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Youth Descriptions of Mental Health Needs and Experiences with School-based Services: Identifying Ways to Meet the Needs of Underserved Adolescents

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Abstract

While schools serve as a common entry point into mental health services for underserved youth, engagement of students in need of care remains a problem. Little is known about the ways schools can best address students' mental health needs, especially from the perspective of youth who struggle to attend school, a vulnerable group with a high burden of mental health problems. A qualitative descriptive approach was used to analyze data from in-depth interviews with a sample of 18 youth with a history of school truancy and mental health problems. Analyses explored how youth expressed mental health symptoms, and their trajectories through, and perceptions of, school-based mental health services. Results suggest that participants experienced multiple, overlapping symptoms; only a portion had their needs addressed. The quality of relationships with school staff and the perceived efficacy of treatment affected service trajectories. Promising school-based approaches to address students' mental health needs are discussed.

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Keywords

Mental health; adolescents; schools; mental health services; qualitative

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Mental health (MH) problems among youth, defined as experiences of emotional or psychological distress that affect daily functioning, are a serious public health issue in the United States. Annually as many as 20% of youth in the US are affected by MH problems that meet criteria for a mental disorder.[1,2,3] Failure to address MH problems that emerge in adolescence, even symptoms that do not meet the criteria for a diagnosable disorder, can have severe consequences, including poor relationships, substance use, truancy, school failure, justice system involvement, and suicide.[4,5,6] However most adolescents in need of care never receive it.[7,8]

Pathways to engaging youth in MH services begin with the identification of a problem, followed by a decision to seek or accept help, and end with selection and receipt of services. [9] Multiple individual, interpersonal, and structural factors are known to influence service pathways.[10,11] Underserved youth, in particular, racial/ethnic minority youth and youth from low-income households, face additional barriers that make them less likely to receive care.[12]

Schools are a common setting for recognizing and responding to youth MH needs, and underserved youth may be particularly dependent on them for care.[13,14] Although schools use a variety of efforts to address the MH needs of students,[15] evidence regarding their effectiveness for meeting the needs of underserved youth is mixed. Several studies document positive outcomes for students successfully engaged in care, such as reduced racial disparities in service use[16,17] and improvements in acute symptoms (e.g., depression, suicidality).[18] While promising, engaging the full population of youth in need remains a challenge. Minority youth tend to use fewer school-based services and to access them at a later age than their White peers.[19] In addition, neither teacher reports of MH problems[20] nor school-based referrals[21] may ultimately lead to service use for minority youth.

Although school-based health services can remove certain barriers to treatment, breakdowns may still occur in pathways linking underserved youth to care. Decreased detection of MH problems among minority youth, potentially due to poor cross-cultural understanding or communication,[22,20] may contribute to breakdowns in service pathways. Even when youth needs are identified, disparities persist in service linkages and completion, as school staff may be uncertain about how to address students' needs.[23] Moreover, distrust of MH professionals, concerns about stigma, or difficulty identifying and accessing services (e.g., due to lack of insurance or transportation) may prevent minority or low-income families from seeking or finding help.[24,21,14] Adding to this challenge are higher levels of school disengagement, truancy, and dropout among underserved youth.[25] While researchers have largely not examined the provision of school MH services as it relates to youth with school attendance problems, it is reasonable to expect that educators may face additional challenges identifying and responding to the MH needs of students who are less present and engaged in school.

In spite of increased understanding of the challenges identifying and linking underserved youth to MH services, current research on factors affecting how they engage with school-based services is sparse, especially from the perspective of potential service-users. Much of what is known regarding how youth MH problems are identified and addressed is from the point of view of school staff,[26] parents,[20,10] or youth who were successfully engaged in care. [26, 27] One of the only qualitative works examining youth perspectives on school-based MH services was conducted with participants who did not necessarily have MH needs or experience with MH services.[27] While research clearly illustrates that not all youth in need of MH services receive them, limited qualitative information is available on factors that influence school processes for identifying and linking underserved youth to care.

To address this gap in the literature, this study reports findings from interviews conducted with a sample of racial/ethnic minority youth with a history of school truancy who reported experiencing MH problems. The first objective of this study was to examine how youth express their MH problems, especially within the context of their school attendance. The second objective was to describe youth experiences with and perceptions of school-based MH services. These youth-centered findings seek to inform school-based policies and programs to identify and address the MH needs of underserved youth.

Methods

The present study comprised a secondary analysis of 39 interviews conducted in the fall of 2013 to explore the experiences of youth with a history of school truancy in Los Angeles County.[28] During the interviews, unmet MH needs emerged as a central theme when youth discussed their struggles to attend school. The present study analyzed data from 18 of the original 39 interviews with the subset of youth who reported experiencing MH problems, defined as emotional or psychological distress youth described as affecting their daily functioning, including but not limited to, their ability to attend school.

Setting and sample

This study used a community-partnered research approach in which three youth research assistants (recruited to optimize age, racial/ethnic, and experiential concordance with the intended sample) contributed to the development of the interview guide, recruited participants, conducted interviews, and assisted with data analysis. Interviews were conducted with 39 youth who: a) were a current or recent (within one year) middle or high school student in Los Angeles County, b) reported skipping class or ditching school at least once per month in the past year, c) had experience with at least one school-, community-, or law-enforcement-based truancy intervention, and d) spoke English or Spanish.[28]

Inclusion criteria for the present analysis were developed based on the Youth Self Report (YSR), a global measure of behavioral and emotional functioning of adolescents intended to assess distress along a spectrum, including at subclinical levels (e.g., by generating a continuous distress score). A short-form, 66-item version of the YSR has been previously validated and has demonstrated metric stability with diverse, non-clinical samples of adolescents in Los Angeles County.[29] The short-form YSR includes an Internalizing Behavior Score (consisting of Somatic Complaint, Anxious/Depressed, and Self-harm

Behavior sub-scales) and an Externalizing Behavior Score (consisting of Attention Problem, Delinquent Behavior, and Aggressive Behavior sub-scales). The short-form YSR was applied to the original study sample in order to identify the subset of youth with MH problems. Youth were identified as having a MH problem and included in the present analysis sample if they (1) reported or described at least three symptoms that were consistent with those from the short-form YSR *and* identified these symptoms as significantly impairing functioning or causing significant distress such that it shaped her/his life trajectory; *or* (2) reported experiencing, having been diagnosed with, or receiving treatment for any mental disorder recognized by the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-V).[30] To identify eligible youth, two members of the study team engaged in two rounds of independent review of interview transcripts and discussion to resolve discrepancies.

Eighteen youth were included in the present sample. Ages ranged from 12-18, with a mean of 16.4 years. A majority of the sample was female (13 youth) and Latino (16 youth), with two participants identifying as African American (quantitative demographic information collected via a brief screening form administered at recruitment). Compared with the distribution of the original study sample, this subset contained slightly more youth who identified as Latino (89% vs. 80%) and female (72% vs. 51%). Youth in the present analysis were reflective of the original sample in terms of risk and experience; although youth were not asked to provide information on socioeconomic markers such as family income, parental education, or immigration status, youth commonly described exposure to conditions such as high rates of crime and violence, poverty, and family instability.

Procedure

In-depth interviews were conducted by one youth research assistant, assisted by one or two members of the study team.[28] The 16-question open-ended interview guide asked participants to describe their story, from when they first started struggling to attend school and ending at the present day. Although youth discussed experiences related to MH problems throughout their interviews, questions that tended to elicit this content included: a) What happened that caused you to begin to cut or skip class? b) Why did you continue to cut or skip class? c) What happened when you were confronted about your attendance? d) How was your school/family/probation officer involved in your school attendance? and e) Can you tell me about any services you were offered or programs you may have participated in to improve your attendance? Interviews lasted approximately 30-40 minutes and were audio-recorded and transcribed verbatim.

All study protocol and instruments were reviewed and approved by the Los Angeles County Department of Public Health and the University of California, Los Angeles Institutional Review Boards prior to implementation. All study participants provided written assent. Participants were compensated with a $20 gift card for their participation.

Analysis

Qualitative data analysis for the present investigation occurred between July 2014 and February 2015. Two members of the original study team and one additional subject-matter

expert in youth MH analyzed the 18 interview transcripts with a focus on understanding youth experiences of MH problems. In accordance with the qualitative descriptive paradigm,[31,32] and mirroring the original study,[28] data were analyzed using a bottom-up inductive technique. The two members of the original study team used close and holistic coding (e.g., development of holistic case summaries) to identify key influences, events, and experiences. The two met after independent review of sets of three to four transcripts to discuss, and then finalize, a coding and thematic scheme, and twice with the external subject-matter expert to understand how youth descriptions compared with clinical definitions and contexts. Data management and analysis was conducted using ATLAS.ti version 7.[33]

Results

Youth descriptions and expressions of MH problems

Youth described experiencing overlapping symptoms of MH problems; the most commonly reported included anxiety or depression, delinquent behavior, and physical or verbal aggression. The majority of youth reported both internalizing symptoms (e.g., worry, withdrawal) and externalizing symptoms (e.g., fighting, lying). For instance, close to two-thirds of the youth with histories of physical or verbal aggression (seven out of 11) and delinquent behavior (eight out of 12) also described symptoms of anxiety or depression. Less than half of youth explicitly discussed having a MH disorder using clinical terms, such as *depression* or *anxiety*; when they did, it was not always clear if the language used reflected having received a diagnosis or that the participant was looking for a way to name and discuss her/his experience. Youth descriptions of their symptoms, as well as how these symptoms related to school attendance and other problematic behavior, are presented in Table 1.

Youth pathways through MH services

As depicted in Figure 1, the majority of youth did not follow an ideal pathway linking them to needed MH services. Seventeen of the 18 participants reported contact with an adult related to their symptoms, representing an opportunity for their needs to be identified. Eleven contacts occurred in schools, whereas six were facilitated by other systems. Thirteen of these youth were offered services, and nine ultimately received services. Youth experiences are described below, followed by a discussion of crosscutting factors that influenced how they perceived and engaged with MH services and supports.

Opportunities for needs to be identified—All but one youth described having contact with an adult related to her/his MH needs. The majority of these contacts occurred in schools, almost exclusively initiated by school staff (as opposed to youth or their families). These encounters included both formal (e.g., meetings with their family and school administrators) and informal (e.g., being pulled aside by teachers and asked about poor attendance) responses to problematic behavior. Formal intervention usually occurred when youth got in trouble, (e.g., for fighting) or when their attendance problems had reached a critical stage (e.g., they had too few credits to graduate); youth described these encounters as primarily focused on discipline, where, if services were offered, they were offered in tandem with sanctions. Six youth had their needs identified for the first time outside of school,

usually after something serious happened: three youth after being arrested and placed on probation, and two after a hospitalization. For example, one 17-year-old girl (#37) with a history of fighting, expulsion, and gang involvement was hospitalized for a drug overdose following the shooting death of her boyfriend. As her case illustrates, the paths of these youth were characterized by multiple warning signs, but no prior reported intervention by schools or families.

Services offered and received—Of the 17 youth who had contact with an adult related to their MH needs, 13 youth reported being offered services, while four did not. Missed opportunities for service linkage were related to the reactions of both the youth and adults; youth were not always willing to engage when adults tried to reach out (see later discussion of influences on youth service pathways) and adults did not always successfully link youth to services, even when they were receptive. In one notable example, a 17-year-old girl with a history of aggression, repeated expulsions, and arrest describes her experience reaching out to a school counselor:

> …I remember one time I went to my counselor and I'll be like, "Oh can I talk to you? This is what, I've been having problems." He's like, "No, no, no." He's like, "I don't deal with problems." He's like, "I don't deal with problems, I deal with classes." He's like, "I give you your classes but I don't deal with problems." I was like, "OK, and that's it." That was the last…that was the first and last time I ever talked to a counselor (#3).

Another 16-year-old girl described a similar experience, in which a service provider who was recommended by her probation officer, failed to follow up to offer anger management classes, although she emphasized the seriousness of her problem during the interview, saying "*I have anger issues, very very very very anger issues* [#28]." When service pathways were hard to navigate or disjointed it led to feelings of rejection or the perception that no one cared enough to help.

Half of the youth in the sample (nine) received at least one formal MH service or support. Three enrolled in anger management classes, five received counseling, and two were prescribed medication. As described further below, youth levels of satisfaction with the services provided were mixed.

Main influences on youth MH service pathways

Youth described a variety of individual, interpersonal, and contextual factors that influenced how they perceived and engaged with MH supports and services. Two overarching themes were identified: 1) the quality of relationships and the setting in which services were offered and, 2) the extent to which youth believed their situation would be improved by professional care (i.e., perceived efficacy of seeking help).

Quality of relationships and setting—While most (11 youth) acknowledged the need to talk about their problems to move past them, not all were willing to do so if they did not have a positive relationship with the adult reaching out. Several youth spoke about the importance of a shared background or extended relationship with an adult with whom they

could confide. This was the case for one 16-year-old girl who discussed her relationship with a staff member at the community center who was influential in changing her behavior, where others were not:

> …she met me since I was little, so with her, I tell her my problems, she helps me out. She has more pressure on us about going to school than the probation officers (#28).

However, even when there wasn't necessarily a long-standing relationship, youth seemed willing to open up to adults they felt genuinely cared for them and believed in their ability to succeed academically. For instance, one 17-year-old girl described the importance of a relationship with a teacher at her continuation school:

> …she always talk to me, like she been there when my boyfriend passed away, you know, she was right there, like, "You're young, you could still keep on going to school," like, "It's going to get in your way sometimes," but she would always talk to me like, "Oh, why you missing school?" like about, "Why you not coming to school?" Like, she don't talk to me in a mean way, like, "We're going to kick you out" (#37).

In contrast, the effect of contentious relationships with school staff is illustrated by one 17-year-old boy who was frequently absent following a death in his family, but hid the reason from his teachers because it was "*personal,*" instead saying he was "*just sick*" (#8). Overall, his narrative regarding teachers is dominated by phrases such as, "*He thought I was dumb,*" "*The teacher didn't like me much,*" and "*They single you out*" and a general feeling of being confronted, judged, and dismissed. Similarly, at least two youth described being suspicious of the motives of services offered through school or probation. For example, one 18-year-old girl reflected on school-based counseling services as being just focused on "*how to progress in school*" and ultimately not helpful (#11). Finally, the desire for greater understanding was echoed by two youth who reported having been diagnosed with a mental illness. Despite taking steps to document their health problems with the school district, both reported feeling judged and penalized by teachers, which led them to further disconnect. One 14-year-old girl described her interactions with her teachers this way:

> …because I have everything filled out the teachers are not allowed to be saying anything. But they still would. Like all the medical papers and everything were signed and shown, but they just didn't believe it and they thought because I was missing so much school that it wasn't true. So I was just like, "Ok, if you aren't believing me and you're just going to talk down, it's like what's the point of me being in your class?" (#27).

Perceived efficacy of seeking help—Youth attitudes and beliefs regarding the efficacy of MH services affected how they responded throughout their service pathways. When youth reflected on their MH needs, at least seven participants felt there was "nothing anyone could do" to fix it and emphasized the role of personal will-power. For instance, one 18-year-old girl reported rejecting school-based counseling services, saying, "*It just really doesn't work cause like there's not much you can do about* [depression] [#11]" and returning to school after she "*stopped making excuses.*" Similarly, several youth who reported experiencing

anger management problems described controlling their behavior after they decided to change their "*attitude*" or "*relax*."

Although some youth expressed fatalistic attitudes regarding formal MH services, others appreciated learning techniques and approaches for coping with their emotions. These experiences were described by one 18-year-old boy who was connected to anger management through his school counselor:

> …it helped, …we'd play games and talk about all of our problems and ways to improve it and to fix it and ways to manage your feelings and to control them, and I could not control my anger [before] but now … it's not a big problem, it's still a problem yeah, now and then when it has to be, but … I've learned ways to get through the obstacle without being physical (#1).

Of the nine youth who received services or supports, four reflected on them as being helpful and contributing to their healing; two received anger management and two received counseling or other support services. These youth described long-term relationships with service providers, learning skills or techniques for coping with negative emotions, being able to share their experiences with adults who they felt understood their backgrounds and experiences, and having someone who cared enough to listen, as valuable to their recovery.

Discussion

This qualitative study sought to explore how low-income, racial/ethnic minority youth with a history of school truancy expressed MH symptoms and experienced school-based MH services. While youth described multiple MH needs related to their struggles to attend school, only half received services to address them. There were several points where breakdowns occurred in pathways linking youth to care: MH needs were not identified, services were not offered, and youth did not participate. Poor relationships and a prevailing belief that there was nothing anyone could do to help contributed to disjointed service pathways.

Many youth in the present study described overlapping symptoms of MH problems. Findings are consistent with evidence of comorbidity between internalizing and externalizing disorders and suggest that easily identifiable problem behaviors, such as frequent fighting, may be symptomatic of a range of underlying MH needs.[34,35] Results also align with emerging evidence on the reciprocal relationship between MH and school engagement.[36,25] Findings illustrate how MH symptoms (e.g., acting aggressively in class, seeming apathetic about school) may contribute to adversarial relationships with school staff, causing additional distress, disengagement, and truancy. Unfortunately, youth in the present study were often provided MH services secondary to disciplinary action; being identified as truant largely did not trigger a formal or comprehensive MH evaluation and many youth were significantly off-track academically or had been expelled by the time their needs were identified. These experiences support previous studies on the consequences of untreated MH problems, especially regarding academic failure and impaired relationships[37,38] and point to the importance of identifying the full extent of MH needs early and advancing more comprehensive strategies to improve youth wellbeing.

Results of the present study suggest that poor relationships with adults and negative attitudes held by youth towards MH services were major barriers to addressing MH needs in schools. In particular, many youth were reluctant to confide in teachers they felt did not support them, or they disengaged when they felt their needs were not understood. Other qualitative work on help-seeking behaviors in schools highlights the importance of sustained and supportive relationships with adults.[27] While some youth in the present study described these types of positive relationships, overall, their school experiences were largely negative and unstable (e.g., expulsions or forced transfers, gaps in enrollment), decreasing opportunities to foster healthy relationships and to identify MH needs. In addition, youth skepticism regarding MH care affected how they disclosed their problems or engaged with service pathways. Although related in part to the context in which services were offered, attitudes of many youth reflected a fatalism regarding the efficacy of professional care and a preference for self-reliance, cognitive attributes that are well documented among low-income and minority youth.[9] Concerns about stigma were also evident in youth accounts— for example, youth tended to label MH problems as physical in nature or describe symptoms using vague terms. Stigma may be of particular concern for minority youth,[12] adding to the barriers that prevent help-seeking.

Implications for practice

Results point to the need for enhanced school-based approaches to address MH problems, especially among underserved youth. Comprehensive school health approaches, such as those recommended by the Whole School, Whole Community, Whole Child (WSCC) model, may offer a pragmatic framework. The WSCC model emphasizes the importance of efforts to promote health among the school community holistically, in addition to providing integrated health services for those in need of care.[39]

One cornerstone of this comprehensive approach, supported by the present analysis, involves identifying youth in need. Although teachers are central in recognizing and responding to youth problems, they may lack the training or professional support needed to engage students and to assess their MH needs.[23] In the short term, in districts where dedicated mental health staff is scarce, teachers could be better trained and supported to address their students' MH needs. However, broader, more sustainable efforts are needed in the long-term. School districts and policymakers should prioritize adequate staffing of MH professionals at school sites, beginning with districts that have high concentrations of youth at risk for MH problems (e.g., those with high rates of truancy and exposure to violence, trauma, and poverty).

Implementing universal, comprehensive MH screenings may provide a structured mechanism to improve detection of students in need and ease the burden on school staff. However, early detection is of no value if the infrastructure is not in place to appropriately refer and/or treat all youth who are identified.[40] Even so, in high-need, under-resourced schools, providing targeted screening and comprehensive MH evaluations may be a potentially cost-beneficial intervention for youth with school attendance problems. Despite the link between truancy and unmet MH needs, many schools do not routinely incorporate

referrals to MH services in truancy reduction interventions, perhaps contributing to the limited impact of these efforts.[41–43]

Finally, results point to the need to improve MH literacy, reduce stigma, and build sustained and supportive relationships with adults as part of a comprehensive, integrated school wellness strategy. Youth ambivalence towards seeking and receiving MH services points to the importance of creating school communities in which help-seeking behaviors are normalized and facilitated by relationships with trusted adults. Culturally relevant school-wide interventions to reduce stigma and promote a healthy school climate represent a promising approach.[44, 45]

Limitations

Although this study provides important insights into youth perspectives, it has a number of limitations. First, like most qualitative research, results are not intended to be generalizable. All youth in the present study had a history of truancy; experiences of this group may not be reflective of youth who consistently attend school or of low-income, minority youth generally. Second, the present study was a secondary analysis of data collected to address a different set of research questions. In the original study, participants were not directly asked about their MH needs or experiences; themes related to MH emerged from youth descriptions of their school attendance history and probes were used to elicit details. Inclusion criteria, developed based on the short-form YSR and in consultation with the subject-matter expert, were applied post hoc to the original sample to categorize youth as "experiencing MH problems" or "not," but do not provide information on their relative level of distress. It is possible that youth with lower levels of symptoms were omitted from the sample. Third, to maximize the comfort of participants and limit concerns over confidentiality, participants were asked to provide only limited quantitative demographic information. Inferences regarding the makeup of the sample in terms of socioeconomic characteristics, such as family income, are based on descriptions present in youth narratives. Finally, it is unclear to what extent youth reports of their service pathways are comprehensive or accurate.

Conclusions

Youth who struggle to attend school may have complex MH needs and may face significant barriers to MH care. Although schools are uniquely positioned to address these needs, modifications to current systems and practices are needed to adequately identify and engage youth in need of care. In particular, poor relationships with school-based adults and low perceived efficacy of professional treatment may prevent youth from disclosing symptoms or engaging with available services. Increased screening, including evaluating MH problems among youth with school attendance problems, coupled with efforts to increase readiness of school staff to respond to MH needs, build relationships, and reduce stigma may support early detection and treatment of underserved youth with MH problems.

Acknowledgments

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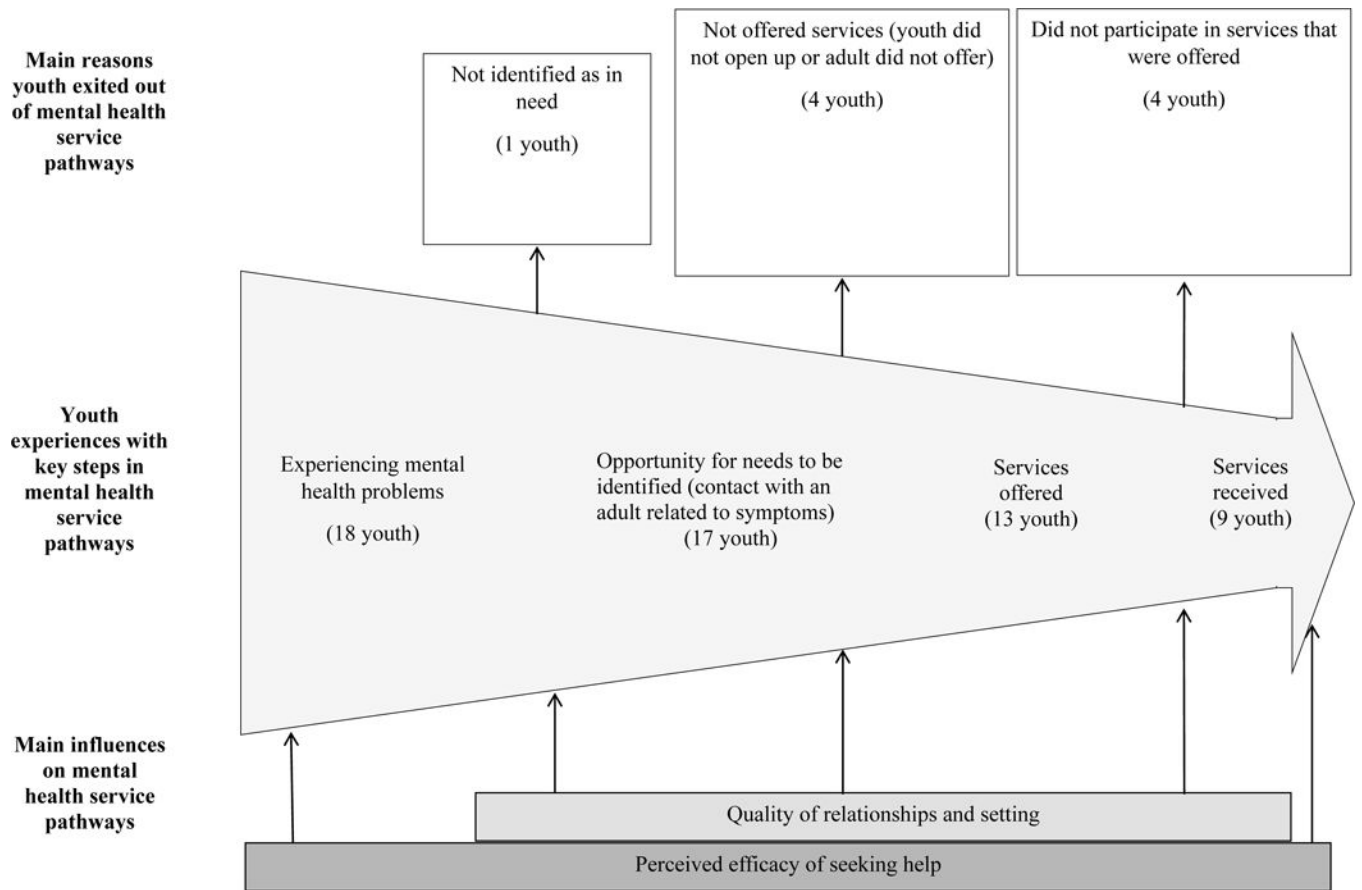
Figure 1.
Youth Experiences with and Factors Influencing School and Non-school Mental Health Service Pathways

Table 1

Youth Descriptions and Manifestations of Mental Health Problems, Los Angeles County, 2013[1]

Category	Youth Descriptions of Symptoms	Associated Behavior[2]	Illustrative Quote	Number of Participants[3]
Anxiety/Depression	'Having problems' 'Just not able to deal with it' 'Going through a depression' 'Stressed' 'Everything is too much' 'Just didn't care at that moment'	Missing school • Due to feeling overwhelmed by emotions • Due to apathy	*…it's too much for me because, one of my illnesses is anxiety. I have panic attacks, so when I'm put into too much pressure, I can't handle it, and I can't be put in a classroom where I know the teacher dislikes me and I can't handle being in that type of environment. So to me it's too much, so I like can't be in class (#27).* *…you don't want to get out the bed. You don't want to get out of the house so, I would just stay home and not go out. That was me for a week straight. And then I would go [to school], and be like I'm not really doing anything here so I would just stay home for another week. And that's how it was once in a while (#11).*	14
Delinquent Behavior	'Hanging with the wrong crowd' 'Being in a clique/crew' 'Being a follower' 'Chilling' 'Partying'	Gang involvement Alcohol and substance use Missing school • to use drugs or hang out with delinquent peers	*When I got to 8th grade, I would skip class to skate and go have fun. I would hop on a metro and, like, just by myself…but, when I was in school, I would cut class just to go smoke or something, and then come back and be all loaded and retarded. Yeah, that was when I was in 8th grade. When I was in 8th grade, I was hanging out with the bad people…really bad people. It wasn't with skaters no more…it was just people in gangs, you know, crews (#32).*	12
Physical/Verbal Aggression	'Bad attitude' 'Getting in fights for no reason' 'Holding grudges, not letting things go' 'People irritate me' 'I wake up mad' 'Bipolar' 'Anger issues'	Physical fights Yelling, arguing Arrest and Probation Missing school • To avoid specific conflicts • To avoid general (potential) conflicts	*I would get mad for the weirdest things ever, like I would see a kid on the side, making a sound with his mouth and I'd be like 'hey can you shut the fuck up?' and you know the kid if he don't shut up then I'm gonna' fight, it's crazy man, I had issues. I would fight literally like every day, you could ask anybody, like I'm bipolar and anger seems to be a way…like, the one that got the biggest fraction of all of them (#1). Sometimes in fifth period, it's really stressful, so I always end up going to my sixth period bad. So instead of snapping, ever since [a previous physical fight], I always stay outside for a while and sometimes it takes me the whole day to calm*	11

Category	Youth Descriptions of Symptoms	Associated Behavior[2]	Illustrative Quote	Number of Participants[3]
			down so I don't go to class for my last period (#30).	
Somatic Complaints	'Having a sickness' 'Vomiting' 'Trouble sleeping'	Missing school due to perceived or actual physical symptoms	*…right now I'm drinking sleeping pills because I can't sleep. But the doctor told me the sleeping pills should work, but I've been drinking them… he told I'm just supposed to drink one, but if they don't work I'm supposed to be drinking two, but I drink two and I still be awake, you know, the whole night. And I be thinking, like, it's because of the stress that I be going through (#37).*	2
Self-harm	'Hurting myself' 'Wanted to die'	Harming self Verbal expressions of suicidal ideation	*When we broke up it just brought me down, like, to a point where I didn't want to live, like, I wanted to die and, you know, I didn't even want to go to school. In 11th grade that's where, um 11th, 12th, I just started falling apart (#13). When I was in 8th grade, I had so many problems, because I was getting punked on and I would skip class and I would, um, harm myself (#30).*	2

[1]No youth described or were coded as having recognizable symptoms of attention disorders.

[2]Associated behaviors were either described or clearly evident in youth narratives in relation to mental health problems.

[3]As most youth were coded into more than one category, totals do not add to 18.