As a reminder, our discussion will be audio-recorded today to ensure that we capture all of your comments and suggestions accurately, _____ and I will be present to take notes to help us later when we go to transcribe the audio recordings. Your names will be deleted from the transcript, but they will help us get to know each other while we are here. To protect your confidentiality, all data will be stored in locked and/or password protected files to which only authorized study staff have access. Risks to participation in the focus group are minimal and the primary benefit is the opportunity to provide essential feedback on school mental health services for Black youth and how to apply what we learn to future efforts to increase access and utilization of school mental health services for Black youth. Your names will be removed from any and all data. Your focus group comments will be combined with others for reports based only on your grade level (6th, 7th, and 8th). You have two copies of the informed consent. Please sign one and keep the extra one for your records.

This work was supported by the Health Policy Research Scholars, a program of the Robert Wood Johnson Foundation. *We appreciate your participation and time today. The goals for this focus group are to identify your thoughts regarding the following:*

1. *Sources of support and opposition in using school mental health services*
2. *Peer relationships as it relates to mental health*
3. *School mental health intervention for Black youth*

4. *Barriers and facilitators to creating and implementing a school mental health intervention for Black youth.*

Facilitator: Let's do a quick introduction. Can you share your first name?

B. Discussion Questions for student focus groups (to be followed with nondirective probes)

1. Who are the people who approve (or support) of you using school mental health services?
    - **Probe:** Why do you think they approve?
2. Who are the people who disapprove (don't support) of you using school mental health services?
    - **Probe:** Why do you think they disapprove?
3. How many people in your life are likely to influence you getting help from a school mental health professional?
    - **Probe:** Who?
    - **Probe:** How many of those people are using mental health services, whether in the school or community?
4. If you had a problem, how likely are you to talk to a peer?
    - **Probe**: Tell me more about how you confide in your peers?
5. Has a friend ever confided in you about their problems or issues?
    - **Probe:** How did this make you feel?
6. Do you think it is ok for you or a friend to tell an adult about what you discussed as friends if it was related to mental health challenges?
    - **Probe:** Can you tell me more about that?
7. If you could design a school peer-to-peer school mental health program that would help Black youth get support from an adult when they have challenges, what would that look like for you?
    - **Probe:** What qualifications/characteristics would you want the peer to have?
8. What would you need to make this program come to life?
9. What do you see as challenges to bringing a program like this to life?

C. Closing

- Closing remarks
- Thank the participants
- Reminder that the results will be compiled into aggregate form to maintain confidentiality of responses. If you have questions or comments after the session, please contact Shlon Smith at shlon.smith@gmail.com

Appendix I: Study 2 Interview Guide – School Mental Health Professionals

Before the focus group begins, the leader will conduct the informed consent process.

A. Introduction

1. Welcome participant and introduce facilitator
2. Explain the general purpose of the discussion and why the participant was chosen
3. Discuss the purpose and process of the interview
4. Explain the presence and purpose of recording equipment and introduce recorder
5. Address the issue of confidentiality and that participants' names will not be used in analyses, comments made during focus group should not be repeated outside of the session

Assent Script:
Hello, my name is Shlon Smith and I am the primary investigator of this study and will be leading the interview today. Thank you for coming today. This is _____ (graduate assistant name) and they will be helping me by writing down notes as you speak. You are one of about 12 school mental health professionals being asked to participate in interviews around the topic of school-based mental health services. You have been asked to participate in this interview because you have been identified as a school mental health professional at _____ Middle School. Your participation is voluntary. Once the session starts, I ask that you stay the full 90 minutes to fully participate in the interview.

As a reminder, our discussion will be audio-recorded today to ensure that I capture all of your comments and suggestions accurately. _____ and I will be present to take notes to help us later when we go to transcribe the audio recordings. Your name will be deleted from the transcript. To protect your confidentiality, all data will be stored in locked and/or password protected files to which only authorized study staff have access. Risks to participation in the interview are minimal and the primary benefit is the opportunity to provide essential feedback on school mental health services for Black youth and how to apply what we learn to future efforts to increase access and utilization of school mental health services for Black youth. Your names will be removed from any and all data. Your interview comments will be combined with other school mental health professionals for reports based only on your school. You were provided with two copies of the informed consent and asked to sign one and keep the extra one for your records. Please let us know if you need another copy.

This work is supported by the Health Policy Research Scholars, a program of the Robert Wood Johnson Foundation. *We appreciate your participation and time today. The goals for this focus group are to identify your thoughts regarding the following:*

1. *Components of a successful peer-to-peer school mental health intervention for Black youth*
2. *Receptivity of implementing a peer-to-peer school mental health intervention for Black youth*
3. *Barriers and facilitators to consider*

B. Interview questions for school mental health professionals (to be followed with nondirective probes)

Peer to Peer School Mental Health Intervention

1. What specific components do you think are necessary for a successful peer-to-peer school mental health intervention designed to increase access and utilization for Black youth?
2. How would your school be receptive of the implementation of a peer-to-peer program for Black youth aimed at increasing access and utilization for their mental health challenges at your school?
    - **Probe:** Can you tell me more about that?
3. From your perspective, are there any challenges in implementing a peer-to-peer school mental health intervention program at your school?
    a. **Probe**: If so, can you explain what those challenges are?
    b. **Probe:** If there are no challenges, can you tell me more about that?

2) To ensure the success of a peer-to-peer school mental health program, are there any factors (barriers or facilitators) that you believe are important to consider?

C. Closing

- Closing remarks
- Thank the participant
- Reminder that the results will be compiled into aggregate form to maintain confidentiality of responses. If you have questions or comments after the session, please contact Shlon Smith: shlon.smith@gmail.com