UNIVERSITY OF CALIFORNIA SAN DIEGO

“Pain Turned Into Passion”:
A Case Study of a Student-Led, Districtwide Mental Health Advocacy Committee

A dissertation submitted in partial satisfaction of the requirements
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by

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The dissertation of Rebecca Levine is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

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ABSTRACT OF THE DISSERTATION

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Professor Amy Bintliff, Chair

To address the youth mental health crisis, youth must be engaged in improvement efforts. However, there is limited research on how youth come to participate in this work and what conditions enable and constrain their efforts. In this yearlong case study, I examined a high school student-led mental health advocacy committee situated in a large urban U.S. district. Interviews (N=31), documents, and field notes were analyzed using a five-cycle inductive and

deductive coding process, guided by social cognitive theory and the critical youth empowerment framework.

The first research question asked what shapes students' pathways into mental health advocacy. Findings reveal seven elements that form the preliminary Proximity-Based Model of Youth Mental Health Advocacy Development: a prosocial orientation, experience related to mental health concerns, empathic concern, disillusionment and frustration with inadequate systems, moral conviction and urgency, self-efficacy, and opportunity.

The second research question examined student advocates' perceptions of school-based mental health supports. Advocates recognized care among school staff while identifying gaps across tiers of support. They described universal initiatives as often surface-level and disconnected from student needs, and they identified various barriers to help-seeking, including overstretched counselors, stigma, and limited awareness of resources or how to navigate them.

The third research question investigated the conditions that enable and constrain student mental health advocacy within a school district. Strong peer relationships, youth-centered leadership, and strategic flexibility characterized the committee's work, and six external supporter roles were essential for converting advocates' goals into systems change. Yet findings reveal what happens when youth voice is valued by a district but not formally embedded in decision-making, highlighting the need for structures that position young people as partners in mental health solution-setting. By centering student advocates' perspectives, this dissertation contributes to scholarship on youth development, mental health promotion, and education systems change.

Chapter 1: Introduction

In recent years, youth mental health has been declining. According to the Youth Risk Behavior Survey (YRBS), a biennial nationally representative survey of U.S. high school students, in 2023, 40% of youth felt persistently sad or hopeless (up from 30% in 2013) and 20% seriously considered attempting suicide (up from 17% in 2013) (Centers for Disease Control and Prevention [CDC], 2023). Worsening adolescent mental health has also been documented by other nationwide surveys (Blanchflower et al., 2025; Rapaport & Silver, 2022) and in other countries including New Zealand (Sutcliffe et al., 2022), Canada (Wiens et al., 2020), and China (Wu et al., 2022). Public concern about youth mental health is also high. In a national survey conducted in 2024, 55% of parents and 35% of teenagers reported being extremely or very concerned about the mental health of teenagers today (Faverio et al., 2025).

As researchers around the world take note of alarming youth mental health trends, they seek potential causes to explain the decline. The COVID-19 pandemic undeniably had a profound impact on adolescent mental health. Isolation, disruption of education and routines, economic hardship, illness and death of loved ones, and uncertainty contributed to increased levels of stress, anxiety, and depression (Jones et al., 2021; Loades et al., 2020; Panchal et al., 2023). Yet the decline of adolescent mental health predates the pandemic; a negative trend emerged around 2010, about a decade before the onset of COVID-19 (Anderson et al., 2023). The reasons behind the decline of youth mental health in the U.S. are complex and multifaceted, but they include stressors related to the economic fall-out of the Great Recession (Hiilamo et al., 2021), widespread incarceration (Jones et al., 2022), highly publicized incidents of racial violence (Anderson et al., 2022), mass shootings (Cimolai et al., 2021), climate change (Ma et al., 2022a; Vercammen et al., 2025), and the opioid crisis (Winstanley & Stover, 2019).

Alongside these stressors are an intensifying academic achievement culture (Luthar & Kumar, 2018) and the pervasive influence of social media (Abi-Jaoude et al., 2020; Burgess, 2025). As these social, economic, health, and technological forces continue to strain youth mental health, scholars are calling for "urgent and coordinated responses" across systems and sectors (Cosma et al., 2025).

Adolescence: A Critical Developmental Stage for Mental Health

Adolescence, a period of substantial physical, emotional, and cognitive changes, is a critical time for mental health (Blakemore, 2019). The combination of rapid brain development, hormonal shifts, and social stressors creates conditions in which mental health issues may arise (National Institute of Mental Health, 2023); in fact, 75% of all lifetime mental health disorders are established by age 24 (Kessler et al., 2005). Mental health issues can, in turn, disrupt key developmental processes, potentially leading to challenges with learning (Halpern-Manners et al., 2016; Lönnqvist, 2010), social relationships (Connolly, 1989; Landazabal, 2006), and physical health (Nabi et al., 2008), while elevating risk for harmful behaviors (Hallfors et al., 2004; Katon et al., 2010; Lehrer et al., 2006) including suicide (CDC, 2024a).

Because adolescence is such a crucial stage for development, it is also a time of immense promise. The changes that occur at this stage open up a multitude of opportunities for growth, learning, and development (Steinberg, 2014). During adolescence, youth are exploring their identities, developing their own personal values, and establishing their beliefs and aspirations, forming the foundation for stability in their sense of self as adults (Kroger, 2006). They are building critical thinking and problem-solving through increased autonomy (Steinberg, 2005) and establishing social networks that act as an important source of belonging and support (Lerner & Steinberg, 2004). Many youth are also pursuing educational and career paths, exploring

interests and talents, and taking on more leadership roles in their families and communities (Hurrelmann & Quenzel, 2018). Meanwhile, youth are establishing habits and routines that can set them up for positive health and mental health outcomes throughout life (Barton et al., 2019; Sawyer et al., 2012). The research is clear that addressing mental health issues in adolescence and fostering positive youth development is crucial for the immediate well-being of young people and for their development into healthy adults.

Mental Health is an Equity Issue

Young people do not experience mental health challenges or developmental opportunities equally; they are shaped by varied and often inequitable circumstances. Key to understanding these disparities are social determinants of health (SDOH), defined as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, n.d., para. 1). Examples of SDOH include home and neighborhood safety; experiences of racism, homophobia, and discrimination; education quality; job opportunities and income; access to nutritious food and opportunities for physical activity; and pollution (Office of Disease Prevention and Health Promotion, n.d.). Systematic and institutionalized forces like structural racism, sexism, and heteronormativity contribute to differences in SDOH and sustain health and mental health inequities (World Health Organization, 2008).

Results from the YRBS (CDC, 2023) show that while youth mental health challenges are widespread, certain subgroups experience elevated mental health issues compared to their peers. Female students (53%) and LGBTQ+ students (65%), American Indian or Alaska Native students (45%), Hispanic students (42%), and multiracial students (41%) are more likely than

average (40%) to experience persistent feelings of sadness or hopelessness, for example. Youth from marginalized populations, and especially youth who experience intersectional marginalization (Crenshaw, 1991; Moradi & Grzanka, 2017), often navigate systemic injustices such as inequitable SDOH in addition to interpersonal discrimination, compounding barriers to well-being.

While progress toward establishing evidence-based mental health interventions has been promising, with many individuals with mental health issues recovering and flourishing (Insel, 2009), mental health services are not where they need to be to effectively serve all youth who need them. Only about 20% of children with a diagnosed mental health disorder receive treatment (CDC, 2024b). Significant disparities remain in treatment access and outcomes for youth of color, LGBTQ+ youth, and youth from low-income families (Bailey et al., 2017; Castro-Ramirez et al., 2021). Barriers include financial constraints (such as prohibitive costs of care, lack of insurance, or insufficient coverage for mental health services) (Castro-Ramirez et al., 2021; CDC, 2024b), resource availability (including scarcity of mental health professionals and limited availability of specialized services) (CDC, 2024b), mistrust of treatment providers (Castro-Ramirez et al., 2021), and a lack of providers with sufficient cultural competence to effectively serve youth of marginalized identities (Rice & Harris, 2021). Persistent mental health stigma in some communities also contributes to reduced use of available resources (Kosyluk et al., 2022).

Co-Developing Mental Health Solutions with Youth

Effective programs and policies aimed at promoting youth mental health can mitigate risks, reduce inequities, and lead to better long-term outcomes (Browne et al., 2004; Macklem et al., 2011). Indeed, youth mental health is currently receiving significant attention at local, state,

national, and global levels, with historic investments in the development and implementation of innovative solutions for prevention and intervention.

However, the population most directly impacted by the success or failure of youth mental health solutions—the youth themselves—have traditionally been left out of the program and policymaking processes altogether. This exclusion is often based on deficit-based assumptions about what it means to be an adolescent. As Watts and Flanagan (2007) argue, adults sometimes uncritically accept that youth are "immature, impulsive, self-centered, naïve, reckless, and silly," descriptions that rely on limiting and harmful stereotypes (p. 782). Relatedly, adults also invoke stereotypes of youth as civically disengaged or uninterested in public issues to justify making decisions on their behalf (Checkoway, 2011). Yet research on youth development and youth civic engagement highlights a multitude of assets, showing how young people are and can be critical resources and changemakers in their communities (Kim & Sherman, 2006; Lerner et al., 2002; Lerner et al., 2005). In fact, engaging youth in mental health solution-setting is of paramount importance for four reasons:

(1) **To protect their human rights**. All people, including youth, deserve to be involved in decisions directly affecting their lives. The Convention on the Rights of the Child (1989) states, "Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child" (art. 12). About a decade later, a statement produced by the Children's Forum and delivered at the United Nations Special Session on Children (2002) declared that children should be "actively involved in decision-making at all levels and in planning, implementing, monitoring and evaluating all matters affecting the rights of the child" (p. 9). Specifically related to healthcare, World Health

Organization members at the historic 1978 International Conference on Primary Health Care called for "maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary healthcare, making fullest use of local, national and other available resources" (World Health Organization, 1978, p. 4). Leading global institutions clearly demand that youth are actively involved in decisions that impact them, including in their health care.

(2) **To increase the relevance of the program or policy.** Second, as Checkoway (2011) succinctly posits, "Young people are experts on being young people, regardless of what others think" (p. 341). Incorporating youth voices can help ensure that mental health policy and practice aimed at improving the lives of youth is grounded in the perspectives and experiences of young people. This is especially relevant in a world that is changing quickly and dramatically. For example, the average U.S. Senator, who was 65 years old in 2025 (DeSilver, 2025), was already 32 years old when the first text message was ever sent in 1992, 44 years old when Facebook was launched in 2004, and 54 years old when the first video was uploaded to TikTok in 2014. Meanwhile, the average age at which children receive their first cell phone in the U.S. is between 11 and 12 years old (Statista, 2019).

In addition to becoming a more online, interconnected world, we are seeing groundbreaking advancements in areas such as artificial intelligence (Wang & Siau, 2019) and childhood health and medicine (Cheng et al., 2016), coupled with an increase in significant stressors such as climate events (National Geographic Society, 2023), rising inequality (World Bank, 2023), and disease, including a global pandemic. Clearly, the world that our young people inhabit is different from the world in which adults grew up, and today's mental health policy and practice must reflect the experiences of being a young person today.

(3) **To increase the impact of the program or policy.** Third, evidence from public health studies supports a process known as participatory design in intervention development and implementation. In other words, when the "users" of an intervention participate in its design, it can lead to particularly effective outcomes and decreased health disparities (Neuhauser, 2017). At its core, participatory design assumes that people have the right to help design the world in which they live, and it emphasizes democracy and empowerment through processes such as collaborative reflection, balancing power relations, and mutual learning, to design products and interventions that have lasting gains for participants (Hansen et al., 2019). By involving young people through participatory design, interventions designed for youth may be more engaging and more likely to be used, increasing the intervention's reach and impact (Hagen et al., 2012).

This holds true in both mental health and educational contexts. McGorry et al. (2022) identified youth participation and co-design as a universal success factor in integrated youth mental health services, noting that it increases trust and reduces stigma associated with help-seeking. Evidence from the fields of youth development and education similarly documents the positive effects of youth-led research and action (Mitra, 2018; Yonezawa & Jones, 2009). For example, through a process known as youth participatory action research (YPAR), youth conduct research on a social justice topic, analyze their findings, and take action aimed at improving their communities. YPAR has successfully "transform[ed] systems and issues closely connected to youth, such as educational injustice and health care access" (Lindquist-Grantz & Abraczinskas, 2018, p. 2). In a systematic review of YPAR for youth substance use prevention, Valdez et al. (2020) found that "youth participation in research and social action resulted in increased community awareness of substance use and related solutions," supporting "the premise of youth participation as an agent of community change" (p. 314). In the domain of suicide prevention,

Haddad et al. (2020) describe a YPAR initiative in which youth co-designed and facilitated research with over 200 peers, translating their findings on belonging, isolation, and stigma directly into prevention outreach. In schools, Yonezawa and Jones (2009) similarly demonstrate that involving students as co-researchers generates insights that inform critical school reform efforts. Across these bodies of evidence, we consistently find that youth involvement is a driver of impact.

(4) **To promote youth development.** Fourth, youth benefit from being heard, valued, and engaged, regardless of the outcomes of any specific program or policy. Research shows that when caring, competent adults scaffold youth advocacy and civic involvement, young people gain opportunities to build leadership, strengthen social and cognitive skills, develop a sense of agency, and experience positive academic and career-related outcomes (Akiva et al., 2014; Anyon et al., 2018; Michelsen, 2002; Mitra, 2004; 2018). Civic engagement programs may also yield mental health benefits, including reduced anxiety and sadness, increased resilience, and a stronger sense of empowerment and belonging (Oubiña López & Gómez Baya, 2025). In this sense, involving youth in matters that concern them benefits the youth themselves, even if the program or policy with which they are involved does not turn out to be effective more broadly in reaching its goals.

Any of these four points alone provide sufficient reasoning and evidence to include youth in mental health solution-setting. Combined, they make a compelling case that excluding youth in such efforts is a failure of our ethical obligations and undermines the effectiveness of our response. Encouragingly, in a departure from traditional processes that have excluded young people, involving youth has begun to take center stage across a number of initiatives. For example, the Children and Youth Behavioral Initiative, established in 2021 to reimagine the

systems that support youth and family mental health across California, is "centering efforts around children and youth voices, strengths, needs, priorities, and experiences" (Department of Healthcare Services, 2022, para. 3). Associated efforts include the establishment of the Youth Co-Lab, a youth committee that co-designed a three-year mental health campaign with the California Department of Public Health; an investment of $50 million to expand youth-driven programs and youth-led practices in 30 California counties; and $10 million to develop peer-to-peer high school support programs that would improve opportunities for youth to connect and heal with members of their own communities. Meanwhile, at the national level, a White House statement released in 2021 included "engaging youth in solution setting" under its recommendations for improving youth mental health and substance use prevention and treatment (The White House, 2021). With this in mind, they announced a partnership with MTV Entertainment Group for the first Mental Health Youth Action Forum in 2022, inviting youth leaders to a two-day White House event to take action to address the mental health crisis through storytelling and media. The forum, part of which was streamed live online, aimed to saturate social media feeds with the mental health campaigns created by the young advocates, with the goal of changing the conversation from awareness to action (White-Gibson, 2022). Some of these young advocates have since continued collaborating with both MTV and Active Minds, a nonprofit organization supporting mental health awareness and education, to launch national multi-media initiatives to address the youth mental health crisis (Paramount, 2023).

At the same time that systems are shifting to recognize and incorporate youth voice in policy and practice, we are also seeing a surge of young people who are passionate about and involved in mental health advocacy. The widespread impacts of COVID-19 accelerated more dialogue, awareness of mental health, and positive momentum for improving accessibility to

support and services (Nealon, 2021). Meanwhile, mental health organizations across the U.S., including Active Minds and Mental Health America, are increasingly offering programs that build young people's capacity to advocate for change at the school, community, and policy level. For example, Active Minds' Mental Health Advocacy Academy facilitates a leadership development academy that empowers BIPOC and LGBTQ+ high school students and prepares them for lifelong advocacy, grassroots organizing, and political engagement around mental health. Despite the skepticism some adults hold about young people's capacity, youth advocacy carries promise: adults tend to be moved by the sincerity of youth perspectives, and the enthusiasm and optimism of young individuals can be effective in driving change within communities (Linton et al., 2014).

Problem Statement

The growing youth movement toward advocacy and the increasing prioritization of youth voice in mental health solution-setting signal a promising shift. By supporting youth advocates and centering youth voices in partnership with adult leaders and practitioners, we will improve our capacity to develop innovative, relevant, and impactful solutions. However, the research lags far behind practice. For one, while research has documented models that explain related constructs such as sociopolitical development, critical consciousness, and positive youth development (Lerner et al., 2005; Nicholas et al., 2019; Tyler et al., 2020; Watts et al., 2011), no studies, to my knowledge, have analyzed how mental health advocacy develops over time. There is reason to believe that youth mental health advocacy development and the supports and barriers involved may be unique in nature, knowing that youth tend to advocate for issues that are personally close to them (Tyler et al., 2020); hence, youth mental health advocates may have mental health-related experiences that significantly shape their advocacy trajectories. With

deeper knowledge about youth mental health advocates and their journeys, we will increase our understanding of this underexplored developmental process, and adults will be better positioned to recognize, facilitate, and support youth advocacy initiatives.

Importantly, there is also limited knowledge of how youth mental health advocacy plays out in school systems, despite the fact that youth spend nearly 20% of their time in school, a time use category second only to sleeping (Hall & Nielsen, 2020). For example, we know little about how youth mental health advocates perceive the support available to them and their peers, or how they effectively work together to achieve their goals for improving that support. Additionally, while research on youth-led work such as YPAR has found positive effects of the work on the youth themselves and their communities, we still lack rigorous research on implementation processes, especially those in naturalistic rather than programmatic settings (Berg et al., 2009; Flicker, 2008; Ozer, 2017; Ozer & Douglas, 2013). It is also important to understand how school systems respond to youth advocacy efforts. While research documents positive outcomes when youth and adults partner together for school improvement, such as enhanced school climate (Petrokubi & Janssen, 2017), the field lacks real-world examples of how districts facilitate or resist youth mental health advocacy, an important gap given the intricacies and complexities of navigating institutional power in school contexts (Fielding, 2004a).

Purpose of Study and Research Questions

In this study, I use qualitative case study methods to examine CARE Well, or CARE for short, which stands for the pseudonym Committee for Awareness, Resources, and Emotional Wellness. CARE is a student-led mental health advocacy committee operating in a large urban school district. First, I explore what shapes the students' pathways into mental health advocacy,

tracing the personal histories and experiences that led them to this work. Second, I examine the perceptions of student mental health advocates regarding school-based mental health supports, centering their perspectives on the systems and services that directly impact them and their peers. Third, I investigate the conditions—specifically the internal dynamics of the committee itself, the partnerships between the committee and those who support them, and broader district structures and policies—that both enable and constrain CARE's efforts. I make the assumption that all of these processes are developing and occurring within contexts that are heavily influenced by issues of power, privilege, and inequitable access to resources and opportunities. To summarize, the three research questions guiding this dissertation are:

1. What shapes students' pathways into mental health advocacy?
2. What are the perceptions of student mental health advocates regarding school-based mental health supports?
3. What conditions enable and constrain student mental health advocacy within a public school district?

Key Terms

Advocacy: "A wide range of individual and collective expression or action on a cause, idea, or policy" (Reid, 2000, p. 1).

Committee for Awareness, Resources, and Emotional Wellness (CARE): The pseudonym used for the student-led mental health advocacy committee at the center of this dissertation.

Mental health: Emotional, psychological, and social well-being (Substance Abuse and Mental Health Services Administration [SAMHSA], 2024).

Student voice: "Opportunities to participate in and influence the educational decisions that shape students' lives and the lives of their peers" (Holquist et al., 2023, p. 704).

Youth: Individuals between the ages of 15 and 24, inclusive (United Nations, n.d.).

Dissertation Organization

This dissertation contains a total of five chapters. In this first chapter, I introduced background information relevant to the current state of youth mental health and the need to involve youth in solution-setting, and I outlined the problem statement, the purpose of the study and research questions, and the definitions of key terms. In chapter 2, I review relevant literature to situate this study in previous scholarship, and I present the two theoretical frameworks and the conceptual framework that guide this study. In chapter 3, I describe the methods used, including a description of the site and data collection and analysis procedures. In chapter 4, I present the findings for each of the three research questions. In chapter 5, I discuss the findings in the context of extant literature and share implications for research and practice.

Chapter 2: Literature, Theory, and Conceptual Framework

“Generation Z” (those born between 1997 and 2012), or “Gen Z” for short, has come of age in a time of increasing racism (FBI National Press Office, 2023), LGBTQ+ oppression (Peele, 2023), and climate crisis events (Ma et al., 2022a), all while navigating the COVID-19 pandemic. This socio-political-environmental climate, while certainly stressful for many young people (Aftab & Gruss, 2023), may also help explain why Gen Z has been described as the most progressive generation since the 1960s (Kaplan, 2020). Taking action in the face of injustice, young people have been leaders in national and international movements like Black Lives Matter, #MeToo, School Strike for Climate, and the Parkland March for Our Lives (Brownstein, 2020). Others have joined local movements or used their own platforms to advocate within their networks for causes they care about. In many cases, progress is not easy; across interpersonal, school, community, national, and international settings, youth are working together to navigate complex social, political, and bureaucratic barriers that are resistant to change.

In this chapter, I first define what I mean by “advocacy” and then discuss the research on its developmental foundations, motivating forces, and mediating contexts, setting the stage for RQ1. Then, I shift to a discussion of school-based mental health and share research on the promise and limits of school as a site for mental health support (RQ2). Next, I present an overview of the student voice literature, including how scholars conceptualize and critique student voice efforts and youth-adult partnerships, which is relevant for RQ3. I close with a description of the two theoretical frameworks and the conceptual framework that guide this study.

Youth Advocacy Defined

I refer to the youth in this study as "advocates" because it is the term that the committee members use to describe themselves. I conceptualize advocacy using the definition provided by Reid (2000): "Advocacy describes a wide range of individual and collective expression or action on a cause, idea, or policy" (p. 1). There are three types of advocacy: self-advocacy (advocating for one's own interests, desires, needs, and rights), individual advocacy (advocating on behalf of an individual person), and systems advocacy (advocating to change the policies, laws, or rules that impact people's lives) (Center for Excellence in Disabilities, n.d.). In this study, I use the term advocacy to represent systems advocacy, because CARE's mission involves changing the policies and practices that impact students' experiences within the school district. In particular, I examine mental health advocacy—efforts to change the policies, laws, or rules that impact people's mental health. I define mental health broadly to encompass emotional, psychological, and social well-being (SAMHSA, 2024), rather than limiting it to only the experiences of those living with a diagnosed mental health condition. This broader definition better reflects both the complex, multidimensional nature of mental health, as well as the scope of advocacy work that extends beyond diagnosis or treatment to include prevention and well-being.

Youth Advocacy Development

In this study, to answer RQ1, I investigate how a group of youth came to engage in mental health advocacy. This question builds on a limited empirical literature base. As Poteat et al. (2020) note, "empirical work on predictors of advocacy… or how [it] develops in naturally-occurring settings has lagged" (p. 2). While a number of frameworks outline characteristics and skills we want to cultivate in youth to support engagement and participation (e.g., the 5 C's of positive youth development, described later in the "context" section), few provide mechanistic explanations for how and why a young person comes to act on behalf of a cause they care about.

One exception is sociopolitical development theory (Watts et al., 1999, 2003), a developmental, stage-based account of how youth, particularly those from marginalized communities, come to recognize systemic inequity and move toward action. Sociopolitical development theory draws on Freire's (1970) concept of critical consciousness, which is the process by which people identify and name the structural forces impacting their lives, recognize injustices, and take active steps toward challenging and changing these conditions. The three components of critical consciousness are critical reflection (the ability to name and analyze the forces of inequality), critical motivation (the belief that one has the capacity to effect social change), and critical action (actual engagement intended to challenge oppressive forces) (Diemer et al., 2015; Freire, 1970; Watts & Hipolito-Delgado, 2015).

Building on Freire's foundation, Watts et al. (1999) developed sociopolitical development theory through their work with young Black men in an urban setting, as the researchers observed a violence prevention and community engagement program called the Young Warriors. In this context, Watts and colleagues noticed that youth's engagement with social issues developed over time in a recognizable pattern, as participants became more aware of the structural forces shaping their lives. From their observations, Watts et al. proposed that sociopolitical development occurs across five stages: acritical, adaptive, precritical, critical, and liberation. At the acritical stage, young people have little awareness of social inequality. As they move into the adaptive stage, they recognize inequity but they accept it as natural or inevitable. At the precritical stage, they begin to question their assumptions and feel a growing sense that things could or should be different. At the critical stage, young people develop a more sophisticated analysis of systemic forces such as racism, classism, and other forms of structural oppression. Finally, at the liberation stage, youth channel their critical awareness into action

aimed at challenging and transforming unjust systems. Throughout this progression, sociopolitical efficacy—the belief that one can, in fact, influence the social and political systems governing one's life—is cultivated through experience, in settings that are affirming of youth's capacity (Watts et al., 1999). Research shows that sociopolitical development is associated with a range of positive outcomes for youth, including greater civic engagement and political participation (Diemer & Li, 2011) and stronger ethnic-racial identity, sense of purpose, and self-esteem (Watts & Hipolito-Delgado, 2015).

More recent scholarship addresses a limitation of sociopolitical development frameworks: that they have largely been developed by adult researchers, without youth input. Using YPAR, Malorni et al. (2024) engaged a group of racially and gender marginalized youth organizers in constructing their own conceptualization of SPD. The resulting framework affirms core elements of critical consciousness and critical action, while adding important emotional and relational dimensions that were previously underemphasized, including empathy, humility, self-love, boundary-setting, and building strong relationships across communities.

Sociopolitical development theory is relevant for this dissertation in its attention to self-efficacy, the recognition of systemic failures, and its more recent considerations of emotional and relational dimensions. However, it is presented here in the literature review rather than being used as a guiding theoretical framework for data collection and analysis because of the differences between the populations and contexts for which it was developed and the youth at the center of this dissertation. Sociopolitical development theory was created specifically in the context of racial and socioeconomic oppression, with that oppression catalyzing advocacy. While mental health is certainly impacted by structural forces, and while the stigma, discrimination, and neglect surrounding mental health is itself oppressive and marginalizing (National Academies of

Sciences, Engineering, and Medicine, 2016), the pathways through which young people come to advocate for mental health—and the youth themselves—may look different from those Watts and colleagues originally studied.

Youth Advocacy: Individual Factors

To further examine the research on why young people engage in advocacy, I move beyond developmental models to the more immediate individual factors and motivational forces underlying advocacy. A foundational insight that requires attention first is that, as early childhood research shows, humans are wired to help. Decades of research on prosocial behavior confirm that children exhibit natural prosocial behaviors from an early age. For example, Warneken and Tomasello (2009) found that infants and toddlers demonstrate empathy, altruism, and helping behaviors long before they develop advanced cognitive and language skills. In another study, the same researchers found that children as young as 18 months old spontaneously help adults with tasks, concluding that toddlers are innately predisposed for prosociality (Warneken & Tomasello, 2006). Eisenberg and Fabes (1998) emphasize that while children have a natural inclination toward prosocial behavior, their environment plays a crucial role in nurturing or restricting these behaviors. Through socialization, empathy can deepen over the course of development and become increasingly connected to motivation for prosocial action (Eisenberg & Fabes, 1998; Hoffman, 2000).

Beyond the early childhood literature, research on civic and political engagement yields additional insights into the individual factors associated with youth advocacy. Civic engagement is a term that encompasses political activities as well as nonpolitical commitments and contributions to the community, including volunteering and advocacy (Wray-Lake, 2019). Political engagement, a subset of civic engagement, refers more specifically to the actions aimed

at influencing the individuals and institutions that make decisions on societal matters (Ekman & Amnå, 2012). Examples of individual factors influencing civic and political engagement include level of interest in politics, efficacy, ideologies, values, and identity. Interestingly, in a longitudinal study of Swedish youth, Russo and Stattin (2017) found that political interest did not stabilize until about 20 years of age, which speaks to the importance of adolescence as a critical developmental stage for fostering this type of engagement. Other research has found that not only individual identity and personality styles, but also collective identity, influence engagement; in other words, youth can be influenced to act through collective identification and connectedness with a group (Klandermans, 2014, 2015; Simon, 2011; Simon & Klandermans, 2001).

Research on motivating factors offers a more detailed look at what youth choose to act on, or in other cases, why they choose not to act. Tyler et al. (2020) interviewed 50 high school seniors in California to understand what motivates youth to engage in critical action, identifying four themes. The first is that youth care about sociopolitical inequalities that they feel connected to, such as if they personally experienced various types of oppression or had friends or family members who did, or if there was an inequality they observed that violated their values or beliefs. The second theme is that youth critically act within various aspects of their developmental system, including self-oriented, interpersonal, community-oriented, and structural systems. Self-oriented action refers to efforts focused on one's own growth or learning; interpersonal action involves engaging one's immediate social circle; community-oriented action encompasses efforts like organizing events or raising awareness within one's school or neighborhood; and structural action targets policies, laws, and institutions. Third, choosing action is dynamic and contextualized, dependent on factors like knowledge of an issue (or lack

thereof); access to perceived support from friends or family; finding the right "fit" between an action and one's personality, interests, or goals; and assessment of barriers. Tyler et al. also differentiated between negative attractors, such as dissatisfaction with unfairness and injustice, and positive attractors, such as the desire to improve others' lives and the emotional rewards of catharsis, enjoyment, and solidarity.

Similar motivational factors were identified in studies of youth advocacy around specific causes, such as Black Lives Matter or LGBTQ+ rights. In a study of undergraduate students who had engaged in some form of action to support Black Lives Matter, researchers identified four reasons why youth acted (Vierra et al., 2023). Similar to Tyler et al. (2020), they found that youth engaged in action that related to their own identity or that of someone they are close to. Political efficacy, or believing that they could make a positive impact in the political sphere, was also cited by participants as a motivating factor. The final two motivations were interpersonal, such as opposing individual racist interactions or advocating for equal treatment, and structural, with the goal of changing the systemic conditions that produce racial inequality. A study by Montagno et al. (2021) of LGBTQ+ youth activists adds that youth can also be motivated to act in order to improve one's own situation and to build community with like-minded individuals.

As seen in the Tyler et al., Vierra et al., and Montagno et al. studies, youth advocacy is influenced by internal or intrapersonal factors, like knowledge of an issue or identifying with the cause, as well as external or interpersonal factors, like perceptions of barriers and level of support from others. At the same time, researchers have identified various reasons why youth choose not to be involved in advocacy, including believing that they don't have the time, skills, or know where to begin (Galer-Unti et al., 2004) or that they lack the confidence in their ability to participate (Carver et al., 2003). In the Vierra et al. (2023) study of undergraduates during the

Black Lives Matter movement, some participants chose not to participate in a protest because of feeling unsafe, anxiety about protesting, or a dislike of getting political. Youth in the study by Montagno et al. (2021) also cited concerns about others' disapproval and disagreeing with the practices or attitudes of some groups as barriers to advocacy. Understanding the personal reasons that attract or prevent advocacy is key for understanding youth advocacy development, sustainability, and needed supports.

Youth Advocacy: Conditions

The environment surrounding a young person fosters and constrains advocacy development in various ways. Structural conditions such as poverty, unemployment, violence, and attending an under-resourced school can impede civic participation by adding stress and narrowing opportunities (Balsano, 2005; Brooks-Gunn et al., 1997; Montagno et al., 2021). And even for youth who find their way to advocacy, sustaining that advocacy comes with its own challenges. Burnout is commonly experienced due to the emotional burden of engagement with issues of injustice, resistance and slow or uneven progress, and lack of adequate organizational support or resources (Gorski & Chen, 2015). Given the limited empirical literature on the specific contexts that foster youth "advocacy," the next section examines research on settings that nurture three closely related dimensions: positive youth development, critical consciousness, and civic and political engagement.

Conditions that Promote Positive Youth Development

One relevant body of research is positive youth development (PYD) (Lerner et al., 2002; Lerner, 2004; Lerner et al., 2005). PYD, from a theoretical standpoint, is a strengths-based approach to adolescence that recognizes the inherent assets and potential of young people. The theory rests on the premise that all youth have the potential to flourish and contribute positively

to their communities. PYD emerged in part as a response to deficit-oriented models of adolescence that focused primarily on preventing or remediating problems.

In addition to its value for theory-building, PYD has also been used as a framework to design and evaluate a wide range of youth programs, emphasizing the need to provide youth with the right opportunities, resources, and supportive contexts to promote the "5 Cs": competence, confidence, connection, character, and caring (Lerner et al., 2005). When these five Cs are well-developed, a sixth C emerges: contribution to family, community, and society (Lerner et al., 2005). Within the PYD framework, contribution is a key indicator of youth thriving, helping to explain why civic and advocacy-oriented engagement is often understood as both an outcome and expression of positive development.

Effective PYD programs tend to share three features: sustained positive relationships between youth and adults, activities that build life skills, and opportunities for youth participation and leadership in family, school, and community contexts (Lerner, 2004). Eccles and Gootman (2002) likewise describe positive developmental settings as those that provide physical and psychological safety; appropriate structure; supportive relationships; opportunities to belong; positive social norms; support for efficacy and mattering; opportunities for skill building; and integration of family, school, and community efforts. These perspectives suggest that advocacy, an expression of PYD, can take hold when young people are supported by adults and given chances to build skills and contribute meaningfully to their communities.

Conditions that Promote Critical Consciousness

In a review of 67 studies on critical consciousness in children and adolescents, three major themes emerged: the role of socialization experiences, the role of relationships, and the importance of context (Heberle et al., 2020). Socialization refers to the messages and modeling

that parents, peers, and schools provide, such as through discussions of racism and injustice and encouragement of social action (Diemer & Li, 2011). Relationships refer to the quality of connections between youth and the peers and adults around them. Trusting, warm, and supportive relationships create the conditions in which socialization messages are received and internalized. Context refers to the broader settings in which youth are embedded—most notably, according to this review, school climate. Across multiple studies, school environments that fostered open dialogue about controversial social issues were associated with greater critical reflection and critical motivation in youth (Heberle et al., 2020). Community engagement contexts also mattered, with participation in afterschool programs and community organizations linked to increased critical action. Indeed, Pinedo and Kruger (2025) found that youth with more access to opportunity structures, such as community organizing events and public forums for political participation, were substantially more likely to engage in critical action. These dimensions of socialization, relationships, and context help youth connect their lived experiences with systemic issues of inequality (critical reflection); and positive experiences within these social contexts foster feelings of self-efficacy that then inspire and sustain critical action (Diemer & Li, 2011).

Conditions that Promote Civic and Political Engagement

In another review, Chryssochoou and Barrett (2017) identified contextual factors that impact civic and political engagement, differentiating between micro-level factors (such as the various ways that family, schools, peers, and the surrounding neighborhood politically socialize young people) and macro-level factors (including political-cultural, economic, legal, and institutional conditions). At the micro-level, family values, parents' level of political socialization, and parents' moral commitment to social change all impact youth civic and

political engagement (Diemer, 2012; Rabaglietti et al., 2012), and in the classroom, having guided and honest discussions about controversial political issues plays an important role (Schulz et al., 2010). Indeed, the support of people important to a young person may matter more than political knowledge, racial or ethnic background, or age in predicting civic commitment and action (Diemer & Li, 2011).

For macro-level factors, research finds that patterns of youth participation in a given country tend to mirror the larger participatory culture among adults in that country (Sloam, 2016). Additionally, youth participation tends to be higher in countries that score well on indices of economic performance, quality of education, government accountability, and human rights (Brunton-Smith & Barrett, 2015; Schulz et al., 2010). At the same time, young people's identity and social positions within their contexts interact with these macro-level forces. Sexism and patriarchal gender norms, for instance, affect opportunities for and behavior related to political engagement across a number of countries (Acharya et al., 2010; Attar-Schwartz & Ben-Arieh, 2012; Cicognani et al., 2012). Girls in India, for example, have fewer opportunities to become politically involved compared to boys (Acharya et al., 2010). A clear takeaway from this review is the importance of attending to the various facets of the ecological system, and how they interact with one another, in order to gain a comprehensive picture of development in context.

Issues in School-Based Mental Health

In the previous section, I summarized scholarship related to advocacy, sociopolitical development, critical consciousness, positive youth development, and civic and political engagement to situate RQ1—an investigation of what shapes youth mental health advocates' journeys. I now turn to the case context itself. The advocates in this study operate as a committee embedded within a school district, making the educational setting a defining feature of the case.

In this section, I outline the potential and promise of school-based mental health supports, as well as the structural constraints and challenges. This section lays the foundation for RQ2, which examines how youth advocates perceive the mental health landscape in their own school communities.

Given that most children and adolescents spend the majority of their waking hours in school, and that many mental health conditions first emerge during these years (Kessler et al., 2005), schools represent a critical site for mental health promotion and intervention. Indeed, research suggests that school-based mental health services can improve students' well-being (Macklem, 2011; Rones & Hoagwood, 2000) while eliminating or reducing barriers such as transportation issues, parental time constraints, and lack of insurance (Swick & Powers, 2018).

To organize mental health supports, many schools and districts have adopted Multi-Tiered Systems of Support (MTSS), a data-based prevention and intervention framework that structures support across three levels of need and intensity. Tier 1 supports are universal and preventative, reaching all students; Tier 2 supports target students at elevated risk through small group interventions; and Tier 3 supports are intensive, individualized services for students with the highest needs (Brown-Chidsey & Steege, 2010; Stoiber & Gettinger, 2016). MTSS relies on universal screening, evidence-based practices, progress monitoring, and team-based decision-making to determine which students need additional support and whether those supports are effective (Stoiber & Gettinger, 2016). The Individuals with Disabilities Education Act (IDEA) supports this framework, with its 2004 reauthorization formally sanctioning tiered intervention approaches. The sections that follow focus on two types of mental health support most relevant to this case: mental health education, as an example of a Tier 1 intervention, and individualized services at the Tier 3 level.

Mental Health Education

Mental health education involves improving students' understanding of mental health definitions and concepts, explaining signs and symptoms, challenging misconceptions, teaching coping strategies, and providing information about resources and support. It aims to promote mental health awareness and equip individuals with the skills and resources to maintain and improve their mental health. Incorporating mental health education in schools, whether as part of a health class curriculum or workshops, is important because adolescents have limited knowledge of mental health, including symptoms and signs of when to seek professional help (Coles et al., 2016). A systematic review of 24 studies involving more than 13,000 youth found that mental health literacy interventions consistently improved young people's knowledge of mental health conditions, risk factors, and pathways to support (Lee et al., 2026).

Mental health education programs can also decrease stigma (Ma et al., 2022b)—the negative attitudes, beliefs, and behaviors held towards mental health issues (Ahmedani, 2011). Stigma, which can stem from myths, inaccurate perceptions, and lack of information about mental health, begins to develop in childhood, continues to emerge in adolescence, and tends to solidify in adulthood (Hinshaw & Stier, 2008). Unfortunately, despite the apparent normalization of mental health conversations in recent years, research suggests that reductions in stigma have been limited and uneven, necessitating continued work around understanding how stigma is maintained and reduced (Pescosolido et al., 2021; Schomerus et al., 2022).

Manifesting as prejudice, discrimination, and exclusion, stigma can have profound effects on those who experience it (Corrigan & Watson, 2002). Stigma can make students hesitant to seek help for mental health issues due to fear of judgment or discrimination from peers, teachers, and family (Corrigan, 2004; Chandra & Minkovitz, 2007; McPhail et al., 2024; Prizeman et al.,

2023). Indeed, a systematic review of 54 studies found stigma to be the most commonly cited barrier to help-seeking for mental health problems among adolescents, identified across more than half of the studies reviewed (Aguirre Velasco et al., 2020). Rather than seeking support, students may instead engage in masking, or concealing, their mental health struggles in order to avoid stigma and maintain social acceptance (Prizeman et al., 2023). This can lead to untreated mental health conditions, which may worsen over time, while the experience of being stigmatized itself can lead to the internalization of prejudice and stereotypes, isolation, and increased feelings of anxiety and depression (Hartman et al., 2013; Prizeman et al., 2023).

School-based mental health education offers a promising avenue for addressing this challenge, with research indicating that interventions can reduce stigmatizing attitudes and beliefs, particularly when they incorporate contact-based approaches such as lived-experience narratives and culturally relevant content (Ma et al., 2022b; Lee et al., 2026). However, these gains tend to be stronger in the short term and may diminish over time, suggesting that sustained, ongoing mental health education, rather than one-time programs, is most likely to produce lasting change in how students perceive and respond to mental health (Ma et al., 2022b; Lee et al., 2026).

Despite these promising benefits of mental health education, many schools lack a structured mental health curriculum due to limited resources, competing academic priorities, and insufficient training for educators (Powers et al., 2020). The absence of comprehensive mental health education in schools remains a critical issue, contributing to unmet mental health needs (Fazel et al., 2014). Addressing this gap requires policy changes and a commitment to integrating mental health education into the standard K-12 curriculum, thereby ensuring that all students are equipped with the knowledge and skills to understand and maintain their mental health.

Individualized Mental Health Services

In high schools, individualized mental health services are typically delivered by a combination of school-based professionals, including school counselors, school psychologists, and school social workers. While all three groups can provide counseling services to students, their roles differ in their training and scope. Counselors typically address both academic and social-emotional needs, psychologists conduct assessments and evaluations, and social workers often serve as bridges between students and community-based resources (Agresta, 2004). In some districts, other licensed therapists or clinicians provide services directly in schools through partnerships with community mental health agencies, expanding the support available on-site (Roche & Strobach, 2019).

Within MTSS frameworks, individualized services represent Tier 3 support. They are reserved for students whose needs are not adequately met through universal (Tier 1) or small-group (Tier 2) services (Brown-Chidsey & Steege, 2010). At the Tier 3 level, services may include one-on-one counseling, crisis intervention, and formal accommodation plans, such as 504 plans, which provide disability-related accommodations to ensure equal access to school, or Individualized Education Programs, which provide special education services and supports for students who qualify under IDEA. For students with more complex clinical needs, school-based mental health professionals also play a coordinating role, facilitating referrals to outside providers and maintaining continuity between school and community-based care (Hoover & Bostic, 2021).

Despite the potential of school-based mental health services, schools frequently lack the capacity to meet students' needs (Fazel et al., 2014). Over half of public schools report insufficient mental health professional coverage to manage caseload, inadequate funding, and

inadequate access to licensed mental health professionals (National Center for Education Statistics, 2024). Though the American School Counselor Association (ASCA) recommends a student-to-counselor ratio of 1:250, the national average was closer to 1:372 during the 2024-2025 school year (ASCA, 2025). Under such conditions, individualized attention is often reactive rather than proactive, with school-based professionals disproportionately focused on acute crises rather than sustained or preventative relationships (Reinke et al., 2011). Students may therefore go without consistent support (Harden & Slopen, 2022).

Access to mental health services is also often unevenly distributed, with schools in low-income and rural areas facing the greatest shortages of mental health professionals and resources (Gamm et al., 2003; Harden & Slopen, 2022). Even where services exist, sustainability is undermined by staff turnover, competing academic priorities, and limited institutional capacity (Shelemy et al., 2022). Meanwhile, teachers are increasingly called upon to identify students with mental health needs and connect them with care, yet research suggests most are not adequately trained to do so (Reinke et al., 2025). It is clear that we need to improve the capacity of schools and school systems to respond to student mental health needs, and youth advocates stand to play a crucial role in this process. Youth advocates are uniquely positioned to identify unmet needs and gaps in existing services, push for increased attention toward student mental health, and generate solutions that are grounded in the lived experiences of themselves and their peers.

Student Perceptions of School-Based Mental Health Services

A growing body of research has examined how students perceive school-based mental health supports. This work does not focus specifically on youth advocates, but it provides an important and relevant foundation for understanding the kinds of gaps and barriers that exist. For

one, research with students reveals a gap between the availability of support and its use. Goodwin et al. (2024) found that adolescents with no prior service experience were largely uncertain about how to access mental health support. This is supported by Gallant and Zhao (2011), who surveyed 701 high school students in a large urban district in the southeastern United States and found that while 93% of students knew that school counseling existed, only 60% were aware that personal, social, or emotional services were available, and fewer than half had ever visited the counseling office for that kind of support. Similarly, in a survey of 3,584 middle and high school students, Auger et al. (2019) found that although most students knew their counselor's name and office location, students were less willing to seek help from school counselors for social-emotional concerns than for academic or college and career concerns.

This gap between awareness and use appears to be related to how students perceive their counselors and understand their role. Bryan and Gallant (2012) drew on the same dataset as Gallant and Zhao (2011) to examine the perceptions of the 215 African American male students in the sample, finding that only about half of respondents rated their counselors as knowledgeable (54%), helpful (54%), friendly (49%), trustworthy (48%), or accessible (44%). Additionally, only about one-third agreed that school counselors were there to assist with personal, social, or emotional issues at all; and when asked who they would most likely turn to with such a concern, only 5% named the school counselor, with most preferring parents or relying on their own coping strategies. Bryan and Gallant (2012) connect this to cultural barriers and stigma specific to African American males, and they point to the importance of cultural competence in counselors, arguing that counselors who cannot communicate high expectations or build culturally responsive relationships are less likely to be trusted or sought out by this group of students. In focus groups with low-income racial and ethnic minority youth at school-

based health center sites, Ijadi-Maghsoodi et al. (2018) similarly found that students often turned first to teachers and peers, rather than mental health clinicians, and that trust, personal connection, and perceived understanding influenced help-seeking.

The importance of trusting relationships is reinforced in other studies. West et al. (1991), in their study of high school seniors, identified that the strongest reason for avoiding counseling, as endorsed by nearly 30% of seniors, was not wanting to share personal matters with a stranger. Other reasons were fear of confidentiality breaches (18%), embarrassment (16%), lack of time (16%), and the counselor being busy or unavailable (15%). Goodwin et al. (2024) underscored the importance of trust, finding that adolescents were worried that disclosures to counselors might not remain confidential, with information they share potentially circulating among peers. In the Auger et al. (2019) and Ijadi-Maghsoodi et al. (2018) studies, students identified similar barriers to school-based mental health services, including confidentiality concerns, stigma, fear of judgment, lack of rapport with providers, and a preference for handling problems themselves or turning to trusted peers, teachers, or family members. Relatedly, Ekornes (2020), studying upper secondary students in Norway, found that students consistently emphasized familiarity and visibility as essential to help-seeking.

In sum, these studies suggest that barriers to adolescent help-seeking are layered, including uncertainty about what services exist and how to access them, misperceptions about the counselors' role, and concerns about trust and confidentiality. While prior research has documented how students think and feel about services, it largely captures adolescents as recipients of services rather than as critical observers and participants in making change. Thus, less attention has been paid to how students organize around their concerns, what they identify as

the key problems, or what they propose as solutions. The next section draws on the student voice literature to explore what happens when students are engaged in improving their schools.

Student Voice

In this final section of the literature review, I examine student voice—a concept directly relevant to understanding the student-led committee at the center of this study. Student voice is the practice of actively involving students in shaping their education and the school environment (Cook-Sather, 2002; Fielding, 2004a; Mitra, 2008, 2009). This concept is grounded in the belief that students, as primary stakeholders in their own education, should have the opportunity to express their opinions and participate in the development of policies and practices that affect their learning and well-being. Through student voice efforts, educators gain insight into how students experience school and their ideas for improvement. They also learn how perspectives vary by demographic; factors such as race, gender, socioeconomic status, and disability profoundly influence how students navigate and perceive their educational environments (Holquist et al., 2023). The youth mental health advocacy committee in this study represents one form of student voice in action: young people actively seeking to improve the mental health policies and practices of their school district.

Approaches to Student Voice

Student voice opportunities vary greatly across many dimensions, including their structure and practices, level of involvement of adults, amount of power the students hold, and overall effectiveness for improving schools. At the most basic level, students might offer their opinions via surveys on topics related to school, providing educators with a snapshot of student perspectives (Mitra & Gross, 2009; Welton et al., 2017). One step further is when educators talk to students directly through interviews or focus groups, which can better capture the nuance and

depth of students' lived experiences compared to surveys (Mansfield, 2014). More substantive approaches to student voice involve young people collaborating with adults to make decisions that address school problems (Welton et al., 2021). Some schools have formal structures, such as student governance or councils, where student representatives solicit feedback from peers and advise educators (Brasof, 2015; Lyons & Brasof, 2020; Wyness, 2003). Offering diverse and accessible opportunities for student voice is important, as students vary in their comfort level with responding to surveys or speaking to administrators.

One area of applied scholarship is youth participatory action research (YPAR). YPAR is defined as "an approach to scientific inquiry and social change grounded in principles of equity that engages young people in identifying problems relevant to their own lives, conducting research to understand the problems, and advocating for changes based on research evidence" (Ozer, 2016, p. 189), and it has a robust evidence base in the development, education, and community psychology literature (McIntyre, 2000; Mirra et al., 2015; Noguera, 2009; Cammarota & Fine, 2008; Duncan-Andrade & Morrell, 2008). From both the YPAR literature and the youth organizing literature, it is clear that youth advocacy efforts can both promote adolescents' social emotional development and make a substantial impact on the world around them (Akiva et al., 2014; Anyon et al., 2018; Michelsen, 2002). Additionally, as Christens and Kirshner (2011) posit, possibly more important than the success of any initiative is the potential of youth to affect the culture of a system over time by altering local power relationships through insisting on youth inclusion in decision-making.

Youth-Adult Partnerships

Researchers interested in the dynamic between students and adults during collaborative decision-making processes have devised various models and frameworks to help conceptualize

power-sharing within youth-adult partnerships. Hart's (1992) foundational work with UNICEF visualizes youth participation as a ladder, spanning from manipulation and tokenism (examples of non-participation) towards the bottom of the ladder and child-initiated, shared decisions with adults (the gold standard) at the top rung. However, this model has been critiqued in light of newer findings in youth-adult partnership research because it undervalues the contributions that adults can offer to the partnership; less adult involvement may hinder, rather than encourage, youth empowerment and optimal development. To account for these findings, a model by Wong et al. (2010) looks like a pyramid, with shared control between youth and adults and the presence of youth active participation at the peak, representing the ideal dynamic.

Within school settings specifically, these partnership dynamics take varied forms. Holquist (2019) simplifies school-based youth-adult partnerships into four types, explaining that the model chosen should depend on the goals and purposes of the collaborative project. The first model is adult-run with active solicitation and incorporation of student feedback and input (e.g., a teacher soliciting feedback on a lesson). The second model is adult-run with adults organizing and leading the activities but sharing decision-making power with students (e.g., having a student representative on a school board). The third model is student-run with students organizing and leading activities, followed by adult approval of the students' decision (e.g., a student advisory group is tasked with making decisions that then need to be approved by an adult). Finally, the fourth model is student-run with limited influence from adults (e.g., a student club charged with completing a task with support of a teacher in an advisory role).

More recently, Holquist et al. (2025) expanded on this work through the Authentic Youth Engagement in Policy Framework. The researchers organize youth involvement into three roles: speaking, co-designing, and designing. Youth often begin in speaking roles and, with scaffolding

and intentional shifts in leadership from adults to youth, move into co-design and design roles over time. The framework also identifies key organizational strategies that support this progression, including creating safe spaces for youth and adults to share, debrief, and build trust; maintaining transparent communication; and ensuring flexibility so that youth can participate in ways that align with their availability and interests.

Barriers and Constraints to Student Voice

Despite evidence demonstrating how student voice can bring unique and impactful contributions to education (Active Minds, 2017; Halliday et al., 2019; Mager & Nowak, 2012; Welton et al., 2021), students generally have few opportunities to participate meaningfully in decision-making. Youth from marginalized groups, including students of color, LGBTQ+ students, students from immigrant communities, and students receiving special education services, traditionally have even less power than their more resourced or privileged peers, as schools reflect and reproduce broader social hierarchies (Bertrand, 2014; Fine, 2008).

Additional barriers and constraints include structural, cultural, logistical, and practical challenges. The traditional American school system is hierarchical in nature; decisions are primarily made by administrators and teachers, and students have limited or no opportunities to participate in decision-making processes (Fielding, 2004a). Educators and administrators may be resistant to shift power dynamics to give students more influence, fearing a loss of authority (Mitra, 2009) or believing that students lack sufficient maturity, experience, or knowledge to contribute (Robinson & Taylor, 2007). Additionally, incorporating student voice requires time for planning, facilitating discussions, and integrating feedback into decision-making processes. This can be challenging within the confines of a system dominated by rigid curriculum requirements, standardized testing, and the overarching prioritization of academic achievement

(Cook-Sather, 2002; Flutter, 2007). Without strong support from school leadership, initiatives to incorporate student voices can fail to take hold, as leaders must support the allocation of the time and resources necessary for effective implementation among competing priorities (Cook-Sather, 2006).

Critiques of Student Voice Efforts

The field of student voice has been subject to valid critiques (Cook-Sather, 2006; 2007; Jones & Hall, 2021). One criticism is that there is no such thing as one "student voice," even though it is sometimes conceptualized as such—students, and therefore their voices, are not a single, monolithic entity (Cook-Sather, 2006). Efforts should be made to attend to diverse representation of voices, and to avoid collapsing important differences in students' perceptions into a singular narrative. Another issue is tokenism: the superficial inclusion of young people in decision-making processes. When students are tokenized, their input is solicited but not valued or considered (Jones & Hall, 2021). In some cases, this may be part of a deliberate effort to create the appearance of inclusiveness rather than genuine inclusiveness. Tokenistic practices invalidate the contributions of youth, erode trust, and reinforce power imbalances (Wong et al., 2010).

Related to tokenism is the problem of co-optation, whereby student voice initiatives are changed or filtered by adults in ways that purposefully align student feedback with pre-existing institutional agendas (Hipolito-Delgado, 2024). Additionally, even when student input is genuinely sought, selective amplification remains a concern, which is when the voices that are elevated belong to students with privilege, such as those with high levels of academic achievement or English proficiency, while marginalized students remain unheard (Rudduck & Fielding, 2006). Finally, participation in student voice efforts can place a disproportionate

burden of emotional and time labor on students without adequate institutional support or reciprocity. Scholars conclude that those seeking to incorporate student voice should take care to avoid these pitfalls and problematic practices.

Examples of Student Voice for Mental Health

The literature contains a handful of examples of students working with school leaders to create a positive impact on mental health practice and policy. At the college level, students in Active Minds clubs, a national organization that promotes mental health awareness and education, have achieved a number of successes over the past few years, including increasing funding for mental health services and staff on their campuses, adding crisis hotline numbers to student ID cards, adding information about mental health accommodations and services to course syllabi, and integrating mental health topics into first-year experiences and new student orientations (Active Minds, 2017). At times, this required students to work with university presidents and other groups on campus to make the needed changes. Also at the college level, a scoping review of student-led initiatives in the Philippines (Vergara & Taja-on, 2025) concluded that mental health and welfare programs are most effective when co-designed with students and grounded in their lived experiences, with practical suggestions including peer-led sessions, creative outlets such as storytelling, and culturally responsive counseling.

At the high school level, researchers in Australia investigated how student voices, via YPAR, were integrated in the development and implementation of well-being programs (Halliday et al., 2019). The study showed that YPAR helped the school better understand student needs, leading to more appropriate well-being education content and greater student buy-in. Participating in the research process also improved students' confidence and communication skills, and it heightened their sense of control over their school environment. Findings support

the notion that when students are actively involved in shaping mental health at school, they can make a positive impact.

However, despite these promising examples, genuine student involvement in school mental health practice and policy is the exception, not the norm. Carter (2025) argues that universal school-based mental health interventions remain limited in effectiveness in part because student involvement in their design is too often superficial or tokenistic. She calls for a shift toward genuinely co-designed programs, advocating for methods that empower students to inform the interventions that affect their well-being. Research is needed both to document cases of meaningful student involvement and to understand what gets in the way.

Theoretical and Conceptual Frameworks

The literature reviewed in this chapter situates this dissertation in three bodies of scholarship: youth advocacy development, school-based mental health, and student voice. They show both what is known about youth mental health advocacy and where gaps remain. I now turn to the theoretical and conceptual frameworks, which inform how I understand the case under investigation and provide the analytical lenses for this study.

For this dissertation, using two theoretical frameworks—social cognitive theory (SCT) and critical youth empowerment (CYE)—helps me examine both the developmental processes that drive youth mental health advocates, and the sociopolitical dynamics that impact their experiences within school district settings. Below, I introduce each theory, describe their core concepts, explain their relevance to the case, and show how the two frameworks complement one another for the purposes of this study. Then, I present the conceptual framework, which I created to visualize how the key concepts in this study fit together. The purpose of sharing my theoretical and conceptual frameworks is to make my thinking explicit, showing the lenses

through which I view the case and how the research questions relate to one another and to the broader context.

Theoretical Framework: Social Cognitive Theory

Social cognitive theory, developed by Albert Bandura (1977, 1986, 1997, 2002), was selected as a theoretical framework for this dissertation because it offers useful ideas that explain how behavior develops and changes over time through experience, observation, and social context. While not a stage-based developmental theory, SCT offers key mechanistic insights into how advocacy behavior may be learned and reinforced, and the theory has previously been applied in studies on health promotion and civic engagement (Bandura, 2004; Metzger & Smetana, 2010). At the foundation of SCT is the concept of *reciprocal determinism*: the idea that a person, their behavior, and their social environments are continuously influencing one another. Development, in this view, is the dynamic interplay between an individual and their external circumstances over time. This dynamic is at the heart of the present study; as youth engage with and respond to their environment via mental health advocacy, their environment, in turn, is changed by them.

Four additional constructs from SCT are relevant to this study. The first is *observational learning*, or modeling, which is the process by which individuals acquire new knowledge, values, and behaviors by observing others (Bandura, 1986). In my interviews, I ask youth mental health advocates to trace their paths toward advocacy, including how they first became aware of and interested in mental health, and who helped nurture that awareness and interest along the way. I consider evidence for how advocacy developed gradually through exposure to parents, teachers, or community figures who modeled care and service within their own cultural contexts.

SCT thus provides a framework for understanding advocacy as something learned and reinforced over time through repeated observation.

The second construct is self-efficacy, defined as an individual's belief in their own capacity to execute the actions required to produce a given outcome within a particular context (Bandura, 1997). Self-efficacy is one of the most frequently examined constructs in the related literature on youth civic and political engagement, sociopolitical development, and youth empowerment, where it is identified as a strong predictor of whether young people move from awareness of an issue to action (Diemer & Li, 2011; Watts et al., 1999; Jennings et al., 2006). In Bandura's landmark 1977 paper, he coins the term and identifies four primary sources of self-efficacy: mastery experiences (prior successes), vicarious experiences (observing others succeed in similar endeavors), social persuasion (encouragement from others), and physiological and affective states (how one interprets body reactions like heart rate or emotions). In the context of districtwide mental health advocacy, self-efficacy looks like whether a young person believes that they, as a student operating within a large institution, can actually make a difference. Understanding how youth develop this belief, and what or who contributes to it, is important for understanding how and why some youth move from concern about mental health to joining a committee committed to action. SCT and the four sources of self-efficacy can also help bring attention to the ways in which self-efficacy can be constrained. For example, youth who lack access to supportive adults or prior leadership experiences may be less likely to develop the belief that their actions can matter.

The third construct relevant to this study is Bandura's framework of *moral agency*, which helps explain both the capacity to refrain from harmful conduct and the drive to act humanely. According to Bandura, morality develops through social learning as one observes others and

receives feedback about one's actions. An important part of moral agency development is the role of *self-reactive mechanisms*, which are the methods that allow individuals to regulate their emotion and behavior. Regulation occurs through monitoring one's own behavior and its effects, and then comparing behavior against internalized personal standards or goals (Bandura, 1986, 1991, 2002). When the comparison between one's actions and standards produces a sense of wrongness or moral failure, the resulting discomfort can move a person to act. For youth mental health advocates, this framework can help explain how moral discomfort, the felt sense that something is wrong and that inaction is unacceptable, can translate into advocacy.

The fourth relevant dimension of SCT is its attention to the *social environment* as both a context for and a product of behavior. Because SCT understands development as occurring through continuous interaction between individuals and their environments, the theory attends to the relationships, structures, and opportunities that surround a young person. Bandura acknowledged that self-efficacy does not operate in a vacuum—social conditions can enable or constrain what individuals are able to do regardless of their beliefs about their own capacity (Bandura, 1997). While the social environment is considered in SCT, critics have raised concerns that the theory, as it is most often applied in the literature, focuses too much on the individual and too little on the environment (Bredo, 1994). This risks both obscuring how social structures play a role in determining what is possible, and placing the burden of change on individuals rather than on systems (Freire, 1970). For this reason, SCT alone is insufficient for understanding youth mental health advocacy. In other words, while SCT is useful because it helps to illuminate the internal and interpersonal dimensions of advocacy development and references the importance of the environmental context, the theory does not explicitly account for how power, privilege, and access affect development. Relatedly, as a developmental

framework, SCT is also insufficient to answer all the research questions in this dissertation, particularly the dynamics of power and resistance when considering youth advocacy in an institutional setting. For this, my second theory—critical youth empowerment—provides an essential complement.

Theoretical Framework: Critical Youth Empowerment

Critical youth empowerment (CYE), developed by Jennings and colleagues (2006), is a framework for understanding how young people develop the capacity to engage in sociopolitical change. It was developed through an analysis of four youth empowerment models—the Adolescent Empowerment Cycle (Chinman & Linney, 1998), the Youth Development and Empowerment model (Kim et al., 1998), the Transactional Partnering model (Cargo et al., 2003), and the Empowerment Education model (Wallerstein et al., 2005)—as well as findings from participatory research with community youth organizations. The result is an integrated framework that attends to both individual and contextual conditions for empowerment.

CYE proposes six interrelated dimensions of youth empowerment, which are relevant for this study (Jennings et al., 2006). The first is the importance of a *welcoming and safe environment*: a space in which youth feel valued, respected, and supported, and where they have the freedom to voice their opinions. Jennings et al. emphasize that this environment is co-created with youth, and adults must be willing to step back so that youth can be the principal actors.

The second is *meaningful participation and engagement*, which refers to opportunities for youth to engage in authentic, youth-determined activities through which they make a real contribution, develop skills and leadership capacities, and experience the challenges and rewards of driving change. Meaningful participation is not merely being present. It requires decision-

making authority and activities that "count as real" (Heath, 1994, cited in Jennings et al., 2006, p. 43).

The third dimension is *equitable power-sharing between youth and adults*, whereby there is a genuine sharing of decision-making authority. Jennings et al. are explicit that this is the most commonly unmet condition. Agencies and institutions often create youth councils or advisory boards that appear participatory, but adults retain control over the agenda and decisions. CYE refers to this tokenistic participation, also referenced in other literature (e.g., Hart, 1992; Fielding, 2004a), and distinguishes it from genuine power-sharing, which involves an actual transfer of decision-making responsibility as youth gain competence and confidence.

The fourth dimension is *engagement in critical reflection on interpersonal and sociopolitical processes*: the development of a critical understanding of the structures, values, and practices that underlie the issues at hand, and of one's own role within them. According to Jennings et al., programs tend to focus on activities without leaving time to analyze why those activities are necessary. Without this dimension, youth may become effective organizers but not critical citizens.

The fifth dimension is *participation in sociopolitical processes to effect change*. This is the behavioral dimension of empowerment, in which youth move from reflection to action, engaging institutions and working collectively toward structural change. This dimension emphasizes civic service as part of the empowerment process.

Finally, the sixth dimension is *integrated individual- and community-level empowerment*: the recognition that individual development and collective impact are interwoven and mutually enforce each other. Youth who contribute to community-level change learn and grow through

that contribution, and communities that foster the capacities of youth are similarly improved when youth participate.

Using the Two Frameworks Together

CYE and SCT operate at different levels of analysis, which makes them useful to use together in this case study. SCT offers more granular insights into how advocacy develops within individuals by explaining the specific processes through which beliefs, behaviors, and motivations are formed over time. CYE, meanwhile, attends primarily to the organizational and institutional conditions that promote or constrain youth advocacy behaviors.

For RQ1—How and why do youth become mental health advocates?—SCT is the primary lens. I explore how advocacy identities and values may be built through observational learning, how self-efficacy is cultivated through various sources, and how moral agency and affective responding connect emotional experience to motivation and action. CYE informs this dimension of RQ1 as well by keeping questions of power, privilege, and access in my analysis, as well as processes like critical reflection as youth come to understand the need for change.

For RQ2—What are the perceptions of student mental health advocates regarding school-based mental health supports?—both frameworks are relevant. SCT's concept of moral agency situates the fact that students have experienced the school-based mental health landscape firsthand, and they have developed moral standards and affective responses to their experiences. CYE's dimension of critical reflection attends to how participants' perceptions may result from a critical analysis of the systems they are seeking to change. CYE also helps to position youth perceptions as legitimate evidence about how school-based mental health systems are functioning.

For RQ3—What conditions enable and constrain student mental health advocacy within a public school district?—CYE is the primary lens. This third research question examines three levels: the committee itself, the external supporters and allies who engage with the committee's work, and the broader district environment. At each level, CYE helps shed light on what conditions enable youth advocacy to be effective, and what conditions limit it. Within the committee, CYE's dimensions of welcoming environment and meaningful participation among members offer tools for examining internal relational and organizational conditions. In relation to external supporters, CYE's attention to youth-adult power dynamics and equitable power-sharing provide the critical lens I use to analyze how power is distributed or lent to students. Finally, at the district level, CYE's emphasis on participation in sociopolitical processes directs attention to whether and how student voice is incorporated into mental health decision-making. I consider the extent to which youth are tokenized or meaningfully included, as well as what institutional features support or resist youth-driven change.

Conceptual Framework

The conceptual framework below (Figure 1) connects the three research questions in a nested structure. The broader environment, which includes the rising youth mental health crisis, mental health inequities, and the lasting impact of COVID-19, forms the context of the overarching problem. Within this context, individual young people develop into advocates (RQ1), share their lived experience as a form of knowledge (RQ2), and organize within their school district for change (RQ3).

The conceptual framework also shows how the research questions connect to one another. The advocates in RQ3 who are working to improve their school district are the same youth whose developmental pathways are traced in RQ1 and whose perceptions of school-based

mental health are investigated in RQ2. Lived experience is foundational to all three lines of inquiry, as it impacts who becomes an advocate, what advocates notice about existing supports, and what drives their commitment to change.

RQ3 then connects back to RQ1 and RQ2, because the reach and success of youth advocates' efforts depend, in part, on whether the institution takes their knowledge and experiences seriously. Within RQ3, this question of traction looks at three levels: within the committee itself (3a), where internal conditions shape advocacy goals and sustainability over time; between the committee and external partners (3b), whose support helps determine how far youth-driven agendas can reach; and across the district environment (3c), where institutional culture and structure ultimately determine who holds power to make change.

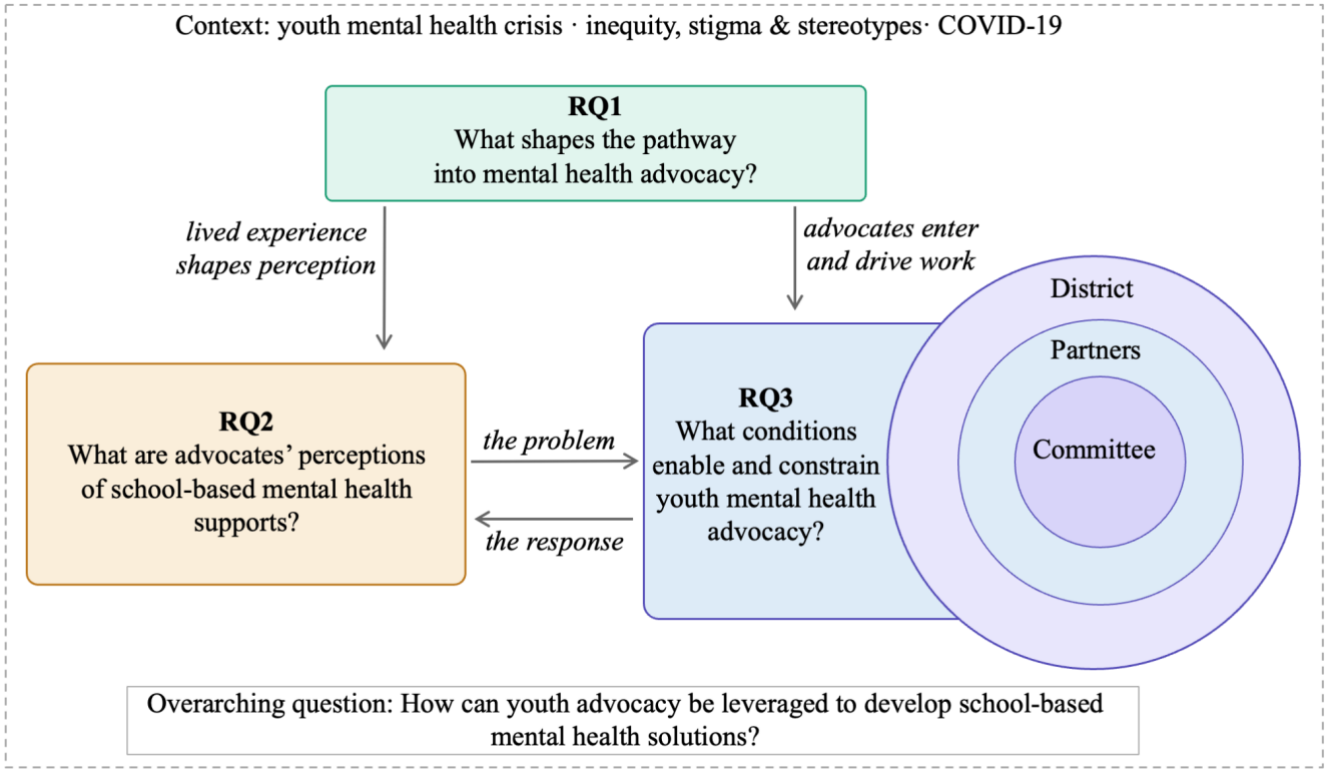

Figure 1: Conceptual Framework

Conclusion

The literature reviewed in this chapter establishes the empirical, theoretical, and conceptual foundations for this dissertation. Research on sociopolitical development, positive youth development, critical consciousness, and civic and political engagement, as well as research grounded in advocates' motivations and experiences, reveals the individual factors and environmental contexts that drive youth toward or away from advocacy. The school-based mental health literature showcases the importance of school as a site for mental health support while also highlighting the gaps and unmet student needs. Finally, the student voice literature reveals the importance and benefits, and also the barriers and challenges, of involving young people in the decisions that define their educational experiences.

These bodies of literature converge to show how youth, under the right conditions, have the potential to become agents of change to guide the needed improvement of mental health systems, and point to the need for research that examines how this looks in practice. I examine these processes using the theoretical and conceptual frameworks presented at the end of the chapter. SCT helps explain how young people come to understand themselves as capable of advocacy; CYE centers the conditions that make youth participation meaningful, supported, and potentially transformative; and the conceptual framework brings these ideas together into one cohesive case study. I build on this empirical and theoretical foundation in the next chapter, where I describe the methodological approach I used to examine the case.

Chapter 3: Methodology

This dissertation relies on case study methods to investigate youth mental health advocacy in a school district setting. Through an in-depth analysis of a single case, I answer three research questions:

1. What shapes students' pathways into student mental health advocacy?
2. What are the perceptions of student mental health advocates regarding school-based mental health supports?
3. What conditions enable and constrain student mental health advocacy within a public school district?

In this chapter, I first describe my positionality and how it informs my approach to this study. I then explain why I selected case study methods for this dissertation and provide details about the case itself and the data I collected. Finally, I outline how I analyzed the data through a five-step coding process, combining inductive and deductive strategies.

Positionality

I come to this work from experiences in both youth mental health and education. After college, I served for one year with City Year, an AmeriCorps program that helps students with academics, behavior, and attendance. As a corps member in a high school in Miami, I worked with students facing various stressors, including community violence and poverty, and I saw the promise of schools as a site for mental health support. However, in line with the research evidence on school-based services, the support available at the school was insufficient to meet the needs of the students. It was during this year that I decided to apply for and later obtain a Master of Social Work to learn how to provide direct clinical care to youth and their families, both in in-school and out of school settings. My social work training and experiences ground

how I approach this work, both as a social worker and now as a PhD student and emerging scholar.

One of the core tenets of social work ethics, as I learned in my master's program, is self-determination: "Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals" (National Association of Social Workers [NASW], 2021). I embodied this practice as a social worker through co-creating goals with clients and remembering that, while I had clinical training in mental health, my clients were the experts in their own lives and deserved the opportunity to design and pursue the life that they wanted to live. The tenet of self-determination continues to drive my work through my dissertation, but at a systems level as opposed to one-on-one clinical work, as I learn how to invite and incorporate youth voice in the mental health policies and practices that impact them.

Another key tenet of social work is honoring the dignity and worth of each person (NASW, 2021). Social workers must be mindful of how each individual is unique in the ways they understand and interact with the world, carrying different lenses and perspectives. This tenet relates to my constructivist approach as a researcher, which rests on the assumption that reality is socially constructed and that the researcher's goal is to "understand the multiple constructions of meaning and knowledge" (Mertens, 2019, p. 18). The constructivist paradigm is evident in my research design as a qualitative researcher who centers participants' subjective experiences, including their development, motivations, goals, and values. At the same time, constructivism reminds us that as researchers, we are not objective; our positionality and experiences inform how we approach and engage with all aspects of the research process.

A third tenet of social work is social justice (NASW, 2021). Social workers promote justice with and on behalf of their clients, striving to end all forms of oppression. This

commitment was central to my practice. In my clinical work, I primarily served individuals living in poverty, living with significant mental health issues, and/or facing discrimination due to other aspects of their identity. This social justice orientation aligns with the transformative research paradigm, which "places central importance on the lives and experiences of the diverse groups that, traditionally, have been marginalized" (Mertens, 2019, p. 21). My dissertation seeks to elevate issues related to justice and social change at the intersection of adolescence, mental health, and schools, and I hope it can be useful to those working to make educational systems more responsive, equitable, and supportive for young people, particularly those navigating mental health challenges.

My clinical background, grounded in the three tenets of self-determination, dignity, and social justice, and my experiences working within school systems, affect how I approach the case. For example, my social work training and values may make me more inclined to analyze school and district systems critically, while my experiences working in education may counterbalance that critical lens by keeping me attentive to the constraints and competing demands placed on schools and their staff. Additionally, my investment in demonstrating that youth-led mental health advocacy is valuable may lead me to over-identify with the youth participants, potentially being less likely to locate problems within the individual youth or the committee. Participants' awareness that I am supportive of youth-led mental health advocacy may also influence what they choose to share with me. As such, I must continuously interrogate and make evident the assumptions that I bring to this dissertation. Later in this chapter, I outline in more detail how I remained reflexive and attentive to how my positionality was showing up throughout this work.

Case Study Rationale

Case study methodology involves an in-depth investigation of a particular phenomenon within its specific context. For my study, I have chosen a single case study design to gain a holistic and robust understanding of a specific site and its operations (Merriam, 1998; Stake, 1995; Yin, 2018). There are three primary characteristics of case study methods that make this methodology suitable for the study at hand. First, case studies allow for researchers to develop a contextual understanding of the case in question (Yin, 2018). In the case of this districtwide committee, factors that have a profound influence on the committee itself include broader district practices, policies, and structures; societal attitudes toward and conversations about mental health; and national and international events that impact mental health, such as COVID-19. It is important for me to consider these factors, which are inseparable from the case itself, to be able to appropriately and accurately draw conclusions from an examination of CARE. Second, conducting a case study enables a rich and thorough exploration, as the methodology lends itself to combining various data sources including interviews, observations, and documents (Yin, 2018). Relying on multiple data sources helps me triangulate my findings and take multiple perspectives of the case into account, including those of current student advocates, CARE alumni, and supporters. Finally, case study methods are adaptable and have room for flexibility (Stake, 1995). The flexibility inherent in case study methods research enabled me to adapt and pivot as the case unfolded throughout the school year.

While case studies do not have to be solely qualitative in nature (Yin, 2018), qualitative methods are best suited to answer my research questions. Qualitative methods are ideal in social sciences research where depth, context, and complexity are essential to understanding the phenomenon (Creswell & Poth, 2018; Merriam, 1998; Stake, 2010). By using qualitative methods, I am able to investigate the context of the case, including processes and experiences;

capture diverse, in-depth perspectives; gather detailed descriptions and rich data; leave room for flexibility and adaptability; and humanize the data by focusing on personal and interpersonal experiences.

Site Overview

When selecting a case for a case study, researchers should aim to maximize what they can learn (Stake, 1995). This does not necessarily mean that one should choose a case that is typical or representative of other cases. The goal is not to study a case so that we can understand other cases—instead, "our first obligation is to understand this one case" (Stake, 1995, p. 4)—which can then help us understand something else: the phenomenon in question. This makes my research an instrumental case study because the case of the student committee is instrumental in generating more insight into student mental health advocacy (Stake, 1995).

For this study, I analyze the case of the Committee for Awareness, Resources, and Emotional Wellness (CARE). CARE is an ideal case for my research questions for a variety of reasons. Founded by students during the height of the COVID-19 pandemic, CARE is currently operated by 40+ student members representing high schools from across a large school district, united in a mission to promote mental health districtwide. In the years since its founding, the committee has been highly active and remains student-driven with the support of select district staff. Initiatives to date include drafting and passing school board resolutions to create and improve mental health policies, hosting panel discussions and social media campaigns, organizing marches, and facilitating collaborative events with partner organizations. As such, CARE is an information-rich case that provides ample opportunity to investigate my research questions. Studying a case that has experienced success is especially useful for generating hypotheses around what enabling conditions look like in practice.

The district that hosts CARE is located in a large urban city in the U.S. Each high school in the district is eligible to have representatives join CARE. While the demographics of the committee itself change from school year to school year as members join and leave, the larger district student body is racially, ethnically, and linguistically diverse. Across the district, a substantial proportion of students come from historically marginalized racial and ethnic communities, more than one quarter are classified as English learners, and over half qualify for free or reduced-price meals. CARE's location within a sizeable urban school district also makes it a valuable case to understand because of the complexities inherent in a large school transformation, which can help showcase the realities of systems change in youth-serving contexts.

Many school districts across the country are reporting elevated student mental health issues and challenges with meeting these needs, and the school district in which CARE is situated is no different. The district is experiencing increasing numbers of students needing mental health support and in crisis while struggling with too few counselors and nurses. District data show that chronic absenteeism rates have increased as well, a trend that is evident across the nation, which some attribute, at least in part, to a rise in student mental health issues.

The need for change in mental health policy or practice in the school district is evident. However, there are indications that district leaders and staff are taking mental health seriously by establishing mental health resource centers, offering mental health-focused professional development, generating districtwide wellness goals, and maintaining strategic partnerships with community-based clinical organizations in order to expand access to mental health services on school campuses. As such, the committee is situated within a context that may show some institutional readiness for the kinds of mental health changes the youth seek to advance.

Bounding the Case

In case study research, a primary consideration is how to define, or bound, the case (Yin, 2018). Bounding a case involves establishing the parameters or boundaries that limit the scope of the study to make it manageable and focused. This is crucial because it ensures that the case study remains coherent and that the research objectives are achievable within the constraints of time, resources, and available data. In this study, I bounded the case to the people directly involved in CARE's activities. This included the committee members themselves, committee alumni, and individuals who supported the students' work. I also bounded the case to committee-related activities and events, focusing on those that were led or organized by CARE over the course of one year. A one-year timeline (May 2025 to April 2026) enabled me to follow CARE over a period that reflected its organizational cycle. Because students joined in May and committed to CARE for one year, this time frame captured one full cycle of membership. It therefore provided an appropriate temporal boundary for understanding the committee' operations.

Ethical and Legal Considerations

As this research involved human subjects, various ethical and legal considerations were addressed. My goal was to ensure that the study not only met, but exceeded, the minimum standards required by research review boards by increasing safeguards and reducing risk for participants. As an early step in the research process, I sought and obtained approval from the district Research Proposal Review Panel, administered through the district's Research and Evaluation department, as well as from the UC San Diego Office of Institutional Review Board (IRB) Administration.

Close to half of the participants were minors under the age of 18, which placed them in a special category of individuals considered more vulnerable and for whom additional ethical and regulatory considerations were required. Accordingly, I obtained written assent from minors and written parent or guardian permission prior to initiating their participation in the study. For participants aged 18 or older, I obtained written consent. I ensured that all parties involved understood that participation was voluntary and could be ended at any time, for any reason. For anyone who did not wish to participate, I refrained from recording their names or any other identifying information during field observations, and I did not conduct an interview with them.

Additionally, due to the nature of my research questions and CARE itself, I reasonably assumed that some, if not all, participants had personal experiences with mental health or were close to others who did. Therefore, I put additional protections in place. First, I offered to send interview questions to participants in advance so that they could fully assent or consent to an interview and prepare for the questions if they were so inclined. I also prepared resources for any participants who identified needing additional mental health support for themselves or others. In the event that a participant shared current experiences or intentions of harm to self or others, I had an IRB-approved procedure in place to respond appropriately. However, no participants shared information that required further intervention to support mental health or safety. Finally, given the sensitive nature of mental health, I informed participants of the steps I would take to protect their confidentiality and to store their data as safely as possible.

Data Collection

This case study employs a qualitative research design to investigate a particular phenomenon in depth within its specific context, using semi-structured interviews, document analysis, and observations as the primary methods of data collection. Data collection began in

May 2025, following approval of the study by both the district research review board and the UC San Diego IRB. At that point, I attended a regular CARE meeting to present an overview of the study to the students. Parents and guardians of students were emailed a letter with details of the study and my contact information (see Appendix A). I also held two evening parent/guardian meetings via Zoom to discuss the study, their children's involvement, risks and benefits, and any questions or concerns. All data were collected between May 2025 and April 2026.

Semi-Structured Interviews

Semi-structured interviews were a primary data collection method for this study, chosen for their flexibility and depth. Interviews allowed me to explore the nuanced experiences and perspectives of participants while maintaining a structured approach to ensure the consistency and relevance of the data collected (Kvale, 2007; Merriam, 2009). Purposive sampling was used to select interviewees who had direct experience or substantial knowledge relevant to the research topic. This method ensured that participants could provide rich, detailed information pertinent to the study's objectives (Patton, 2015).

I interviewed participants from three groups: current committee members, committee alumni, and committee supporters. Current committee members were positioned to contribute valuable insights for all research questions. Committee alumni were interviewed to learn key information about the committee's founding and past initiatives, enabling me to trace committee functioning over time and learn about its history and past initiatives from those directly involved. Committee supporters, including district staff and community partners, shared experiences related to advising or collaborating with student mental health advocates.

Interviews were scheduled at a time convenient for the participants and conducted via Zoom. Each interview lasted approximately 45 to 60 minutes, allowing sufficient time to explore

the topics in depth while respecting participants' time. At the start of each interview, I reviewed basic information from the consent form with the participant, including the study's purpose, their rights as a participant, confidentiality, and compensation (one $25 gift card per interviewee, emailed at the conclusion of the interview). Then, I asked open-ended questions from the interview protocol, designed to elicit detailed responses. They included demographic questions followed by key prompts to ensure all relevant topics were covered while allowing flexibility for participants to discuss issues they found important (Rubin & Rubin, 2012). See Appendix B for the interview protocols. After each interview, I wrote a brief analytic memo documenting initial impressions and emerging ideas and questions.

Interviews with alumni and supporters were conducted between May 2025 and February 2026. For current committee members, many of whom joined CARE in May 2025, interviews were conducted between December 2025 and March 2026, allowing students at least several months of active participation in the committee before being interviewed.

Field Observations

I completed 27 total hours of field observations over the course of one year (May 2025 through April 2026), including 16 hours of CARE's regular, recurring Zoom meetings; seven hours of in-person events; and four hours of Zoom meetings with subsets of the committee and external partners for initiative brainstorming and event planning. I took field notes either on paper (for in-person observations) or on a secure Google doc (for Zoom observations) documenting the setting, topics and activities, and my reflections on emerging patterns relevant to the research questions. Field notes were taken during (when possible) and immediately following observations in order to capture both descriptive detail and initial analytic insights.

Written field notes were transcribed at home soon after the in-person events. They are cited in the findings as "Field Notes" followed by the month and year of the observation.

For this research study, my role was *observer as participant*, meaning that I participated in and supported CARE activities as desired by the group while remaining transparent about my roles and responsibilities as a researcher. The *observer as participant* role was ideal in this research context for three reasons. First and foremost, because the aims of CARE were related to health and equity, it felt unethical to observe without contributing to the cause in some manner. One example of this was helping connect youth advocates with a university-based contact who could serve as a resource for a partnership. Second, supporting the committee's activities functioned as a form of reciprocity, helping to make the research relationship-centered and mutually beneficial. Third, by taking on an *observer as participant* role, I was able to observe and interact more closely with participants, thereby gaining a more complete understanding of the case. Kawulich (2005) described the *observer as participant* role as an ethical approach to qualitative research, one in which the researcher's activities are transparent to the group being studied and data collection remains the primary focus.

Documents

I also collected and analyzed documents to help me understand the case more fully and examined it in relation to my research questions. Some documents, such as the committee constitution, mission statement, and committee history, are posted publicly on CARE's website. Through my work with the committee, I also gained access to additional documents that deepened my analysis of the case, such as meeting agendas and minutes, presentation slides, articles and publications featuring the committee's work, and board resolutions they wrote. These documents came to me in two ways: some were shared with me directly during committee

meetings or events, while others were emailed to me after interviews, when a participant referenced something they had worked on or wanted me to see and followed up afterward.

Documents were treated as qualitative data rather than as published sources. To preserve confidentiality, documents are cited in-text using general descriptors, such as "CARE Constitution," along with the month and/or year when appropriate. These documents provided important contextual information about the committee's history, structure, goals, and activities, and they also helped me situate and interpret what I observed in interviews and field observations. See Appendix C for a list of documents by type, content, and how they were accessed.

Data Storage

All data collected for this study were stored securely to protect participant confidentiality. I saved audio recordings, transcripts, field notes, and documents on a password-protected computer and stored them in the UC San Diego Google Drive, which requires two-step authentication for access. No individual other than myself had access to the raw data at any point during the study. To further protect participant confidentiality, I removed all identifying information from transcripts, including the names of the district and schools, and replaced participant names with pseudonyms. I maintained a separate document linking pseudonyms to participants' real names, stored separately from the remaining data to minimize the risk of identification.

Participant Recruitment

Initial recruitment for student interviews took place at a committee meeting in November 2025, after months of observing CARE meetings and events. At this point, I re-shared the overview of the study and collected the names and email addresses of interested students via a

brief secure survey. In February 2026, I asked committee co-chairs to send one final invitation to anyone interested in participating in an interview, in case students had missed the first invitation and to broaden the pool of potential participants. Keeping participation opportunities open and accessible supported my aim of interviewing a diverse group of students representing a range of identities, grade levels, and experiences.

For alumni and committee supporters, I used snowball or chain sampling. This strategy is commonly used to identify and recruit participants when the participants themselves are in a better position than the researcher to recommend data sources due to their positionality (Noy, 2008). For example, one entry point into this network was a committee supporter with whom I had a prior professional relationship; she introduced me to the founders of the committee, who then reached out to other alumni with study details and my contact information. Additionally, after each interview, I asked whether there was someone the participant would recommend for the study, recorded their information, and sent an email invitation.

Interview Participant Demographics

My interview sample consisted of 31 total participants: 17 current committee members, seven committee alumni, and seven committee supporters. A list of participant pseudonyms and ages can be found in Appendix D. Demographic data are summarized below, but they are not linked to participant pseudonyms in Appendix D (with the exception of participant age) in order to preserve anonymity.

Committee Members

Of the 17 committee members, eight identified as female (she/her) and five identified as male (he/him). The remaining four students identified as non-binary or gender non-conforming: two used they/them pronouns; two used she/they pronouns; and one used any pronouns. When

asked to describe their racial and ethnic background, twelve students identified broadly as Asian or Asian American (in their own words, five were Filipino/a or Filipino/a-American; four were Indian or Indian-American; one was Asian American; one was South Asian; and one was Chinese-Filipino), and five students identified as white. Their ages ranged from 15 to 18 years old (M = 16.29, SD = 0.92).

The 17 interviewed committee members represented 11 unique schools across the district. To better understand the schools my interviewees attended, I consider each participant's school-level high-need percentage, operationalized as the proportion of students included in the state's unduplicated pupil count. Because multiple participants attended the same school, some school-level values repeat. Participant-linked school high-need percentages ranged from 21.0% to 79.7% (M = 46.37%, SD = 21.83). For reference, the districtwide unduplicated pupil percentage was considerably higher than the average school represented by interviewees, indicating that the average school represented in the sample served a lower proportion of high-need students than the district overall. The exact districtwide percentage is masked to preserve anonymity.

Committee Alumni

All committee alumni were high school graduates who had been active members of the committee for at least one school year during their high school career. At the time of their interview with me, five were in college and two had recently graduated with their Bachelor's degrees, and they were living in geographically diverse places in the U.S. and internationally. Of the seven total alumni, five identified as female (she/her) and two identified as male (he/him). In terms of racial and ethnic background, two identified as white; one identified as half white, half Afro-Latino; one identified as half white, half Native Mexican-American; one identified as Vietnamese-American; one identified as Indian; and one identified as Filipino-American.

Alumni ranged in age from 19 years old to 22 years old (M = 20.71, SD = 1.11). As such, all alumni are considered "youth" along with the current CARE members, according to the United Nations definition (i.e., individuals between the ages of 15 and 24, inclusive).

Committee Supporters

The seven committee supporters were two youth, including one mental health advocate from another district and one student voice advocate; two community members; and three district staff. All five adult supporters had a clinical mental health or counseling background. Of the seven supporters, most were female (n = 6) and white (n = 5); one identified as male, one as Indian, and one as Filipina. Their ages ranged from 19 years old to 54 years old (M = 40.86, SD = 14.39).

Data Analysis

I used MAXQDA, a qualitative research software program, to organize and analyze my data. Interviews were recorded and transcribed by Zoom, then uploaded to MAXQDA for analysis. Field notes and documents were also uploaded and organized in MAXQDA as part of the case record.

I followed a five-cycle analytic process adapted from Bingham and Witkowsky's (2022) analysis of a qualitative case study of a personalized learning school. Although the cycles below describe the general flow of analysis, the process was not linear. As is common in case study research, I moved back and forth between data collection, memoing, and analysis, as there may be "no particular moment when analysis begins" (Stake, 1995, p. 71). Across the five cycles, I used both deductive and inductive strategies to develop a more complete and rigorous understanding of the case.

Cycle 1: Attribute Coding and Data Organization

The first step involved organizing the case record in MAXQDA. Each file was tagged and catalogued according to its source and relevant attributes. Interview transcripts were labeled by participant pseudonym, interview date, and participant group (member, alumnus, or supporter). Field notes were labeled by date and event type (committee meeting, planning meeting, or event). Documents were tagged by document type (meeting materials [e.g., presentation slides, meeting notes], student-written article or publication, news article, district governance documents [e.g., board resolutions], administrative committee documents [e.g., committee constitution, subcommittee tasks], or outreach materials). This cycle helped create a structured database of the case and allowed me to identify gaps or areas where additional data might be needed (Miles et al., 2014).

Throughout all cycles, I engaged in memoing to capture analytic insights, reflexive observations, and methodological decisions (Saldaña, 2016). This included tracking where my professional background and values may be influencing my interpretations, reflecting on moments of convergence and tension, and considering where emerging themes warranted alternative explanations. I regularly reviewed these memos, along with the memos recorded after each interview, as analysis progressed.

Cycle 2: Deductive Coding Aligned to Research Questions

In the second cycle, I reviewed all files in the database and sorted data into three categories aligned with the research questions: (1) elements that shaped the pathways into advocacy, (2) perceptions of school-based mental health supports, and (3) the conditions that enabled and constrained mental health advocacy. As I read and re-read the data, I further categorized number 3 into three levels: (3a) committee conditions, (3b) external support, and

(3c) the district environment. Cycle 2 helped narrow the analytic focus and identify the data most relevant to answering the research questions (Stake, 1995). This coding process also helped me refine initial impressions, which I documented in memos.

Cycle 3: Inductive Open Coding

In the third cycle, I used open coding to identify discrete units of meaning within the data and generate initial codes grounded in participants' words, experiences, and actions. This process allowed me to remain close to the data while staying open to ideas that were not predetermined. For example, within the broad categories established in Cycle 2, I developed codes related to (1) specific factors shaping students' pathways into advocacy, such as early life influences, experiences with mental health, emotional reactions, and cognitive processes; (2) perceptions of school-based mental health supports, such as issues related to access and stigma; and (3) conditions for systems-level advocacy, such as committee structures and processes, types of external support, and district attitudes, culture, and structures. I also coded contextual information that helped situate the case within its broader social, temporal, and cultural context, including the influences of COVID-19 and societal assumptions related to mental health.

Cycle 4: Pattern Coding and Theme Development

During Cycle 4, I reviewed the coded data to look for patterns across and within data sources. I used pattern coding (Saldaña, 2016) to group the initial codes from Cycle 3 into broader analytic concepts. I then identified themes by condensing these patterns into a smaller set of key ideas related to each research question. Memoing at this stage helped me track the analytic decisions I was making as I organized the emerging themes.

Throughout this cycle, I combined insights from multiple data sources in order to develop a more comprehensive understanding of the case. This process supported triangulation, a strategy

in qualitative research used to enhance the credibility and trustworthiness of findings by drawing on multiple sources of evidence (Merriam, 1998; Patton, 2015; Yin, 2018). To triangulate across sources, I looked for areas of convergence, where data from different sources aligned and strengthened the credibility of an interpretation, as well as areas of divergence, where discrepancies across sources pointed to different perspectives or prompted me to refine my interpretations. Memoing supported this process by helping me construct a coherent narrative that reflected the integrated findings across interviews, observations, and documents.

Beginning in Cycle 4 and continuing through Cycle 5, I also used memoing to critically examine the themes and consider rival explanations (Yin, 2018). Considering rival explanations, or alternative factors that might account for what I observed in the data, helped me remain attentive to complexity, reflect on how my positionality was interacting with the data, and avoid drawing conclusions that were not well-supported by the evidence.

Cycle 5: Theoretical Coding and Interpretation

In the final cycle of coding, I reread the data and applied codes aligned with concepts from my theoretical frameworks and relevant literature. Concepts drawn from social cognitive theory (Bandura, 1977, 1986, 1997, 2002) included self-efficacy and its sources; observational learning, including observing community-oriented family members and peers; and moral agency. Concepts drawn from critical youth empowerment (Jennings et al., 2006) included opportunity and access; youth-adult partnership dynamics; and the relational, organizational, and institutional conditions that enabled or constrained youth advocacy. This cycle involved both deductive and inductive analysis because, in addition to applying these *a priori* concepts, I also re-examined and reinterpreted the inductive findings in relation to theory and prior research. As I memoed, I asked questions such as: What do these findings mean in context? How are they related to the

existing literature? What can be learned from these findings? (Bingham & Witkowsky, 2022). Through this process, I identified how the findings exemplified, extended, or diverged from existing theory.

Table 1: Five-cycle data analysis process

Cycle	Name	Approach	Description	Examples of codes/themes
1	Attribute coding & data organization	Deductive	Organized all files in MAXQDA; tagged transcripts, field notes, and documents by source, participant group, date, and type.	Transcript labeled by participant group (member, alumnus, supporter); field notes tagged by event type; documents tagged by type
2	Deductive coding aligned to RQs	Deductive	Sorted all data into three broad RQ-aligned categories; subdivided RQ3 into committee conditions, external support, and district environment.	RQ1: pathways into advocacy; RQ2: perceptions of school-based mental health supports; RQ3a: committee conditions; RQ3b: external support; RQ3c: district environment
3	Inductive open coding	Inductive	Generated initial codes grounded in participants' own words, experiences, and actions within the RQ categories from Cycle 2.	Peer distress (RQ1); "band-aid solution" (RQ2); formal committee structure (RQ3a); workshopping together (RQ3b); district belief in the cause (RQ3c)
4	Pattern coding & theme development	Inductive	Grouped Cycle 3 codes into broader analytic concepts; identified themes across data sources; triangulated across interviews, field notes, and documents; considered rival explanations.	Experience with mental health concerns (RQ1); resources without a foundation (RQ2); anchored adaptability (RQ3a); the partner (RQ3b); student voice: belief and reality (RQ3c)
5	Theoretical coding & interpretation	Both	Applied concepts from SCT and CYE; re-examined inductive findings in relation to theory and prior literature	Self-efficacy and its sources (RQ1); relationships and community (RQ3a); the power-holder (RQ3b)

Note. Adapted from Bingham & Witkowsky (2022).

Conclusion

This chapter described the methodological approach used to examine CARE. I began by sharing my positionality and the professional and personal commitments that informed my approach to the study. I then explained the rationale for using qualitative case study methods, described the case and its boundaries, and outlined the data sources used to understand the committee's work, including interviews, field observations, and documents. Finally, I detailed the five-cycle coding process through which I organized, coded, interpreted, and triangulated the data. In the next chapter, I present the findings organized around the three research questions guiding this dissertation.

Chapter 4: Findings

This chapter presents the findings of this dissertation, organized by research question and then by theme. Quotes from interviews are attributed using participant pseudonyms, and I cite field notes and documents where appropriate.

RQ1: What Shapes Students' Pathways into Mental Health Advocacy?

When youth described their pathways into mental health advocacy, a pattern emerged. Their journeys were typically shaped by seven elements: a prosocial orientation, experience related to mental health concerns, empathic concern, disillusionment and frustration, moral conviction and urgency, self-efficacy, and opportunity. Not all elements were present in every case, but as they accumulated across a young person's development, they often converged to ignite action for improving student-serving mental health systems. These seven elements form the basis of a preliminary Proximity-Based Model of Youth Mental Health Advocacy Development, presented in Figure 2 and described toward the close of this section.

Prosocial Orientation

Student mental health advocates shared a prosocial orientation: a disposition toward or desire to care about others and to act in ways that benefit others. Youth described themselves as empaths, attuned to the feelings of those around them and compelled to help. As such, many were trusted individuals their peers often sought out for support. Nam stated simply, "I was just that friend, I guess, where people go to for advice." He identified this as a source of pride, explaining, "It's really nice just to be someone people naturally gravitate to and be established as a helper. . . Just someone people can go and talk about their mental health with." Grace emphasized the importance of care in mental health advocacy, asserting, "I've always said that

no student is in this work if they don't care. Having empathy and compassion is really important."

Several youth recalled how they had been community-oriented from a young age, and they shared how mental health advocacy served as a way to help them feel more connected to others and to a larger, prosocial purpose. For these youth, advocacy felt like a natural extension of who they already were. These values were rooted in family upbringing, cultural identity, religious tradition, and early lived experience. Grace, for example, connected her values to her cultural identity, noting, "Coming from a collectivistic culture, that love of community was very apparent to me early on. I love huge family gatherings where distant cousins all come together." For Maya, community service was a religious obligation. She described how a Hindu moral value called *sevā*, which she defined as "giving back to one's community," was instilled in her from a young age: "When I was three years old, my mom used to take me to the food bank. . . When I was five, I used to go with her and do volunteer work in my community at libraries, or homeless shelters. . . Whenever I went and volunteered, I felt just such a happiness within my soul." When she encountered mental health advocacy, she found it to be an expression of an internal drive she already felt: "I had always had this internal belief that I want to do something with my life where I can give back to my community. . . When I entered this world of mental health and realized there were so many other issues that people were facing, that really struck a chord in my heart."

Consistent with this prosocial orientation, some youth had previously been engaged in other advocacy work to improve their communities, including climate and racial justice. August observed that many of the most passionate committee members carried a strong concern for social justice, and that mental health advocacy, in this view, was continuous with a larger

commitment to equity and inclusion. However, he shared that "mental health is not usually the first thing that people fall into." Unlike more publicly visible causes, August explained, mental health tends to become a priority only once someone is older and better understands its weight and importance through experience.

Experience with Mental Health Concerns

For many youth, mental health advocacy was a response to lived experience. As Anika put it, "I think a lot of mental health advocacy is very, like, pain turned into passion-driven. . . It's a way for a lot of advocates to, like, channel what they've been through and make a change in the world." She reflected on her own path, noting that her mental health struggles, particularly during COVID and quarantine, became the foundation for her advocacy: "I kind of turned my pain into purpose." These experiences fell into two categories: personal mental health challenges and witnessing mental health challenges of peers.

Personal Mental Health Challenges

Youth shared with me personal stories of depression, anxiety, insomnia, academic pressure, family challenges, loneliness, disordered eating, and the general emotional weight of adolescence. For Grace, middle school was a period when "everything just felt really heavy. . . It felt like it was bigger than me, and I struggled to understand what I was feeling—how to communicate that to others." Some youth described adolescence as inherently overwhelming, a period often marked by change, increasingly complex interpersonal dynamics, and pressure to plan and prepare for adulthood.

Throughout interviews, this pressure was frequently cited as a source of stress that affected mental health. Youth described an academic environment characterized by competition, comparison, and a drive to take on more classes and more extracurriculars, all in service of

looming college applications. As Kaveri explained, when high school started, “Everyone’s just trying to stack up their classes, get the hardest classes as possible, join as many extracurriculars and internships and whatnot,” driven by a nagging question: “Am I doing enough?” She described how her own quality of life deteriorated, sleeping less and forgetting to eat; in a fast-paced, high-pressure academic environment, “people do forget to do those basic things,” she observed.

Students shared that often, this pressure came directly from school staff and parents who hold high expectations and place considerable weight on college acceptances. Other times, when schools tried to intervene to protect students, students pushed back. At Victoria’s school, for example, counselors warned students against overloading on classes, even requiring parental sign-off during class registration to acknowledge the toll on well-being, but her peers largely ignored the warning. For some youth, this pressure extended beyond stress into struggles with academic performance, family relationships, and mental health. Devika and Nam separately shared what it was like to be high-achieving students in middle school but have their grades slip in high school, which brought about family tension and anxiety. Devika channeled what she was feeling into mental health advocacy, thinking, “Maybe if I put on this facade and help other people, I’ll get better myself.”

When youth were struggling, many faced judgment and stigma, which added another layer of distress. Victoria explained, “I wasn’t motivated to do my schoolwork, or I was, like, struggling to get myself to go through the daily motions, and I feel like people didn’t understand that. They’re just like, ‘Oh, you’re lazy, you don’t want to do your work.’” She continued, “That perception really needs to be changed, because struggling with mental health is, like, a major

impact on your life, and it's kind of hard to explain." Her reflection points to the added harm of being misjudged for something that is so fundamental to daily functioning.

Of note, committee members and alumni ranged in age from around 10 to 17 years old in 2020 when the COVID-19 pandemic began, and many referenced this period when they shared their mental health advocacy journeys with me during interviews. While one participant thrived during school lockdowns, since being home in a safe, controlled environment helped her manage her eating disorder, many spoke of the immense challenge of lockdown isolation. Aurora explained the impact of isolation on her well-being: "During 2020, you know, I was in middle school, I was dealing with a lot of, like, inner emotions, very sad, like, I went to therapy and stuff like that, and then during COVID especially, I was, like, dying inside. Like, I could not handle it." Aurora goes on to describe how her "desperation" for connection motivated her to create an online mental health support group, a direct example of turning personal struggle into advocacy.

Witnessing Peers' Mental Health Challenges

Youth also shared stories about their friends' mental health challenges, including suicidal ideation and self-harming behavior. Five youth specifically brought up suicide of a friend or peer as a formative event that spurred advocacy. Zoe's friends confided in her some "very dark thoughts," and self-harming was so frequent in one of her friend groups, especially among boys, that it had become "kind of normalized." She explained the weight of this experience: "I was dealing with a lot on my shoulders as, like—I was really thinking about this when I was, like, 11, 12, 13, and me and one of my girlfriends were just very overwhelmed by feeling, like, we need to care for these guy friends in our life." As friends opened up to them about these experiences, the youth in this study developed an intimate understanding of what it can feel like to navigate mental health concerns. Maya explained how witnessing others' struggles motivated her to act,

even when she had not experienced those same challenges herself: “I’ve realized that, you know, I don’t necessarily always need to go through the same experience in order to understand an issue that a community is facing, and just because I didn’t go through something doesn’t mean I can’t be a point of contact, or I can’t be an advocate for that need.”

Empathic Concern

In response to their own experiences with or adjacent to mental health challenges, participants described a range of emotions rooted in connection. These were youth who already saw themselves as empathic by disposition. They were attuned to others and oriented toward helping. Reflecting on mental health challenges she and her friends experienced in middle school, Grace shared, “I just really felt for everyone, and for myself as well, and I think at times I would feel, like, a broken heart.” Nam, after experiencing a mental health crisis in 10th grade, named how his experiences created “a heightened sense of empathy—because we know what it’s like.”

Some youth described anguish, worry, and the helplessness of not knowing where to turn for resources or adult support. Zoe captured this feeling: “It’s like when you have people around you that are struggling so much that they’re cutting their arms, and they’re hurting themselves, and they’re in so much pain, you don’t know what to do.” Samira described a similar sense of being stranded. In 8th grade, a close friend confided in her that she was self-harming and thinking about suicide. Samira encouraged her friend to tell her parents and urged her to seek professional help, but she knew that wasn’t enough: “There’s so little I feel like I can do. I was an 8th grader.” Youth were profoundly impacted by an immense concern for the welfare of others who were struggling; and for those who had

struggled themselves, they were immensely concerned that others would experience what they did without adequate support.

Disillusionment and Frustration

As advocates deepened their awareness of the mental health landscape around them, their concern began to find a more systemic target. Youth described a growing sense of disappointment, frustration, and anger, and they recalled moments of questioning the systems that were supposed to help. Barriers to mental health care were commonly encountered, including long waitlists, therapist turnover, and providers with whom students couldn't relate. Maya, who faced her own significant mental health challenges while also serving as an informal support for peers, shared her frustration: "I would be a point of contact for them, but it disheartened me. Why am I the only person in this big community that they can go to? Why don't we have proper resources that these students know about and trust?"

Some youth directed their frustration directly at school, a place they believed had the opportunity and the obligation to do more to care for student mental health. Zoe recalled walking in circles during PE while her friends were in an active mental health crisis: "This school cares so much about our physical education that they're having us run in laps, but no one has actually sat down with some kids who really need it and been like, 'Hey, are you okay? What's going on in your life?'"

Similarly, Victoria argued that even when resources did exist, they were not accessible or sufficient in practice. At her school, counselors were advertised as a supportive resource, but the reality looked different: "Counselors are usually, like, really busy. Like, if you go at lunch, which is the only time you can go without missing class. . . They're just not there, because they

have other duties, like, they're in charge of lunch supervision… I think one of our counselors also does custodial stuff. So they're just not there." Across interviews, youths' stories shed light on a pattern where students didn't know where to turn for support, and the resources that did exist were stretched thin. Youth recalled becoming increasingly disillusioned and frustrated.

"That Can't be Right": Moral Conviction and Urgency

From empathic concern, disillusionment, and frustration came a stable belief: *this must change.* After Nam's mental health crisis, he wanted "to make sure no one is ending up like that, too." Victoria, whose counselors were often busy at lunch, argued, "The only time you can see them is if you leave class, and I feel like students shouldn't have to leave class to get help." For Holly, a single moment crystallized her conviction. She was taking a test in her freshman science class, and she started experiencing a panic attack; her hands were shaking and she was having difficulty catching her breath. When she asked her teacher if she could step outside—"I just need to get air in my lungs," she pleaded—he told her she couldn't leave, and if she did, she would fail the test. She explains what happened next: "I finished my test, and I walked out of the classroom, and I was like, that can't be right. There's no way that students have to trade off their mental health for their academics."

The next day, Holly met with the on-campus nurse, mental health therapist, and counselor, who helped her start the process of establishing longer term school-based support. She felt relieved, but also frustrated that this process wasn't explained to her earlier. She couldn't shake the feeling that she was only able to access these resources because she was comfortable talking about mental health and advocating for herself, which isn't a luxury afforded to all: "You know, mental health is a really, really, really heavy topic, and just because I feel really comfortable and secure talking about my own personal struggles, that's not the way everyone

else is. And the amount of justifying and, like, self-discovery and self-advocacy that I had to do to get the resources—it's unrealistic for so many students." She goes on to explain how this fueled her advocacy: "I'm one of those people that doesn't want bad things that happened to me to happen to others, and if there's something I can do about that, I'm going to do it."

Alongside the conviction that systems needed to change was a sense of urgency. Students felt that something must change, and soon. The stakes felt immediate and concrete. For example, one of Zoe's close family friends had died by suicide. Reflecting on the lack of response from adults or systems, she explained, "The way I feel about it is, no, like, kids are dying. Like, I experienced kids dying." She continued, "I knew students are struggling, *right now.* I'm really worried about students, *right now*. And to not take any action—I felt just so stifled." This urgency was also rooted in the recognition that mental health underpins students' wellbeing, learning, relationships, and ability to navigate everyday life, and therefore needs to be a priority. Anika explained: "It [mental health] is like, such a fundamental thing to, like, who you are, the work you're doing, you know, how you succeed, or what school you go to, and, like, what education you're getting. Mental health is, like, a fundamental part of all of it, and I think if it's missed out on and people don't know how to take care of others and themselves, or, like, support others and themselves, it becomes, like, very hard, and kind of creates a gap and disconnect between everyone and yourself."

Self-Efficacy

Youth were convinced that the system was failing and felt frustration, anger, and urgency for change. Still, a prerequisite for advocacy was that they needed to believe that they, as students, *could* make a difference at all. The experiences they shared as contributing to self-efficacy map closely onto Bandura's foundational work (1977).

One source of self-efficacy that emerged from interviews was encouragement from others (*social persuasion*, per Bandura), including feeling seen, heard, and overall taken seriously by adults. For August, the accumulation of positive feedback from teachers and family across many years about his leadership and public speaking skills gave him the confidence to step into CARE leadership roles. "[They] told me, like, 'Oh, you're good at this,'" August recalled, as his confidence was built over time by the people around him. Similarly, Zoe explained, "My parents always very much encouraged me to be ambitious. They were like, 'You're gonna be President one day'. . . And I took that very seriously. . . That really just instilled a sense of, like, okay, the world is kind of your oyster." Other members described being encouraged by peers to join CARE and begin their journeys as mental health advocates. Across their accounts, self-efficacy was socially cultivated through affirmation and invitation. This encouragement helped youth see themselves as capable speaking up and influencing change, making advocacy feel like an option.

Youth also drew confidence from watching peers succeed in similar endeavors, a process Bandura calls *vicarious experience*. For example, Ana recalled that it felt "daunting" to draft a new district board resolution with CARE, but she was encouraged when she heard about the committee's past successes: "I think at the same time, because I heard [CARE alum] and [CARE alum] say that they passed something, I got a little excited. I was like, 'Okay, maybe there is room for this to happen.'"

A final source of self-efficacy was previous success in advocacy efforts, known as *mastery experiences* in Bandura's work. For example, early in her high school career, while learning about sustainability in her AP Environmental Science class, Zoe realized that her own school didn't have recycling bins. She shared, "I told my school I wanted recycling cans, and, like, they bought them. That's awesome. I started the recycling program, and then I was just like,

oh, I can just, like, kind of ask for things, and people will do them? Like, what?" For Zoe, this win created a new understanding and appreciation of her own agency. This kind of realization, however, does not always come easy, especially for youth who have often been conditioned their whole lives to defer to adults. Silas expands on why self-efficacy can be a challenge during the transition from childhood to adulthood: "There's a lot of power in a group of young kids, but I don't always think that they see that. As a kid, you're like, okay, I'm gonna do it if my parents say I can. Like, my parents told me to go shower. Great, I'm gonna go shower. My mom said I can't go on the big slide—I'm not gonna go on the big slide. So it's like, it feels like there should be some permission that needs to be asked, but there really doesn't."

In this way, developing self-efficacy, according to Silas, involves not only gaining confidence, but also unlearning the assumption that action must be initiated or authorized by adults. When asked where their sense of their own power came from, Silas shared: "My whole life, I've been raised, like, let's go to a protest. . . If that's what you think, like, go think that. . . You're allowed to make that decision on your own." Ana, meanwhile, pointed to the absence of certain experiences, such as the absence of undue or overly harsh criticism, as important for her self-efficacy development. Reflecting on her extensive public speaking background from years of community organizing, including in high-visibility, high-stakes situations, Ana clarified:

> Interviewer: How did you get the confidence to, like, do that? Like, to speak in front of the public like that?
>
> Ana: I think public speaking never really scared me. That was never one of my issues. . . I was never really taught to be afraid of, like, giving my opinions, but just to be, like, mindful that, like, they might not always be received.

Opportunity

Mental health advocates' journeys raise important questions about privilege, access, and support. Not all youth have equal access to the opportunities that enable mental health advocacy. One reason is related to mental health itself: many youth who are intimately familiar with the need for change are in the midst of navigating their own mental health challenges. Nam, a CARE alum from an immigrant and low-income background, put it simply: "It just goes down to the resources." Students who are actively struggling with their mental health, he said, "have to be focused on themselves." As such, they may not have the bandwidth to advocate because their energy is directed toward taking care of their own mental health needs. Prior to entering advocacy, Nam received help first. "I can't take care of others if I don't take care of myself," he explained. He credits his teacher, therapist, and family with being the support system that created the capacity to look outward and push for change.

August observed how socioeconomic inequality also contributes to unequal access to pathways into advocacy. He noted that students from lower-income schools are consistently underrepresented in the committee—not for lack of caring, but because extracurricular participation itself was "less advertised" at those schools, and students there were "less encouraged to become leaders," pointing to structural differences that lead to unevenly distributed opportunities. Allison, a committee supporter, agreed with this sentiment, explaining how socioeconomic status, as well as level of family involvement and support, impact whether students find their way to CARE: "I'm not quite sure we have a true representation of our student population within the district. It seems as though a lot of people involved are of higher socioeconomic status, maybe have parents who are really involved. But I think that's an access issue—I think that there probably are some kids that would be involved in this, but they don't have the support or the ability or the access to do so."

The reality is that privilege, access, and support are important ingredients for mental health advocacy. The implication of this is that the students most likely to have unmet mental health needs, navigating the most stressful and under-resourced circumstances, were also the least likely to be advocating for change.

A Proximity-Based Model of Youth Mental Health Advocacy Development

Figure 2 below presents the preliminary Proximity-Based Model of Youth Mental Health Advocacy Development, which is a visual representation of the seven elements that shaped participants' pathways into mental health advocacy. I refer to this as a proximity-based model because youth entered mental health advocacy through closeness to mental health concerns, whether experienced themselves or through witnessing others.

In the model, two foundational elements, a prosocial orientation (1) and experience with mental health concerns (2), are depicted on the left side of the figure. Arrows indicate how both of these elements contribute to a set of emotions and beliefs (right), comprising empathic concern (3), disillusionment and frustration (4), and moral conviction and urgency (5). Self-efficacy (6) is depicted separately at the bottom of the figure, a parallel developmental process informed by accumulated experiences over time, including receiving encouragement from adults and peers, learning vicariously from others' successes, and achieving prior mastery experiences. Surrounding all elements is opportunity (7), depicted as an outer oval to reflect how broader structural conditions impact the access, resources, and support that determine capacity to advocate.

While the figure depicts a directionality and distinct elements, pathways into advocacy were not always linear or uniform. The elements in the model are best understood as cumulative and interactive, and they vary in their intensity across participants. Additionally, the model

should be considered preliminary due to its development from a small, non-representative sample from a single site. That being said, for many of the youth, the elements depicted here were key ingredients in their journeys toward mental health advocacy, and the model offers an account of what these pathways looked like.

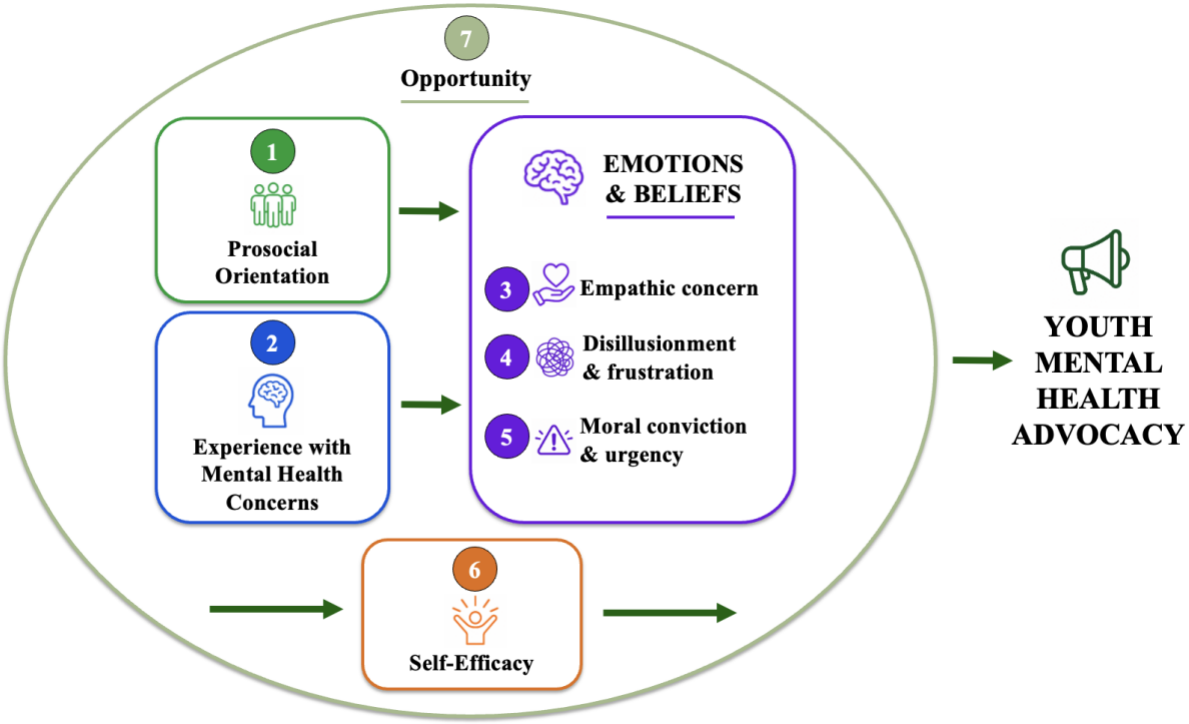

Figure 2: Proximity-based model of youth mental health advocacy development

A Note on Variation

Not all participants arrived at mental health advocacy the same way. Many of them, especially those who founded or held leadership roles on CARE, had been pulled into advocacy by lived experience, either through their own mental health struggles or by watching friends in distress. For these youth, advocacy was a response to something that had already happened. By contrast, a subset of advocates explained that they joined CARE for more instrumental reasons, including interest in mental health as a career or the benefits of CARE membership for college applications. They cared about the topic, but their involvement was rooted in opening doors for

their futures rather than an immediate felt need to improve the mental health and wellbeing of their peers. The practical consequence, as observed by a few participants, was that members without a deep personal connection were more likely to disengage when the work was slow or met with resistance. This "really threatens the promise of CARE," shared Kishor, since the committee relies on sustained student effort toward a long-term mission.

It is worth noting that many of the youth, regardless of their reasons for joining the committee, were living inside the stressful conditions they joined CARE to address. The academic pressure and competitive culture that drew them toward the committee for their college applications was also affecting their own well-being. Nik explained how this pressure leaves little room for developing passion or purpose:

> There's a lot of pressure, especially because you see other people getting national awards, doing this, doing that, and it's almost like the natural aspect of gaining a passion for something and slowly pursuing it is put in the back end of somebody's mind. They're more focused on getting something done right now, looking for an opportunity right now. Like, I don't even gotta genuinely care about it, I just gotta get a high leadership role, do something that's worthwhile. . . That aspect of truly caring about an activity's kind of been, like, ripped out of society, almost, for high schoolers, at least.

He quickly added that most committee members seemed different and that their care for mental health is real—"they're not just there to, I don't know, check off a box, you know?"—but the pressure he described was operating in the background for all. As such, for some youth's journeys, the elements of lived experience with mental health, empathic concern, disillusionment with the system, and conviction and urgency may have been less central or completely absent from their pathways into mental health advocacy. Instead, their advocacy stemmed from other sources, including the fear of not being accepted to a "good" college or any college at all, and what that might mean for their future.

RQ2: What are the Perceptions of Student Mental Health Advocates Regarding School-Based Mental Health Supports?

Across interviews, participants identified limitations in available school-based mental health supports, specifically around issues of communication and access. Importantly, these perceptions are of youth advocates who have spent time critically analyzing their schools, discussing their observations with peers, and organizing for change. As such, they share insights into not only what is unhelpful or helpful, but why. Five themes emerged from the data: (1) resources without a foundation; (2) resources without a map; (3) the complex role of school counselors; (4) stigma, stereotypes, and fear of judgment; and (5) pockets of support.

Resources Without a Foundation

When asked about their school's mental health landscape, participants frequently referenced Tier 1 supports—supports that are universal, proactive, and preventative, designed to support the mental health of all students (Brown-Chidsey & Steege, 2010). While participants appreciated that efforts such as awareness ribbons and wellness week activities acknowledged mental health, the general sentiment was that Tier 1 initiatives felt largely surface-level and mis-aligned to actual student needs. Students' impression was that few used or benefited from these resources. For example, Victoria shared how finals week wellness initiatives at her school, which included distributing bubbles in the cafeteria and bringing a therapy dog to campus, felt disconnected from the pressures students were facing. "I think that kind of helps some people," she explained, "but I don't think, like, bubbles are the solution to students' bad mental health. I feel like they [the school] kind of tried to put, like, band-aids over it." Victoria highlighted a downside of Tier 1 supports: universal efforts can feel dismissive or alienating, and they can

unintentionally give the impression that mental health support is an afterthought rather than integrated into a systematically supportive environment.

Anika shared another example, a district-distributed suicide prevention video, that showcases the limits of passive, decontextualized support. Each September, for Suicide Prevention Month, her school showed a 20-minute long video on "why suicide wasn't good," as she put it. Anika recounted how some teachers seemed to play the video reluctantly as students spent the 20 minutes scrolling on their phones, while other teachers skipped the video entirely because of their own discomfort and lack of training on how to talk to students about mental health topics. "Nobody was actually watching it. Nobody was paying attention. It had no effect. And they would do this every year, and they would think it was doing something," Anika observed.

Another common Tier 1 strategy is promoting mental health resources schoolwide to increase awareness of available supports. These efforts included advertising hotlines and other resources on posters, on the back of student ID cards, via email, or over loudspeaker announcements. However, participants explained that these resources are rarely converted into tangible sources of support, for two main reasons. The first reason is that often, these messages don't even reach students. Anika noted that administrators "put out a poster with mental health resources, or they put it on the back of our IDs for us to look at if we ever need to, but nobody is ever looking at those resources." She then illustrated what this looks like in practice: "If I see a poster, I usually just walk by it. I don't usually look too much into it. Even if I am struggling with my mental health, I don't go up to the poster and, like, stand in front of it." Denise, a community supporter, corroborated students' accounts. She explained, "We advertise like we

think we need to advertise. We'll either send an email or make an announcement. Well, the kids aren't necessarily listening to that stuff."

For students who do pause and look at a poster or a phone number on their ID card, a second problem emerges. Anika clarified that posters, hotlines, and wellness initiatives are not inherently bad resources; the problem is that students have a limited foundation of mental health knowledge to make use of them. She explained, "If I knew, like, what the resource on the back of the card did, and how effective it could be for myself, and how much it could actually help me, I would definitely use it. But a lot of people don't know." A few participants drew a useful contrast with the nurse's office, which students know to seek out when they feel physically unwell because accessing that resource has been normalized from an early age. Mental health resources, on the other hand, are typically introduced through channels students tune out; and when students do encounter a poster or hear an announcement, they lack a framework for processing the information or understanding how it could be helpful to them. As a result, many students either remain unaware of the resources available to them, or they are aware of the resources but do not know how to use them.

Resources Without a Map

Even among students who were aware that resources existed, they had difficulty navigating what was available. Silas captured this explicitly: "I have never seen a clear pathway. I've never heard anyone say there's a clear pathway to getting support if you need it." Across the district, each school has different counselor formulas and resources for mental health. As such, as Maya explained, students are often "overwhelmed with all the resources that they have given to them, that they might just take a step back, because they don't know what to do with all the information being thrown at them."

Maya shared more detail about these navigational barriers, specifically around the mental health resources listed publicly on the district's website. She recalled her peers asking her, "Okay, which one's for suicide prevention? Which one's for, like, PTSD?. . .Which number do I call if I need help with something like this?" She expressed her own surprise about her peers' confusion: "That was just a really interesting fact that I observed, because, you know, I feel like, especially in my generation with social media and technology being a big thing, you know, most of the time you think, 'Oh, like, you know, a student can, like, look at a resource and kind of navigate around it.' But no. I guess a lot of these resources were just confusing for students to operate around, or they weren't aware of how to use them properly." In response, Maya and other CARE members spent months redesigning the district's outreach materials to organize resources by type of need, and they added new resources with chat features for students who preferred different methods of support. She looked back on this as one of her proudest contributions during her time with CARE.

The Complex Role of School Counselors

Across interviews, school counselors were frequently discussed as relevant but complicated figures in the landscape of student mental health support. First, there was widespread uncertainty and confusion about what counselors do. In some schools, counselors were positioned as a go-to resource for mental health support; but in other schools, counselors were perceived as primarily administrative rather than emotionally supportive. For example, Samira explained that at her school, counselors are "advertised more as an administrative resource"; they are the designated contact for course registration, college application materials, and academic- or teacher-related grievances, but not for personal concerns.

Students were also confused by the complexity of student support roles, and they had difficulty knowing where to turn for help. Samira continued, “So then people are like, there’s a school psychologist, and then I have my counselor, but my counselor does my classes and things like that, and then—it just kind of gets lost, like, who do you go to, you know?” Even students who wanted to see a counselor often found it difficult to do so. Counselors were often out of their offices attending to other duties or busy seeing other students. Some also kept their doors closed even when technically available, which made students feel unwelcome. Students recognized that underlying all of these dynamics is the fact that counselors are overextended. Denise confirmed that the caseload for a single counselor can be up to 450 students at some schools, and she explicitly acknowledged that “you’re not going to be able to do a lot” as a counselor when it comes to social and emotional support, especially for students with high needs.

Beyond availability, participants referenced barriers related to the nature of the student-counselor relationship itself. Multiple students raised concerns about their counselors’ status as mandated reporters and what that meant for confidentiality. Anika explained that students were often afraid to share personal struggles, especially around suicidal ideation, fearing that the situation would escalate and that parents or guardians would be notified in ways that might cause more harm. Devika added that students with undocumented parents worried that disclosing details about their home environment might prompt a counselor to contact Child Protective Services, putting their family at risk for deportation. Some also feared having incidents “filed” in a way that could permanently mark their school record. As such, for various reasons, counselors were often an untapped resource for accessing needed mental health support.

Stigma, Stereotypes, and the Fear of Judgment

Stigma was a persistent barrier to help-seeking. While students believed that their generation had made progress in normalizing conversations about mental health, they were also clear that stigma had not disappeared. Samira described a pattern she observed among friends during junior year, a time she and her peers called “the trenches” as students focused intensely on academics and extracurriculars to strengthen their college applications. As Samira explained, no one talked about the toll this year took on their mental health. “I could recognize it in the moment last year, but it was never, like, a said thing,” she explained. Instead, they would go to school each day and “put on a face.” Even among friends, there was a limit to how much they could be vulnerable with one another: “There’s, like, this fear of opening up too much to your friends, and it’s like, ‘Whoa,’ like, ‘trauma dump,’ you know? Because that’s not necessarily acceptable.”

Silas explained how stigma and judgment from peers can deter students from using school-based supports: “There’s also a fear of students being, like, are people gonna make fun of me. . . because people will do that, which is messed up, but like. . . it’s a valid fear.” Anika made the striking observation that this stigma can prevent students from even calling a crisis line, which shows how stigma can persist even when no one is watching. She shared that students may “feel, like, shame. . . ashamed to, like, call it. They think it’s, like, a sign of weakness or vulnerability that shouldn’t be shown.” Beneath this shame was the additional complexity of recognizing, naming, and becoming ready to discuss one’s own mental health needs in the first place. As one student summarized, “I always knew there were resources and adults there, but I never used or talked to them. I don’t think I really was ready to open up to anyone about my feelings at that point. Even now, there are things I’m not really ready to unpack about myself” (CARE Outreach Materials, 2025).

Relatedly, mental health stereotypes persisted, even among the group of mental health advocates in this study. Manny, for example, described the gendered stereotypes that came up for him during a period of emotional distress: “I know it’s, like, more common for girls to cry… I don’t know if, like, any sexism is coming across for me, but I did feel, like. . . really weak in that moment.” He went on to explain that his peers, particularly those in high-status, “super clique-y” social groups like cheerleaders, never appear to struggle. However, he suspected that they are masking their difficulties, explaining, “I wanna say they’re just, like, trying to act perfect. I’ve tried to do the same thing, and I’ve, like, gotten compliments on my attitude, even though I was going through, like, a rough time.” Manny highlights how students are praised for appearing fine while struggling, which reinforces the message that mental health challenges should be masked, and that concealing them is admirable.

There was also a more generational dimension to stigma. Several youth described their experiences with adults who minimized or dismissed student mental health concerns. This took various forms: assuming students were exaggerating their stress, attributing their difficulties to being oversensitive, judging mental health concerns as “crazy,” or holding a “pick yourself up by the bootstraps” attitude (Field Notes, July 2025). As Devika explained, “A good chunk of my teachers are, like, the older generations, and, like, they may judge us as people for our problems that maybe don’t even seem that big to them.” She described hearing teachers dismiss student stress with comments like, “Oh, you guys in your generation, like, you worry about all this stuff,” which, she noted, makes students hesitate about opening up to them. Comments such as these, even if intended to provide reassurance, invalidated youth experiences and closed the door on what could otherwise have been an important source of support.

Luz shared her analysis of the generational divide: "I feel like my peers are more. . . well-versed on mental health, like, they know that you're not crazy if you have mental health issues—you just need help. And it's just, like, the older adults in our life, like our teachers, our counselors, our administration, really do, like, have that mindset, and it's something that we really need to change." Emily observed that when youth bring concerns to an adult and are met with disbelief or dismissal, the problem is, "They're much more likely to go back to the world of adolescence to try to solve the problem, and that isn't the greatest group of problem solvers ever." Indeed, challenging the stereotypes held by adults, and continuing to push for change despite the older generation's discomfort with mental health conversations, was an explicit charge of the committee: "As leaders, the number one thing that we're doing is having the conversations that make adults uncomfortable" (Field Notes, June 2025).

Pockets of Support: The Role of Individual Adults

Amidst the barriers described above, participants also identified exceptional adults who made them feel seen and cared for, creating pockets of support. For example, Nam shared a detailed account of a teacher who made all the difference for his mental health. When she learned that Nam was struggling with depression, a difficult home environment, and intense academic pressure, she called Nam's brother to advocate for therapy, filled out the necessary forms, emailed other teachers on Nam's behalf, and made herself available outside of class hours, including by phone. "She's really just there to be like my second mom," Nam reflected. "Teachers like that really go a long way."

Devika described another teacher who stood out from the others as exceptionally perceptive and caring. "He notices everything," explained Devika. She gained the courage to open up to him after observing how he supported her peers: "There's all these people that are

always, like, opening up to him, and they always seem, like, great whenever they leave. So I guess, like, it couldn't hurt trying." Meanwhile, Lori credited strong teacher-student connections to her small school size. With fewer than 200 students per grade, she knew all of the teachers by name. "There are a lot of teachers that people can go up to," she said, "and I know that my friends, personally, they have problems at home or with friends, and they can go to those teachers and talk to them." Finally, though Cody acknowledged barriers to accessing counselors at his school, when he did speak to them, he felt genuinely cared for. "I love how they introduce the fact of, like, how are you doing first before getting into the subject that is at the core," he reflected.

These examples highlight the essential role of relationships in accessing mental health support. Calling a hotline, messaging a chatbot, or stepping into a counselor's office without a pre-existing relationship can be uncomfortable for students. Maya summarized that for many youth, "If they just know you and they know they can talk to you, they feel way more comfortable just going to you and talking to you over this random website and this random person behind a screen that they probably will never meet in their entire lives." In other words, relationships are part of the infrastructure through which support becomes accessible.

RQ3: What Conditions Enable and Constrain Student Mental Health Advocacy within a Public School District?

I now shift attention to CARE itself to examine the conditions surrounding student advocacy. To answer this research question, I consider what supported and constrained CARE's work. I first examine the organizational conditions internal to the committee, then the external support that propelled their work, and finally the broader district environment in which they operated.

Committee Conditions

A set of organizational features enabled and sustained the committee's advocacy work, organized into five themes: relationships and community; anchored adaptability; distributed, youth-centered leadership; diversity and representation; and sustainability. Below, I outline each of these themes, highlighting both the strengths of organization as well as associated constraints and tensions where applicable.

Relationships and Community

CARE members deliberately cultivated a strong sense of community. Friendships were built through regular in-person meet-ups designed for connection and fun, including bonfires, scavenger hunts, and poetry sharing. Kishor explained, "We really value this exclusive time we get—for just developing connections." These relationships, he argued, helped sustain the advocacy work when it became difficult: "We go through multiple cycles of opportunities coming up, them falling through, things working out, things not working out. . . To stay together, and to still believe in each other, and to still want to work with each other—you need to have those long-term relationships."

This sense of community helped to create the conditions for members to speak openly about mental health, both with one another and in more public-facing contexts. Kaveri described the joy of finding peers who shared her interests: "Sometimes even within your own friend group, you may not find those people who are really totally ready to talk about mental health." The friendships formed within CARE were also healing in and of themselves, helping youth feel less alone and more connected to people who share similar values, goals, and life experiences. As such, the relationships formed within the committee were understood as both intrinsically valuable and instrumental to advocacy outcomes.

However, because the district is geographically dispersed, Zoom was the only viable format for CARE's regular bi-weekly meetings. Despite the efforts to build community, this online format created barriers to connection. Students had become accustomed to turning off their camera and muting their microphones after many months of remote instruction during COVID-19. Silas described how conversations therefore easily stall on Zoom, creating a sense of awkwardness: "A few of us will be like, 'So how was your guys' weekend?' Everyone would just be like, 'Good.' And it's like, 'Oh, okay.'" This also jeopardized the committee's ability to collaborate and work efficiently: "Sometimes we just don't ever say anything in the breakout room. . . Someone will be like, 'Hey, I'm doing that same thing,' and it's like, 'Oh, okay, well, I didn't know that.'" Sentiments like those expressed by Silas made it even more important for the committee to build and regularly nurture relationships, as they can fade for adolescents in an online space.

Anchored Adaptability

The committee had a clear organizational architecture. A formal constitution, an explicit mission statement, a set leadership structure, and clear membership expectations gave CARE coherence and purpose. August explained, "You just have a framework to kind of work off of each year. . . So you're not just, you know, flying by the seat of your pants, trying to just do whatever you feel like is right in the moment." The existence of a written constitution also lent a sense of formality felt among the committee members—"that's very legit," as Nam put it.

CARE's structure allowed for considerable flexibility. For example, prior to the first committee meeting of the year, the two newly elected co-chairs met together to set CARE's goals and deadlines for the year, working within the established mission statement. This structure enabled the committee to adapt each year to pressing needs and emerging ideas while staying

grounded in its founding purpose. While the committee's anchored adaptability had its benefits, some participants observed a tension embedded in this practice: CARE did not have a consistent process for ensuring that each year's goals reflected the priorities of the general membership of CARE or of the district at large. Goals often came down to co-chairs' preferences, with the specific direction shifting depending on who was in charge. One participant questioned whether the committee's initiatives reflected student input: "How much of this is just from this core group, and how much of this is really representative of the student body?" The committee similarly lacked established benchmarks for assessing progress toward its goals. As a result, the flexibility that allowed CARE to remain responsive also made its work difficult to assess and compare across years.

Distributed, Youth-Centered Leadership

CARE was led by two co-chairs, a vice chair, and a small core team of other specialized executive roles. A clear leadership structure was essential given that all members—high school students juggling school, sports, jobs, and family—needed people to keep the work organized and moving, particularly through the "second semester slump." One of CARE's two district-appointed advisors was required to attend every meeting, but their involvement was minimal; advisors spoke infrequently at these meetings, and really only did so when directly asked a question by one of the students. CARE was, at its core, run by students, as was intended by its founders.

However, that meant that when student leaders faltered, whether due to competing responsibilities, burnout, or simply losing momentum, it had cascading consequences for CARE's work. Maya explained, "There's a saying that all the co-chairs say, where if the co-chairs end up kind of shaking, the entire committee will shake and completely fall. . . The

committee members will also feel disheartened and very impassionate and unmotivated to move forward if they're seeing the co-chairs not even giving their 100%."

While a substantial amount of responsibility rested on the shoulders of the executive leadership, CARE was also designed to intentionally distribute ownership and agency among the full membership. Most biweekly meetings were dedicated almost entirely to small-group subcommittee work time in Zoom breakout rooms, giving members the opportunity to take ownership over their involvement in ways that aligned with their strengths and interests. Zoe explained, "Our concept is, like, everyone needs to feel like a leader. Like, all of these organizations, they have, like, club members. And we're like, we don't believe in that, and no one feels inspired by that. We actually know that every single person, if they're contributing something, like, they are being a leader. . . In order to keep people engaged, and to feel like they're fulfilling a purpose, they need to feel that they're a leader, too."

While many spoke to the personal growth opportunities and committee successes that were sparked in these breakout rooms, the high level of autonomy left some members feeling adrift, at times. Victoria expressed, "As much as I like having the freedom for our subcommittees to do whatever we want, I wish there was also more directives—specific ones from leadership about what they want us to be doing, or things that we could work on, because I feel like everybody is just kind of floating around." CARE leaders provided support to each subcommittee by rotating visits to each breakout room, but interviews revealed how the balance between providing direction and preserving member independence was difficult to strike.

Diversity and Representation

Participants spoke frequently about the importance of having a diverse and representative committee membership. Students understood that mental health needs and resources vary

significantly across demographics and regions, and they recognized the benefits of working with students from across the district: “If you limit yourself to the bubble you’re in, you would never know the perspectives of people from different areas,” explained Samira.

However, participants acknowledged persistent gaps in diversity and representation. The goal of the committee was to have two representatives from each high school in the district, but this goal was often unmet. Allison observed that the committee remained “pretty top heavy in higher SES, kind of college-bound students.” Indeed, while I did not collect demographic information of all students in CARE, the demographics of my student and alumni interviewees indicated that CARE members may come from higher socioeconomic backgrounds, on average, compared to the broader district body; and students from racially and ethnically marginalized groups, including Black and Latinx students, remain underrepresented. Allison linked this pattern to structural barriers: “I think there probably are some kids that would be involved in this, but they don’t have the support or the ability or the access to do so.” Due to inequitable distribution of mental health resources across socioeconomic and demographic groups, this meant that the students most likely to have unmet mental health needs were also the least likely to be in the room advocating for change.

To close these gaps, the committee actively attempted to recruit members from high schools in under-represented areas. For example, at a committee meeting open to alumni, Ana shared her plan to return to her alma mater, an under-resourced high school with no current committee representation, to speak to counselors and attempt to recruit students (Field Notes, June 2025). The committee displayed ongoing efforts such as this to improve reach and representation, though they were candid about their limited success in broadening the diversity of committee membership.

Though committee membership lacked diversity and representation in important ways, students kept issues of equity at the center of their work. CARE dedicated multiple subcommittees to reaching demographics historically underrepresented or missed by traditional mental health initiatives. For example, one of CARE's subcommittees focused on student athlete mental health. Holly explained, "[CARE] has a full three, maybe four guys? … And so we have this whole demographic of people that we're just completely missing." In her interview, she discussed how boys have higher suicide rates compared to girls, as well as the stigma around mental health specifically for athletes ("it's usually seen as a sign of weakness"). Another CARE subcommittee focused explicitly on supporting students from racial- and gender-minoritized communities, including LGBTQ+ and undocumented students harmed by the current political climate. Students in this subcommittee were tasked with compiling and emailing resources to school nurses, counselors, and associate principals monthly (Meeting Agendas, September 8, 2025). They also launched a new speaker spotlight series featuring diverse students from across the district sharing their mental health stories, hoping to normalize conversations about mental health across different communities and help students see their own experiences reflected in others (CARE Outreach Materials, 2025).

Sustainability

Most members serve on the committee for one or two years before they graduate, and leaders are typically seniors, so sustaining CARE's momentum across transitions was at the top of students' minds. Students understood advocacy as a long-term endeavor, and they saw each year as one chapter of an ongoing, larger effort. Maya explained her thinking: "I wanted to create the foundation for future projects and initiatives to continue even after I left… because I didn't

want to just show up in these spaces and say, 'Oh, I want to do this,' and then it ends after I leave."

Specific processes and structures were established to support sustainability over time. For example, the vice chair role was designed to be a year-long onboarding experience, during which students could observe the co-chairs and ideally step into that role the following year. The committee also had a tradition of an annual check-in between the co-founders and each year's new cohort of student representatives. At this meeting, the co-founders share details about their original vision for improving mental health district-wide and the stories behind their passion (Field Notes, June 2025). This tradition served multiple purposes: members had an opportunity to feel connected to the group's collective and sustained purpose; and alumni shared inspirational messages (such as reminding members, "You are saving children's lives" [Field Notes, June 2025]), answered questions, and provided advice.

External Support

In this section, I move beyond the committee itself to share findings related to external support, defined as direct involvement from people or groups who were not CARE members themselves. Participants described interactions with a range of supporters, categorized below into six roles: the power-holder, the champion, the connector, the advisor, the partner, and the mental health specialist. For context, these roles were not mutually exclusive; a single individual might occupy more than one, and the same person could shift roles over time or across initiatives. Below, I describe each of these six external roles and provide examples to illustrate the types of support offered.

The Power-Holder

Power-holders were people with actual authority to change policy, allocate resources, or formally institutionalize the committee's work. The school board, in the case of CARE, was an obvious example of power-holders, as the top formal decision-making body in the district; any districtwide initiative required the school board's approval. Committee members were strategic in their work to move these power-holders to create change. For example, they discovered that a new Senate bill was pushing for mental health education in the state, and they positioned the district as having a chance to get ahead of the mandate. An alumnus recalled, "So we found that research, put it into the resolution, and we said, 'The state's going to do this in a few years anyway. It's most likely going to be approved. So why not get ahead?'" CARE then worked closely with board members to write and co-sponsor the resolution. In doing so, they ensured that the resolution already carried institutional investment when it arrived at their desk for a vote.

The power-holder role was not limited to the district. Participants described a parallel version of it at the school-site level. For example, one expectation of committee members was that they run a CARE-affiliated club at their schools, where they could be more in touch with local mental health needs, directly provide information resources to peers, have open conversations about mental health, and be a conduit between each school and the districtwide committee. However, school policies required that any official club have a certificated staff member as an advisor, which gave staff significant power and control over the formation and maintenance of such clubs. Students often ran into issues with securing an advisor, such as Aurora, who said, "I literally went to every teacher. . . And no one wanted to do it." Staff capacity was a limiting factor; participants explained how teachers with existing relationships with students were already advising other clubs, while the remaining teachers were often ones students had a limited or strained relationship with. While students were understanding of

teachers' time and capacity, the problem remained: without a certificated staff member to advise a club, it couldn't exist. The shortage of well-functioning school-site clubs was a persistent and recognized issue in CARE. In this way, CARE's success relied on power-holders across multiple levels, including moving the board at the top and teachers on the ground.

The Champion

The reality for the youth advocates was that they did not have sustained access to many power-holders or institutional decision-making spaces. They were able to attend public meetings like school board district meetings and reach out to power-holders like the superintendent, and they were occasionally invited into conversations to provide feedback, but often, they needed a champion: someone who believed in their cause and could be a voice for students in rooms they were not invited into. An alum explained that she brainstormed anyone who could be "in any way touching on this topic" to bring them in on the committee's goals and plans, and that "the reason why we were able to do so much in our first year alone was based off of the fact that we could lean on other people who could speed up the process."

Champions did not necessarily hold formalized power to make change, but they were trusted by power-holders and vouched for CARE's mission and goals. Their ability to access rooms that CARE members weren't in, their relationships with power-holders, and the positions they held within institutions gave them leverage that student advocates did not have. Jonathan highlighted the complementary roles of the champion and the power-holder: "Usually you gotta find a staff member that believes in the work and is willing to put in the time to help see it through. And then you need direction from the top saying that's what we want to have happen. And really both of those need to work. If you just have one, it probably won't work."

The student board member at the time of the committee's founding was a clear example of a champion. He was already a well-known student voice in the district, and he had spent years encouraging and reminding the district to take student voice seriously. One of the co-founders described how she was "whispering in his ear all the time—this is what we think should be happening," and the student board member, who had lost a friend to suicide and was, too, passionate about mental health, carried those concerns into spaces the committee could not access. He gradually built familiarity at the district level until mental health "slowly kind of shifted to become a bigger focus."

Another champion emerges in CARE's origin story: a philanthropist family, with no formal authority in the school district. One of the founders of the committee, a high school junior at the time, had written a mental health issue paper as part of a philanthropy-backed leadership fellowship, and she sent a thank-you note to the family with her issue paper attached. She reflected on what happened next: "I really do not think that that's what I was angling for, but they immediately sent it to the superintendent, who contacted my principal, who came to get me." Her principal pulled her from class—"He's like, 'Yeah, so I got an email from the superintendent, and she got an email from the [philanthropy] family, and they really like what you're talking about with mental health, and. . . I'm really passionate about mental health, I want us to work together.'" In this way, involvement from this champion, the philanthropist, set in motion the chain of events that would lead to CARE's creation.

However, one potential problem with the champion dynamic deserves mention—the "game of telephone," as Grace called it. Champions, by definition, are intermediaries. They carry student perspectives into institutional spaces that students themselves cannot or do not access, and they carry institutional responses back out. This intermediary function is valuable, but it

introduces a vulnerability. When the champion is the only conduit between student advocates and decision-makers, the fidelity, completeness, and timing of the message depend entirely on one person's capacity, priorities, subjective interpretation, and communication skills. As such, the champion dynamic, however well-intentioned, may, at times, substitute for the more demanding but important work of actually including students in the rooms where decisions are made.

The Connector

Another role was that of the connector: people who linked advocates to other advocates, organizations, and networks that were difficult for students to find or access. CARE's origin story features an essential connector. A student had reached out to a former vice principal, who was then working at the district, to share an idea for a districtwide committee focused on mental health. This former vice principal happened to know another student at another school who shared this passion, and she directly introduced them. Without an adult who knew them both and made the connection, these two students with complementary visions might never have found each other across a large urban district. Connectors were essential at the school level, too. The committee relied on school district staff, including principals and counselors, to spread the word about CARE's mental health campaigns and initiatives and to advertise openings on the committee itself; many members reported that they first learned about CARE through a school counselor or teacher.

Connectors are important because students typically have few relationships to power-holders or champions. August described the committee's district-appointed advisors as essential connectors: "They literally got us into these meetings. . . This person knows who we should go to, who we should talk to, to get things done, to raise this concern." Laura, a supporter,

underscored why helping students get into the right rooms is so important: “We all act differently when there are students in the room. I think adults are a little bit more cautious—is this resonating with them [the students]? Because if they’re making faces and telling you it’s dumb, I think you’re gonna have to rethink what your position is.” Zoe also reflected on how invaluable the connector role is, and how forming connections can be a strategy during uncertainty. She advised, “If you can’t do anything for someone, connect them with someone else.” In other words, even if a person doesn’t know how to help, continued introductions are more likely to help than if a conversation’s momentum comes to a full stop.

The Advisor

Another external support role was the advisor: people who shared institutional knowledge, demystified district processes, offered guidance and advice, and acted as a sounding board for the committee. The people who most closely and formally fit the advisor role were two district staff members appointed to support CARE. These advisors were attuned to students’ developmental needs and limited experience navigating adult systems. For example, they helped ensure that events were planned far enough in advance with all logistical pieces considered. For one event, advisors helped facilitate communication between students and event space staff, reminding students to specify how many tables and chairs they needed and whether they required audio-visual equipment to meet their event needs (Field Notes, February 2026). Advisors also helped students navigate email etiquette with administrators and parents, a skill that few students had practiced. For example, at one point, a CARE member did not know to reply-all to a superintendent’s email, requiring advisor intervention to keep a meeting on track (Field Notes, October 2025).

Advisors also supported members in navigating the committee's internal interpersonal dynamics. While inter-member conflict was infrequent, advisors were a helpful resource when tensions did arise. For example, halfway through the school year, a district leader suggested that one of the subcommittees change their name. This suggestion landed poorly with the students involved, who had developed a strong sense of ownership over their work and the title of their subcommittee. In this moment, advisors listened without judgment and helped members process and reach a resolution together (Field Notes, October 2025).

The two district advisors took care to be intentional about when and how they intervened in what was meant to be a student-led space. In fact, the committee's constitution states that advisors shall "minimize their intervention" during committee meetings (CARE Constitution, 2020). The advisors were required to ensure that CARE's work remained within the rules and regulations of the district, but beyond that, one committee supporter summarized how to advise a student-led group this way: "The ideas come from them. It's really just how to implement their ideas is where I tend to step in more." This could mean enthusiastically reinforcing ideas that seemed promising, while helping students workshop other ideas as needed to make their vision come to life.

Sometimes, being in an advisor role meant watching promising opportunities go unpursued. For example, one supporter shared, "There's so many times that I've come and approached them [CARE] and been like, 'Oh my gosh! It's like the greatest idea ever,' and they'll just be like, 'Meh.'" Another supporter explained, "If you really want the [committee] to be motivated and excited about something, it has to come from them. . . If we're just telling them what they need to do, that's not very motivating—and we do that for their whole lives." In this sense, the advisor role demanded knowing both when to step in and when not to, and

appreciating the value of student ownership and the student-directed process regardless of outcome.

The Partner

The partner role was held by individuals or organizations who collaborated with students as co-contributors to shared goals. These external supporters worked alongside CARE in a non-hierarchical, sustained, and solution-oriented capacity. At times, this took the form of genuine co-creation, where people with different expertise collaborated to create something new. The drafting of board resolutions exemplifies this dynamic, as board members contributed institutional and procedural literacy, while the committee members brought the vision and the urgency of lived student experience, and workload was distributed accordingly. Other times, partners operated at the level of an organization. For example, when CARE collaborated with a more established student-serving organization on a large event serving over 300 students, the partnership served multiple functions simultaneously: it distributed the labor of event planning and execution, expanded the committee's reach, and lent CARE and its events institutional credibility (Field Notes, February 2026).

The partner role stands in contrast to times when the committee was looking for support and partnership, but was met with sympathy and questions rather than action, or passive listening with no follow-through. Zoe identified a catch-22, where it's possible for students to feel "too heard" when they were really looking for a partner in the work: "Sometimes feeling, like, too heard.. . . doesn't feel like they actually care enough. It's like, I'm trying to brainstorm with you for solutions, and sometimes they're not focused on that. I was coming to the table with a lot of solutions, and they were coming to the table with a lot of sympathy and questions."

In another example, when conveying the urgency behind the need to improve mental health systems, some youth told personal stories of mental health challenges. As Zoe explained, students weren't looking to be consoled in these moments: "We are just, like, telling the story so that, like, you lock in. . . We're trying to convince you to care about us. . . and they're like, 'Oh, we're so sorry.' And it's like, yes, you should be. Do something, please." August echoed this, noting that what students were really looking for was someone willing to "workshop tangible solutions" and "follow up over time," rather than a single conversation or "just humoring us and being like, 'Okay, you spoke—that's fine.'" True partnership was solution-oriented and took place over repeated conversations and interactions. Partnership had the added benefit of helping people understand the constraints on both sides—both the capacities and limitations of the students, as well as the capacities and limitations of district staff working in a complex, resource-limited bureaucracy.

The Specialist

The last form of support is a more clinical role: the mental health specialist. Because the committee necessarily engaged with sensitive content, and because advocates were also often the population in need, supporters with clinical training served an essential function. They helped CARE members structure events to limit the risk of retraumatization, and they were present as needed to debrief emotionally after difficult conversations (Field Notes, January 2026). Denise, a supporter with a counseling background, put it bluntly: "You never know… with kids, when they're gonna react and be activated, and it's like, 'Oh, crap, who's gonna take care of this,' you know?" Those in the specialist role needed to hold the complexity of operating in a student-led space while trusting their clinical judgment to add safeguards that limit the risk of harm.

District Environment

In this final findings section, I zoom out to examine the district environment. CARE was situated within a large urban district that shaped the committee's work in important ways. On one hand, the district was home to staff who believed in student voice and the importance of addressing student mental health. On the other, the district was a large, complex institution with all the bureaucratic features typical of such an organization, making change slow despite largely good intentions. In this section, I outline the ways in which CARE was both supported and constrained by the district environment. I start with an illustrative story of a CARE initiative from earlier in the committee's history, pieced together from multiple interview transcripts. I then explore the tension of stated support for student voice and its uneven translation into practice, as well as the ways in which the committee pivoted in response to be able to still carry out its mission.

"The District Is a Big Bureaucracy"

Allison stated it simply: "The district is a big bureaucracy." Throughout interviews, participants described challenges stemming from bureaucratic red tape, siloed departments, staff turnover, and limited resources. The committee's effort to embed mental health education into the district curriculum serves as a case study within a case study of what navigating this institutional bureaucracy looked like in practice.

The Story of Mental Health Education.

One of the CARE members had a "big dream": a vision for incorporating mental health education into the core curriculum. The idea was that a shared foundation of mental health literacy would reduce stigma, correct stereotypes, and create a culture in which students felt comfortable seeking help and staff felt equipped to offer it. The curriculum would also teach students coping skills to support their day-to-day wellbeing. CARE therefore set out to co-

sponsor a board resolution mandating the research, development, and districtwide implementation of a mental health curriculum for all middle and high school students.

In reality, drafting the resolution itself was labor intensive and technical, and it is difficult to imagine it passing without the side-by-side support of partners. Participants described a steep learning curve in institutional language and procedures, and they brainstormed back and forth with board members for months during the writing process. Then, just days before their planned presentation at the board meeting to share their proposal, the district's legal team sent back a request to completely rewrite the resolution. The last-minute demand was not only stressful, but disheartening, as it revealed to the students how much was happening in rooms they hadn't been invited to. One CARE alumnus explained:

> We had district employees that we were working with, but they were not necessarily communicating with us. Decision-making was happening inside a room where we were not there. We were more or less just having conversations with one person, and they represented all of us—and that was incredibly frustrating. Because then you're playing telephone: you tell someone else, and they go to the decision makers, and it comes back to you, but it might be late, or it might not be the full message. And like in a game of telephone, a lot got lost there.

The group worked hard to meet the quick turnaround, and the resolution passed, which was a win celebrated by all involved. It should not be overlooked what this meant for the students, and the courage and collaborative work it took to make this happen. Ana elaborated: "And so we were really happy because it's scary. . .You have, like, this whole open forum. It's public. It's recorded. There are so many issues on the table, and so many parents that are on the calls, and you get your name called for your public comment once it's in the docket and, like, you have no idea what's going to happen."

Yet the work of turning the mandate into an actual curriculum ran into new obstacles. An alumnus described what happened: "They passed a resolution for this curriculum to be created.

And I was like, 'Great.' Like, that was my job. And now it's time. The school district is gonna write the curriculum, and they're gonna implement it, and it'll be awesome. And then they were like, 'No, you're creating the curriculum.' And I was very taken aback. I was like, 'Okay. I'm not educated in curriculum creation. I have no background in that. I've never taught, or learned anything about education. . ."

CARE navigated this challenge by convening a collaborative curriculum-writing group that brought together students, district staff, and a subject matter expert from a local university. A student described the curriculum-writing process as meaningful, as it presented a unique opportunity for young people to contribute to educational content. Then came another obstacle, as explained by an alumnus: **"**We were working on the curriculum with a certain district employee, and we spent a lot of time writing it, but then learned that they weren't necessarily communicating our progress to other departments in the district, and then that employee left the district. . . The transparency and information sharing was lacking, because the district tends to work in silos."

When this district employee left without warning, the committee reached out to other departments to continue the work, only to find that those colleagues had no knowledge of the curriculum at all: "We reached out to some other people, and they were like, 'We had no idea you were doing this.' And we were like, 'We were being told that you were telling us to do this.' It was super frustrating. It was a bit of a betrayal, like, from a mentor who had been there for so long, to just disappear without any communication." Students feared their hard work on the lessons might be discarded entirely, and that they had lost all curriculum progress.

Despite this setback, the curriculum was retained in part, though some portions required revision. Once the curriculum existed, a new question emerged: where in the school day would it

be implemented? One CARE alumnus held the opinion that the curriculum should be implemented in physical education, where wellness practices could be naturally embedded. But the question of implementation proved complicated, and in the end, little progress was made. For one, CARE members acknowledged the difficulty of training teachers to discuss mental health and the hesitation about adding emotionally demanding content on teachers whose plates were already full. At some point in the process, the teachers' union also became involved to protect teachers' time and scope of work. Plus, the PE proposal was met with resistance. One alumnus did not hold back her disappointment and frustration: "PE teachers were not happy about it, which makes me sad. . . Talking to kids about these things and teaching wellness practices is more emotionally intensive, even for the adults leading it. Like, yeah, maybe it is more fun to teach a tennis lesson. But if we're gonna be serious about creating an environment where students can thrive, I think it's essential."

By the time of this dissertation, a few years later, the curriculum had been implemented in a limited way, and participants themselves seemed uncertain about its status. "I think they've done one lesson, I think in science, probably. . . It's kind of a bummer," shared one alumnus. A district staff member noted that budget cuts had put even that limited implementation in jeopardy: "Last year it was starting to be implemented in some schools. But the school district had a huge deficit this year, and a lot of cuts were made." She shared an honest assessment of the curriculum's future: "I'm not sure if we're going to do that again."

The mental health education story showcases remarkable effort, persistence, and teamwork among students, staff, and community partners, from securing a board resolution to developing a mental health curriculum. Yet its trajectory reveals how even a policy victory can be stifled by the features of a large institution, including siloed departments, personnel turnover,

union dynamics, budget pressures, and the fundamental constraint of students remaining outside of decision-making spaces.

Student Voice: Belief and Reality

The district dynamics described above unfolded in an environment that was nominally supportive of student voice. Supporters, including district staff, consistently articulated that adults cannot effectively design supports without hearing from students. In one supporter's words, "You just can't make decisions for students unless it's informed by the students, because how do you know what they need if you're not asking them?"

This belief was particularly salient when it came to mental health, given the recognized generational gap between students and adults. Participants agreed that older generations, including some parents and teachers, "don't understand mental health, or they're like, 'Oh, that's not a thing, you just need to persevere and get through it,'" as Victoria explained. Luz concurred, noting that while students today are "well-versed on mental health," some adults in their lives often hold that older mindset. Participants shared several explanations for why today's youth are more conversant in the language of mental health, including how social media normalized mental health conversations, the availability of information online, and the distress associated with COVID-19. This created a problematic mismatch, as Emily named—"a group of young people that are able to really talk about their mental well-being in a nuanced way, and a generation of practitioners and adults and policymakers who do not have that set of skills"—reinforcing the need for student voice in an adult-led, student-serving system.

COVID-19 also had a profound impact on district attitudes toward mental health. In some ways, the pandemic may have primed the district for CARE's work. August noted this directly: "It should not be overlooked that [the founders] started this in the very start of COVID, midway

through 2020, because it enlightened people to just how dire those circumstances were and how they got worse. . . The need for resources and awareness became more of a thing." One supporter agreed, sharing that engagement with mental health shifted after COVID-19: "Ten years ago, I would go to school sites and school sites didn't even know that the district had a mental health department." Because of the pandemic, she suggested, adults who had previously held more dismissive or judgmental attitudes toward mental health were more open, "because they themselves were struggling and couldn't pull themselves up by their bootstraps."

Indeed, at the district level, the generational dismissiveness and stigma that students encountered at school was largely absent. More commonly, participants identified individual board members and district leaders whose personal connection to mental health, through family experience or loss, had produced a commitment to CARE's mission. For example, the school board president at the time of the committee's founding had a son deeply involved in mental health advocacy, and another district leader had lost a family member to a mental health-related death. These personal experiences, as interpreted by participants, appeared to produce authentic engagement with the committee's cause.

Yet at the end of the day, the district had not yet formally institutionalized the voice and perspectives of the committee into its decision-making processes. The data revealed a consistent disconnect between stated belief in student voice and its meaningful enactment, and students, at times, felt overlooked and unheard. The mental health curriculum story is one example of how that gap played out. Grace captured the overarching sentiment: "A lot of people will say, 'Mental health matters, student voice is important,' but then not necessarily putting in the actions to match up with that. I see that we are told that we're valued, but it doesn't necessarily align with

their actions from time to time. A lot of times when we recognize students, it might more or less be, like, superficial. But the actual inclusion in the day-to-day decision making is not there."

Grace's point maps directly onto the difference between consultation and collaboration, where students are asked for input while adults retain the power. The district did solicit input from the committee, but it was often ad hoc, with district staff presenting at CARE meetings to ask for feedback on specific mental health initiatives like a poster design or campaign (Field Notes, October 2025; March 2026). From my observation, it was not communicated back to the committee if and how their feedback was incorporated, and more broadly, there was no structural, ongoing mechanism for student input to inform district decisions. In many cases, the adults closest to this work wanted to include students, but because opportunities to incorporate CARE's voice had never been baked into the district's structure and regular procedures, well-intentioned staff did not have a clear roadmap for how to do so. As such, inclusion was something that happened to the committee or that the committee sought out, rather than something the committee was built into.

Part of what makes structural inclusion of student voice challenging is that it is a demanding task that can require a fundamental shift in thinking about power. Some adults, Emily argued, hold the idea that power is "seen as a slice of pie," such that youth participation necessarily diminishes adult expertise and authority. Jonathan elaborated: "There's a lot of fear around what it means to include young people. . . And then a lack of a desire to take the time to increase what processes will come about, based on bringing new stakeholders into the conversation." As such, even when people believe in the value of student voice, as seemed to generally be the case at the district, meaningfully incorporating it requires changes in structures and policies—which are themselves hard to change in a complex bureaucracy.

Not all participants, however, attributed the gap between student voice and district action solely to the district. One supporter suggested that bureaucracy was not always the main obstacle: "They [Students] would have these great ideas, but they wouldn't start working on them, and things take so long in the district to get approved or to coordinate. It wasn't that the bureaucracy was stopping them—it's just that the students were not starting it soon enough so that it could actually develop and take place." In her view, good ideas may fail to take hold because of the mismatch between how long institutional processes take and students' expectations, which she expressed to be not inherently the district's fault.

Furthermore, even when the district took active steps to better serve student mental health, its efforts were not always visible to students. Several participants suggested that the perceived lack of support stemmed, at least in part, from poor communication between the district and students. August explained: "A lot of students just felt like they're on their own a lot of the time. One of the things we tried to communicate was just, yeah, students just don't know what things are, where they are, or that the district is trying to help them in any way." Because of this issue, one goal of the committee was to act as a conduit, translating and communicating district efforts to students so that they could see the ways in which the district was prioritizing mental health. This disconnect between what the district was doing and what students actually experienced was highlighted repeatedly as a reason why incorporating student voice in mental health decision-making matters.

Student Responses and Pivots

Students did what they could within this large bureaucratic system. When they hit walls, they pivoted without losing engagement or passion. However, while alumni spoke proudly about passing board resolutions and contributing to systemic changes, district-level advocacy was not a

central or explicit focus during the year of data collection. Instead, CARE's energy was directed toward compiling and sharing resources, forming community partnerships, and creating localized change through events and school-based CARE clubs.

The committee's organizational features, with its emphasis on relationships and sustainability, helped students keep going and stay committed to their mission. It also helped calibrate their expectations over time and predict potential roadblocks. In one interview, a student recalled hearing about how, several years earlier, a co-chair had "worked her butt off" surveying students to build a data-backed case for more safe spaces on school campuses, only for the district to decline funding for the initiative. Stories like this one, and the one about mental health education, seemed to shift CARE's strategies over time while they stayed committed to the larger mission of supporting student mental health.

For example, one strategic move was pursuing initiatives that could bypass formal district approval entirely and could therefore be done faster and with fewer barriers. Holly articulated the urgency behind this logic: "I don't have to wait for district approval. . . Youth mental health is not slowing down, so we don't get to slow down, either." For example, recognizing the pervasive issue that students do not know about available resources, I observed CARE subcommittees spending a substantial amount of time compiling mental health resources and sending them to principals throughout the district, as well as posting them on CARE's social media. Holly explained, "I just want resources out there. I was like, students need resources. They don't even know [CARE] exists. . . . We're doing all this awesome work, which is great, but if nobody knows that we're doing it, it doesn't really matter."

In other instances, CARE members also embraced the philosophy of depth over breadth. Some advocates shared the view that meaningful impact on a smaller number of students was

more valuable than superficial reach across many. Kishor was explicit: “What we are reaching for is that even if there’s a few kids from each school who really need the support of [CARE], we’re able to make a very big, meaningful impact on them. So we’re really prioritizing the depth of what we’re able to do more than the breadth of it.” This philosophy was both pragmatic, as students recognized the many obstacles facing a youth-led organization in a large school district, as well as a rejection of shallow or surface-level projects.

Jonathan summarized how CARE exemplified persistence over the years: “Persistence doesn’t necessarily mean beating somebody down until they say yes. Sometimes it means completely forgetting about that person and going to someone else, finding a new way and a new avenue.” In this sense, a defining feature of CARE is their sustained commitment to improving mental health in an institutional context that was still learning how to incorporate them.

Conclusion

This chapter presented findings from the case study of CARE, organized around three research questions. First, I shared the preliminary Proximity-Based Model of Youth Mental Health Advocacy Development to show how students’ pathways into mental health advocacy were shaped by a combination of factors: a prosocial orientation, experience related to mental health concerns, empathic concern, disillusionment and frustration, moral conviction and urgency, self-efficacy, and opportunity. Second, I described student advocates’ perceptions of school-based mental health supports, highlighting themes related to resource communication and navigation, students’ understanding of and access to counselor support, the impact of stigma on help-seeking, and the care provided by individual adults. Finally, I examined the conditions that enabled and constrained CARE’s advocacy within the district, showing how internal committee structures, external supporter roles, and the broader district environment determined both success

and setback. In the next chapter, I discuss these findings in relation to the literature and theoretical frameworks, and I consider their implications for research and practice.

Chapter 5: Discussion

In this dissertation, I examined a student-led mental health advocacy committee situated within a large urban school district across three research questions: (1) what shapes students' pathways into mental health advocacy?; (2) what are student mental health advocates' perceptions about school-based mental health supports?; and (3) what conditions enable and constrain their advocacy within a public school district? In this final chapter, I synthesize findings within existing literature, specifically highlighting youth passion and potential, context and conditions, and the gaps between systems and the students they serve. I then discuss implications related to both student mental health and student voice and conclude with limitations and future research directions.

Youth Passion and Potential

First and foremost, the findings from this study remind us of the remarkable capacity of youth to advocate for a cause they care about. CARE members exemplified what Lerner et al. (2005) call the sixth C of positive youth development, Contribution, as an expression of thriving. Youth advocates displayed advanced interpersonal and leadership skills, maintained their commitment despite barriers, and collaborated across peer and adult networks toward goals they had defined for themselves, all in service of improving their school communities. This finding connects back to the youth development literature, which holds that youth can flourish when given the right opportunities, resources, and relational support (Chryssochoou & Barrett, 2017; Eccles & Gootman, 2002; Heberle et al., 2020; Jennings et al., 2006; Lerner, 2005).

The many capacities displayed by the student mental health advocates in this study, including empathy, morality, critical thinking, collaborative problem-solving, creativity, and persistence, are urgently needed today. As groundbreaking advancements in artificial intelligence

transform the nature of education, work, and daily life (Wang & Siau, 2019), schools are increasingly called upon to place these human qualities at the center of their teaching (Luckin, 2025). At the same time, youth today are growing up amid multiple stressors, including a mental health crisis, climate anxiety, racial violence, and academic pressure (Anderson et al., 2022; Anderson et al., 2023; Luthar & Kumar, 2018; Vercammen et al., 2025), leaving less room for the slow process of cultivating passion and a sense of purpose. The youth in this study found their way to advocacy anyway, and they did so through a youth-initiated and youth-driven effort, not a structured program. The case of CARE is an example of what youth contribution can look like in practice, on their own terms.

The Preliminary Proximity-Based Model of Mental Health Advocacy

This study contributes a preliminary model of a pathway through which youth come to engage in advocacy for mental health. Mental health advocacy is a domain that, despite the urgency of the current crisis, has received little empirical attention. Prior research on youth advocacy development has examined civic and political engagement broadly (Wray-Lake, 2019; Ekman & Amnå, 2012), sociopolitical development in the context of racial and socioeconomic oppression (Watts et al., 1999, 2003), and targeted advocacy efforts toward goals like LGBTQ+ rights (Montagno et al., 2021) and racial justice (Vierra et al., 2023; Malorni et al., 2024), but the factors that draw young people toward mental health advocacy had not been previously explored.

This study maps how youth mental health advocacy develops through a combination of various elements: a prosocial orientation, experience related to mental health concerns, empathic concern, disillusionment and frustration with systems, moral conviction and urgency, self-efficacy, and opportunity. The model draws on SCT to consider how advocacy behavior is learned through observation, including witnessing family members and teachers model care and

service, and reinforced through mastery experiences, vicarious experiences, and social persuasion (Bandura, 1977, 1986). Additionally, Bandura's (2002) concept of moral agency helps explain the concern and action that arise from the gap between student mental health needs and the available resources. CYE (Jennings et al., 2006) complements this by reminding us that who gets to become an advocate is also a question of access, power, and whether the environments around young people invite their meaningful participation, labeled as opportunity in the model. While the model I developed requires further testing across different populations and contexts, it can serve as a starting point for researchers who seek to understand how to identify, cultivate, and support the next generation of mental health advocates.

The Role of Context and Conditions

My findings underscore how context and conditions surrounding youth deeply impact their development and mental health, as well as the success of their advocacy efforts. Across the data, three contextual forces stand out for discussion: power and privilege, relationships, and the catalyzing moment of COVID-19.

Power and Privilege

Power and privilege shape who becomes an advocate and what advocates can accomplish. Privilege was present from the very beginning in the form of the structural features that determine access to resources and support. For one, whether youth were able to receive adequate support for their own mental health challenges depended on who was around them and the resources they were able to access in both school and family contexts. This mirrors the literature on social determinants of health, confirming that the conditions in which people live, learn, and grow affect both their mental health and their opportunities to thrive, and that these

conditions are vastly unequal across groups of people (Office of Disease Prevention and Health Promotion, n.d.; World Health Organization, 2008).

Furthermore, access to CARE itself was determined by power and privilege. Structural conditions such as poverty, under-resourced schools, and family instability are well-documented barriers to civic participation because they constrain time, energy, and access to opportunity (Balsano, 2005; Brooks-Gunn et al., 1997; Montagno et al., 2021). This raises important questions about whose voices remain unheard and elevates Augsberger et al.'s (2018) concern that youth voice efforts can inadvertently reinforce inequality when participation reflects existing privilege instead of the diversity of the community. Selective amplification, where the voices elevated tend to belong to students with greater privilege (Rudduck & Fielding, 2006), is a real concern present in the data. Importantly, CARE members were aware of this concern. Students themselves recognized that the committee did not fully represent the range of identities, experiences, and mental health needs across the district, and they took steps to mitigate this limitation. This included efforts to broaden participation, attend to whose perspectives were missing, and create a subcommittee specifically focused on mental health of minoritized groups. These efforts do not eliminate the concern of selective amplification, but they show that students were not reproducing inequities uncritically.

Once on the committee, power continued to determine what CARE was able to achieve. CARE did not hold institutional authority on its own; the committee's successes were largely dependent on supporters who lent their platforms and access to amplify youth voices. Only in limited moments were students positioned as co-designers, working with adult partners to design mental health initiatives, such as when students and board members worked together to draft and co-sponsor the mental health education board resolution. As such, CYE's third dimension—

equitable power-sharing—was only partially realized in the case of CARE (Jennings et al., 2006). This distinction is important because student voice is not just about whether youth are heard, but whether their perspectives influence decisions and action (Cook-Sather, 2002; Fielding, 2004a; Holquist et al., 2025). In this case, CARE members were often affirmed and listened to, but their influence remained contingent on the adults in power.

This study deepens our appreciation and understanding of power-sharing and youth-adult partnerships. Research on youth-adult partnerships has consistently established that adults serve varied functions in youth voice efforts (Mitra, 2009; Zeldin et al., 2013), and the six external supporter roles identified in this study—the power-holder, the champion, the connector, the advisor, the partner, and the mental health specialist—echo extant findings. For example, the connector role resonates with Burt's (2004) concept of brokerage, in which intermediaries bridge gaps between groups, providing access to networks and resources. Mitra's (2004, 2009) work on student voice documents how adult allies function as amplifiers, providing students with access to forums and decision-making spaces they could not otherwise enter. And Watts and Flanagan (2007), in their study of a youth organizing initiative, found that adults offer "consulting functions" including technical assistance and other forms of support that parallel the advisor role described in this dissertation.

The taxonomy developed here builds on existing literature by providing a more detailed and comprehensive account of the distinct functions allies serve in youth advocacy, specifically as they relate to how they hold and use power in different ways. The six roles, when organized and presented together, remind us that sustaining youth advocacy in institutional settings often requires a distributed network of allies, and the taxonomy provides a vocabulary for their different roles and purposes. My findings extend the literature by showing that these roles do not

need to be held exclusively by adults. Youth allies also exercised power in distinct ways and, at times, served as connectors, champions, advisors, and partners in CARE's work.

Finally, it is important to note that developing this distributed network itself required power and privilege. Forming relationships with power-holders, connectors, champions, and other allies required social capital (Bourdieu, 1986), confidence, and communication skills, including the ability to identify those with influence, initiate contact, and build relationships with people occupying different institutional positions. In this way, power factors into youth advocacy as part of the process of acquiring allies, before any questions of equitable power-sharing can even be asked.

Relationships

Similarly, relationships emerged repeatedly as a crucial context across all three research questions: for individual development, for mental health, and for the committee's ability to function and persist. For individual advocates, relationships were foundational to the development of self-efficacy (Bandura, 1997). Two of the four sources of self-efficacy, vicarious experiences (observing others succeed) and social persuasion (affirmation from others), are inherently relational (Bandura, 1977). Youth who became passionate advocates consistently described adults who believed in them. Affirmation from teachers, mentors, and family, delivered over many years, built the confidence that their voice and actions mattered. Indeed, the importance of positive, warm, and supportive relationships for individual youth development saturates the literature (Diemer & Li, 2011; Lerner, 2004; Heberle et al., 2020).

Relationships also mattered enormously for student mental health. Through finding pockets of support in their schools, students described how the presence of a known, trusted adult made a difference. Research confirms that students prefer turning to trusted adults over

formal services with strangers (Bryan & Gallant, 2012; Ijadi-Maghsoodi et al., 2018). These trusted adults create the relational safety that allows students to open up, and they can connect students to further resources and higher levels of care through warm hand-offs (Bryan & Gallant, 2012; West et al., 1991; Ekornes, 2020). Indeed, youth who have a trusted adult at school—adults who make students feel known and seen as individuals—display lower rates of depression, anxiety, and suicidality (Mollenkof et al., 2026). Relationships, in this sense, are part of the infrastructure of mental health support, helping students overcome hurdles to care.

Relationships were also at the heart of the committee itself. CARE deliberately carved out time for connection separate from its advocacy activities. When initiatives fell through or met resistance, friendship held the group together and helped them keep going. The relational culture of CARE appeared to function as a protective factor against burnout, a well-documented risk for youth advocates (Gorski & Chen, 2015), while providing a space for collective healing (Baker, 2024).

Finally, relationships between youth advocates and external supporters, including district advisors, university partners, and community members, similarly reminded students that they were not doing this work alone. Supporters lent their power and resources, as well as their presence, care, engagement, and belief in the students and their work. These findings align with both CYE's emphasis on a welcoming and safe environment as a condition that supports participation (Jennings et al., 2006), and with research demonstrating that sustained positive relationships are central features of contexts that support advocacy and civic contribution (Lerner, 2004; Wong et al., 2010; Heberle et al., 2020).

Meeting the Moment of COVID-19

In case study research, the case cannot be separated from its context (Yin, 2018). As such, the case of CARE cannot be fully appreciated outside the context of the COVID-19 pandemic and the crisis building up to that moment. Mental health advocates were sounding the alarm well before COVID-19, calling for scaled-up services and for schools and governments to treat mental health as a public health priority, but these calls and recommendations remained largely absent from policy agendas (Lancet Global Mental Health Group, 2007).

Then, in 2020, the COVID-19 pandemic reached the United States. Consistent with existing research on the impact of COVID-19 on children and adolescents (Panchal et al., 2023), youth in this study frequently referenced the pandemic as a time of considerable distress. Loneliness, isolation, economic uncertainty, grief, and anxiety became much more widespread, touching the lives of nearly everyone (Singh & Singh, 2020). Many parents and teachers also now felt mental health struggles personally while witnessing firsthand the toll the pandemic was taking on the youth they were caring for.

CARE was first established in this context, at the height of the pandemic. Research shows that COVID-19 accelerated more open dialogue about mental health and generated momentum for increasing accessibility to support and services (Nealon, 2021). Youth in this study became even more acutely aware of what it was like to live with mental health challenges and how resources were falling short, while adults at the district became more receptive to talking about mental health and more motivated to help create change, as they were navigating their own struggles during this period of collective crisis. Plus, with fewer extracurricular commitments, students found themselves with the time to undertake the considerable work of establishing a new districtwide committee, including drafting a constitution and recruiting members and district advisors. The committee emerged at this critical moment when the urgency students felt matched

an openness among the adults in power, at a time when students had the bandwidth to act. While advocacy may not require a moment like this, this case suggests that when passion, receptivity, and opportunity align, the conditions for change may be favorable.

The Gaps Between Systems and Students

Another contribution of this dissertation is the persistent gaps between what schools provide and what students experience or need. These gaps operate from two vantage points, described below: that of student mental health, and that of student voice.

Student Mental Health: The Gap Between Resources and Use

This study illustrates a gap between the intent behind school-based mental health supports and the way students experience them. Universal, Tier 1 supports, including wellness week activities, suicide prevention videos, and posters advertising hotlines, were described as surface-level, performative, and disconnected from students' experience of distress. To students, efforts that acknowledged mental health without addressing its weight felt more like a checkbox than real support. It is worth mentioning that when participants described the universal mental health supports at their schools, they rarely mentioned structured curricula or programs, instead primarily referencing one-off initiatives and events like wellness week. Whether this reflects an absence of Tier 1 programming in their schools, or whether such programs existed but did not come to mind during interviews, is unknown. Either possibility suggests that students were not experiencing regular Tier 1 programming as a coherent part of their school's approach to mental health.

Students also reported a general absence of foundational mental health literacy to make use of the resources that could help. Participants made the point that seeking or receiving mental health support, unlike physical health care, is not typically normalized from a young age. As a

result, students encountering a poster or hearing an announcement had no framework for understanding how these resources could help. This finding is consistent with research demonstrating that mental health literacy is a foundation for effective help-seeking, and that adolescents' limited knowledge of mental health concepts, symptoms, and available supports contributes to unmet need (Coles et al., 2016). Goodwin et al. (2023) confirmed that students themselves recognize gaps in their knowledge of mental health services, and they want more detailed information about how to access appropriate supports.

Even among students who were aware that resources existed, navigating them was its own obstacle. Resources varied from school to school, leaving students without a coherent map of what was available or how to access it. Students who did try to engage were overwhelmed by the volume of options. Indeed, the importance of mental health service navigation has received increased attention in the broader mental health literature as providers recognize the barriers people face in accessing care and the need to support individuals in identifying, accessing, and remaining connected to appropriate mental health services (Waid et al., 2021). The findings from this study show how resources built and advertised by adults may assume a level of mental health knowledge and skill that many adolescents had not had the opportunity to develop. These gaps between what schools provided and what students needed were part of what drew many participants into advocacy in the first place.

Student Voice: The Gap Between Valuing Student Voice and Incorporating It

This study also revealed a gap between the stated value of student voice and the structural conditions that allow it to have impact. Student voice in mental health was broadly endorsed across the district. All participants interviewed in this study expressed the belief that students should be included in mental health decision-making and that the committee's work was

valuable, and few recalled anyone explicitly getting in the way. Instead, the barriers could often be attributed to the structural conditions of the district. Because the committee was not formally embedded in district decision-making processes, inclusion was not guaranteed. Students were invited into conversations occasionally and consulted sporadically, and they pushed their way into decision-making conversations and opportunities where they could, but they were less often positioned as genuine co-designers of their schools' mental health policies and practices. This made the work of CARE fragile and largely dependent on the capacities of the CARE co-chairs year to year, as well as on the partners who supported them. The work was especially vulnerable to disruption because students naturally moved on as they graduated or shifted their attention to academics and other activities, while adult staff frequently transitioned roles or left the district entirely. The onus fell on both students and their supporters, rather than on the system itself, to sustain the work, and turnover on both sides made that dynamic unstable.

The absence of structurally embedded student voice opportunities is well-documented in the literature. Flynn and Hayes (2021) found that when students are consulted at the district level, those consultations tend to remain one-off events, producing calls for greater involvement rather than the kinds of institutionalized structures that would make student input a routine part of decision-making. Kaba (2000) confirmed that even when students are given a seat at the table, they are not always given a corresponding opportunity to substantively change their schools. Wong et al. (2010) shared the consequences of such tokenistic practices: they can erode trust and reinforce adult-centric power structures. Fielding (2004b) sums up the issue succinctly, arguing, "Student voice activities, however committed they may be, will not of themselves achieve their aspirations unless a series of conditions are met that provide the organisational structures and cultures to make their desired intentions a living reality" (p. 202). My findings, and this body of

evidence, point to a broad deficit in what CYE terms meaningful participation and engagement—authentic, youth-determined opportunities through which students make real contributions (Jennings et al., 2006).

Cook-Sather (2006) helps explain why these conditions for student voice are rarely met. She argues that schools are organized around "premises of prediction, control, and management," making them resistant to the changes that are demanded by student voice work (p. 26). As such, adults ceding authority to students runs against deeply ingrained professional norms. However, as I found in the case of CARE, the barrier was not belief or attitudes. The adults involved valued student voice in the context of mental health support. Instead, the barrier was capacity; meaningfully and systematically incorporating CARE's ideas would necessitate changing processes and structures that themselves are resistant to change, requiring time and effort of adults who were already stretched thin. As such, the moments when CARE made structural change were due to extraordinary effort and specific enabling conditions, not routine practice.

The structural gap between student voice and its integration was felt by students and adults alike. Students experienced a mismatch between the urgency of their concerns and the pace of institutional response, and between being told they were valued and feeling that their knowledge informed decisions. They therefore, at times, pivoted away from district-level advocacy and toward efforts that were more localized or immediate. Meanwhile, district staff, navigating resource constraints and bureaucratic complexity, did not always understand how invisible their efforts were to students. This mutual invisibility, with students unaware of adult effort or how to navigate bureaucracy effectively, and adults unaware of student experience, is underexplored in the student voice literature.

Implications Related to Student Mental Health

The findings of this study underscore both the urgency of student mental health needs and the work still required to close the gap between what students need and what schools currently provide. Students' accounts of heightened stress mirror the existing literature, which confirms that this generation faces new and intense challenges ranging from the lasting toll of COVID-19 to increasing academic pressure (Anderson et al., 2023; Luthar & Kumar, 2018). Worryingly, despite the escalating need for mental health support, participants described a school-based mental health landscape marked by misalignment, uncertainty, and structural constraints, and the persistent and harmful effects of stigma continue to lead to the masking of symptoms. These findings point to specific implications: the need for universal mental health education, the need to invest in relationships, the need for increased funding and resources, and the need for student feedback loops for continuous improvement of school mental health systems.

First, I join the student advocates in this study, as well as a growing body of literature, in calling for robust mental health education in schools. The advocates understood awareness and education as foundational for mental health, and their conclusion is supported by existing evidence. Mental health education can help students understand what mental health is, recognize when they or their peers are struggling, reduce stigma that harms students and prevents help-seeking, and build the skills needed to seek support when it is needed (Ma et al., 2022b; Lee et al., 2026). Evidence-based social and emotional learning programs can extend this work further by teaching students strategies for understanding and responding to their emotions, behaviors, and social contexts, with research demonstrating gains in social, emotional, and academic outcomes when such programs are implemented well (Cipriano et al., 2023; Collaborative for Academic, Social, and Emotional Learning, 2020; Macklem, 2011).

This kind of universal, Tier 1 investment is important because of its direct benefits for students and because it creates the conditions in which other mental health supports can be reached. As my findings indicate, mental health education should include clear information about the role of school counselors, what kinds of support they provide, what confidentiality does and does not mean, and how students can access help. Resources must be understandable, visible, and easy to navigate. They also must be communicated in ways that feel genuine to students, rather than as another poster, announcement, or one-time event that signals concern without building trust; students may dismiss outreach that appears superficial or disconnected from the realities of their daily lives.

Second, this study shows that access to support is not only informational, but relational. At times, youth may not make use of a resource encountered outside of a trusted relational context. Counselors and other support staff who are known to students by being visible within the school community and available outside of formal appointments are more likely to be sought out when students are struggling. Teachers can also make support more accessible by demonstrating care and trustworthiness in everyday interactions, including noticing when students seem distressed, responding with warmth instead of judgment, following up after difficult moments, and communicating that students' well-being matters beyond their academic performance. This has implications for how schools structure counselors' time, the types of training teachers may require, and putting the two together to improve mechanisms for how teachers refer students to counselors or other mental health professionals. Universal mental health screening may also help by shifting some of the burden of help-seeking away from individual students and onto the system, but screening is only useful if schools have the staffing,

capacity, and follow-up systems needed to respond (National Center for School Mental Health, 2023).

Third, stronger relationships and clearer communication cannot compensate for inadequate capacity. As existing literature documents, closing the mental health support gap requires more resources than schools currently have (National Center for Education Statistics, 2024). Counselors carry caseloads and other responsibilities that make sustained social and emotional support difficult, if not impossible. Increased funding for mental health personnel and programs is therefore necessary if schools are to serve all students who need support.

Finally, these recommendations are only as strong as schools' understanding of students' actual experiences. School and district leaders must continually ask students how they experience mental health services and support as part of a feedback loop, in which students are able to see how their perspectives are used. The participants in this dissertation had specific and actionable knowledge about where supports fell short, yet this knowledge is often underutilized. Schools must hear not only from student advocates with strong and critical perspectives, but also from students who are marginalized or less likely to enter formal advocacy channels, including students with unmet mental health needs and students facing structural injustices, such as LGBTQ+ students, students of color, and students from low-income backgrounds. Building regular opportunities to hear from all students about their experiences of care, along with clear procedures for acting on what they share, would give leaders a more grounded and accurate picture of where supports are insufficient and how they might be improved. In sum, these implications point toward a school mental health system that is better resourced, more relational, and more attuned to its students.

Implications Related to Student Voice

The investment of time, energy, and creative effort required to build and sustain a committee like CARE is significant. It was made possible by a combination of extraordinary students and supportive adults willing to carve out time and space, and aided by the historical moment of COVID-19. Yet schools should not wait for the next crisis to create the conditions that meaningfully incorporate students in decision-making, and this dissertation makes a clear argument for building student voice into the structure of schools.

Practically, this means embedding opportunities for student voice in a genuine and consistent way, and ensuring that these opportunities are accessible to all students, not only ones who self-select into advocacy roles. When schools and districts are approached by student advocates like those in CARE, systems should be in place to receive and act on their input, or be more easily built, because incorporating student voice is already part of how the institution functions. This might look like standing student representation on district wellness or MTSS committees, a designated staff liaison responsible for connecting student input to planning and evaluation processes, or clear protocols for student-generated board proposals. Accountability structures can also help make sure student feedback is not shelved or used selectively or symbolically.

This means that adults must be willing to dismantle the parts of the systems that impede student voice. They must actively create structures and processes that invite student participation, rather than waiting for students to find their own way through the institutional complexity. This can enable what Wong et al. (2010) described at the top of the pyramid of youth participation, where adults and young people work together as partners. Professional development for district staff and school leaders can help build this kind of capacity for knowing when to lead, when to

step back, how to build the participatory structures that are needed for sustained youth engagement and effective youth-adult partnerships.

The final implication for educational leaders is simply to believe students. To return to the statement by Checkoway (2011), "Young people are experts on being young people, regardless of what others think" (p. 341). I implore adults to be curious about students' experiences and what they have to share, at the very least as a starting point for learning more. What students say may be disappointing, uncomfortable, or even hard to believe, but there is always value in it, as it provides a window into their realities. Adults, in turn, should consider how their own power can be used in service of youth voice and youth agendas. The systems currently in place were designed by adults, in ways that keep power from students—but they don't have to remain that way.

Limitations and Future Directions for Research

A common criticism of single-case study research is that it is limited in its generalizability. However, case studies such as the one presented here are not intended to generalize to populations. As Yin (2018) explains, case studies can instead be generalizable to theoretical propositions and can contribute to the expansion and refinement of theory, and Eisenhardt (1989) reminds us that multiple cases are often needed to test and confirm emerging constructs. To account for the limits of case study design, I take care to situate the findings within the specific context of this case: a youth mental health advocacy committee within one large school district. The patterns observed here reflect the features of this context, including the structures of this particular district and the nature of advocacy for mental health. At the same time, the findings are valuable as they offer theoretical and practical insights into how youth advocacy may develop and be supported and constrained within institutional settings.

Specifically, the preliminary model of proximity-based youth mental health advocacy development requires further empirical investigation. Generated from fewer than 30 youth advocates who were largely Asian American or white and living in a specific urban area of the U.S., the model's generalizability is substantially limited. Future research should examine whether and how the pathways, motivations, and barriers identified here apply across different populations and contexts. The model can help guide what researchers ask as they further investigate which elements are necessary or which vary across groups and settings.

As I underscore throughout this dissertation, advocacy itself requires privilege. The time, access, social capital, and support that enable advocacy are not equally available to all youth. Future research should continue to examine the barriers that prevent youth from historically marginalized racial and ethnic communities from participating in formal mental health advocacy structures such as CARE, and explore how models of advocacy might more authentically reflect the various ways students want to engage in change-making. Future research should also attend to the emotional and psychological dimensions of youth mental health advocacy work. Participants in this study described carrying significant emotional weight as a result of their close connections to mental health and their frustrations with the slow pace of institutional change. Some recent scholarship explores the role of emotion in youth sociopolitical development and advocacy (e.g., Malorni et al., 2024; Lozada et al., 2025), including how collective advocacy can serve as an important site for meaning-making and healing from trauma (Baker, 2024). Further research is needed to understand the impact of these emotional demands on youth mental health advocates, particularly given that many have lived experience related to mental health challenges, and for whom advocacy may stem from both purpose and grief.

Furthermore, because the youth participants in this study are not representative of young people broadly, many youth perceptions of school-based mental health supports are not captured here. This is an important limitation for both the generalizability and equity implications of the findings. For example, youth from historically marginalized communities may have distinct and urgent mental health needs and different relationships to school-based supports. Additionally, the findings reflect the views of a particular subset of youth who chose to become mental health advocates, and who therefore may hold more critical views of those systems than peers who are not engaged in advocacy. The perspectives captured here are thus those of an engaged, critically oriented group and do not reflect the full range of experiences and viewpoints held by the general population of students.

Another limitation is that this study prioritizes youth voices and perspectives rather than seeking balance between youth and adult participants. However, this was a purposeful decision. Adults, particularly those in institutional roles such as district staff and administrators, hold more positional power than youth within school systems and are therefore more likely to have their perspectives represented in existing policy and practice. Focusing on youth, whose voices are often excluded from decision-making processes, was an intentional decision to counterbalance these dynamics. Additionally, the study was framed around youth as they are best positioned to speak about what it's like to access and receive mental health supports in their schools. That said, some adult perspectives were incorporated to provide institutional context and to corroborate or complicate what youth described, helping to situate youth accounts within the organizational landscape of their advocacy.

Finally, this study does not evaluate the tangible impact or effectiveness of youth-driven mental health policies or practices. The research questions are more process-oriented than

outcomes-oriented, focusing on experiences and perspectives related to advocacy rather than measuring whether specific policies or practices produced measurable changes in student mental health outcomes. Process-oriented research is valuable on its own: understanding how youth come to advocacy, how they organize, and how systems respond to their efforts is essential knowledge for practitioners, district leaders, and policymakers who seek to meaningfully engage young people. At the same time, further research should examine the outcomes of youth-driven or co-designed mental health policies and programs. There is limited research examining whether schools and districts that meaningfully involve students in mental health decision-making actually produce better mental health outcomes for students. This absence was evident within the case study itself, where no formal mechanisms existed for youth to evaluate the impact of their own efforts. Complementing this process-oriented work with studies on effectiveness would help establish links between youth engagement and concrete improvements in outcomes.

Conclusion

The youth mental health crisis is urgent, and schools must do more to meet students' mental health needs. This case study documents how youth come to engage in mental health advocacy, how they perceive school-based mental health supports, and the conditions that enabled and constrained their advocacy efforts within a large public school district. The students in this study demonstrated capacity for and commitment to contributing to systems-level change. They are ready to help shift how we approach and improve mental health in schools. We need to make room for them.

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Appendix A

Parent/Guardian Letter

Dear Parent/Guardian,
The purpose of this letter is to inform you of a research study participation opportunity for your student. You are receiving this letter because your student is a member of [committee] in [district].

What is the research study about?
Rebecca Levine, a doctoral candidate in Education at UC San Diego and licensed social worker, is conducting this study to better understand youth mental health advocacy in schools. The goal is to learn about youth mental health advocacy development and how schools and school districts can partner with youth leaders to promote mental health for all students.

Who is participating?
[Committee] members, [committee] alumni, and supporting staff and community members are being invited to participate.

What does the research study entail?
If you agree to have your student participate, they will complete one 45-60 minute interview about their experiences with [committee]. Rebecca also plans to observe committee-related activities.

Please note that:
- Your student's participation is completely optional
- Study participation or non-participation will not affect your student's ability to be involved with [committee]
- You can end your child's participation at any time
- Data will be stored securely and the researcher will take additional steps to protect your student's name and any other identifying information

If I would like my student to participate, what should I do?
Please see the consent form (attached). If you approve of your student participating, please sign the form, scan, and email it to [email].

This study has been approved by both the [District] Research Review Board and the UC San Diego Institutional Review Board.

Please don't hesitate to reach out to Rebecca Levine if you have any questions via email, call, or text.

[email address], [phone number]

Thank you for your consideration.

Rebecca Levine

Appendix B

Interview Protocol

Thank you for taking the time to meet with me today. As a reminder, this interview is part of a research study about student mental health advocacy. I'm interested in learning from your experiences and perspectives.

A few notes before we begin. First, this is a semi-structured interview, which means I have a set of topics and questions I'd like to cover, but I may also ask follow-up questions depending on what you share. However, you do not have to answer any question you would prefer to skip, and you may stop the interview at any time.

Second, your participation is confidential. This means that what you share will be kept private to the extent possible, and any reporting from this study will avoid using identifying information.

The interview should take about 45 minutes to one hour. As a thank-you for your time, you will receive a $25 gift card in your email after completing the interview.

Before we begin, do you have any questions for me?

To help me remember our conversation, would it be okay if I audio record our conversation? The recording will only be used for research purposes.
→if yes, "Thank you. I'm starting the recording now."
→if no, "Thank you. I will not record our conversation. I'll take notes instead as we talk."

Protocol #1: Committee Members and Alumni*

Part I: Participant Background

1. Tell me a bit about yourself.
   a. Probe for: age, grade, gender identity, racial and ethnic background

Part Ia: for committee founders only

Can you share with me the history of [Committee]?

a. Why did you decide to form this committee?
b. What were the steps involved in the creation of the committee? Any challenges?
c. Who were the people involved? (probe for other students, adult partners [school staff, district staff, community partners])
d. What was the initial mission and vision for the committee?
e. From what you have seen, how has [Committee] evolved since its founding?

Part II

2. Tell me a bit about your journey to becoming a mental health advocate.

a. When would you say your awareness or interest in mental health began?
b. Why is this topic something you are passionate about?
c. What do you hope to change or improve when it comes to youth mental health?
d. Are there any adults, like family members or teachers, who have supported your mental health advocacy journey? In what ways have they been supportive?

3. From your perspective, how is the mental health of high school students today?
   a. What are you noticing that is giving you this impression?

4. In what ways, if any, is school a positive influence on the mental health of you or your peers?

5. In what ways, if any, is school a negative influence on the mental health of you or your peers?

6. What do you think schools need to do differently to take better care of students' mental health? Why do you think so?

7. What continues to drive your commitment to the work of mental health advocacy?

Part III

8. Tell me a bit about [Committee] and your experiences with the committee so far.
   a. Why did you decide to join the committee?

9. How would you describe the overall mission and goals of [Committee]?

10. Can you share with me one or two examples of work you've done with [Committee] that you have found to be impactful or successful in some way?
    a. Probe for details of the example(s): who was involved, how the initiative was carried out.
    b. Why do you think this initiative was successful?

11. What are some future plans or goals you have with [Committee]?

Part IV

12. What are barriers or challenges, if any, when it comes to [Committee] and the work you're trying to do?
    a. Probe for: roadblocks related to school/school district policies, procedures, practices.

13. I'm also trying to understand how adults in schools, like district staff, teachers, and counselors, can better help youth advocates in reaching their goals. Who are some of the adults you have interacted or worked with as part of [Committee]?
    a. Can you tell me a story of working with an adult that was positive and helpful?

14. What are some ways that you think schools should support you all in the work that you do? What are some things that you think adults should not do?

Part V

15. How has being a member of the [Committee] committee impacted you personally, if at all? In what ways, if any, have you felt like you have grown or changed because of your involvement with [Committee]?

*note: some questions may be phrased in the past tense for alumni

Protocol #2: Committee Supporter

1. Please tell me a bit about yourself and your current role.

2. How long have you been working with the [Committee] committee?
    a. How did your work with the committee begin, and why do you continue to work with them?

3. How would you describe your role when it comes to working with [Committee]?

4. Can you share with me one or two examples of work you've done with [Committee] that you have found to be impactful or successful in some way?
    a. Probe for details of the example(s): who was involved, how the initiative was carried out.
    b. Why do you think this initiative was successful?

5. What are barriers or challenges, if any, that you have noticed when it comes to the work the committee is trying to do?
    a. Probe for: roadblocks related to school/school district policies, procedures, practices; as well as challenges working with youth advocates in general.

6. What have you learned or what has been reinforced when it comes to working with student advocates?

7. What additional supports would be helpful to help [Committee] advocates achieve their goals? These can be individual, school, and/or district supports.

8. How do you see your work with [Committee] changing or evolving in the future?

9. What advice would you give someone else in your position who is interested in supporting students to improve school-based mental health?

Appendix C
Documents

Document Type	Content/Purpose	Access
Committee constitution	Outlines committee structure, membership requirements, and governance	Publicly available
Mission statement	Describes committee goals and values	Publicly available
Committee history	Traces the founding and development of the committee	Publicly available
Meeting agendas and minutes	Records topics discussed, decisions made, and action items	Provided by participants
Presentation slides	Documents presentations created for district and student audiences	Provided by participants
Articles and publications	Documents committee activities as covered by media and other outlets	Publicly available; provided by participants
Board resolutions	Formalizes district-level decisions related to student mental health advocacy	Provided by participants

Appendix D

Participant Pseudonyms

Committee members: Nik (age 15), Riley (age 15), Silas (age 15), Kaveri (age 16), Cecilia (age 16), Victoria (age 16), Luz (age 16), Aster (age 16), Cody (age 16), Eric (age 16), Kishor (age 16), Lori (age 17), Devika (age 17), Holly (age 17), Aurora (age 17), Manny (age 18), Samira (age 18)

Committee alum: Maya (age 19), Juliana (age 20), August (age 20), Nam (age 21), Ana (age 21), Grace (age 22), Zoe (age 22)

Committee supporters: Anika (age 19), Jonathan (age 22), Madison (41), Laura (age 48), Emily (age 49), Allison (age 53), Denise (54)