

Exploring Self-Referral as a Low-Burden, Universally Administered Strategy to Connect Adolescents to Mental Health Supports Following Anonymous School-Based Screening

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Integrating widespread, low-burden approaches to facilitate connection to school-based care may be helpful in expanding mental health reach in schools. The present study describes students' use of a single-item self-referral process following a school-wide anonymous screener of mental health and substance use. The Substance Use and Risk Factor Survey included a school-based referral request item in 47 Massachusetts public middle and high schools in fall 2023 ($N = 16,236$; 47% girls; 4% gender diverse; 41% racially or ethnically marginalized or minoritized). Students who self-referred, in comparison to those who did not self-refer, endorsed more symptoms of depression and anxiety ($M_{\text{self-referral}} = 3.7$ [$SD = 3.8$], $M_{\text{noReferral}} = 3.0$ [$SD = 3.3$], $p = .0001$), psychoticlike experiences ($M_{\text{self-referral}} = 1.1$ [$SD = 1.6$], $M_{\text{noReferral}} = 0.9$ [$SD = 1.4$], $p = .0004$), emotional reactivity ($M_{\text{self-referral}} = 24.4$ [$SD = 23.7$], $M_{\text{noReferral}} = 20.8$ [$SD = 20.8$], $p = .001$), and inattention and hyperactivity ($M_{\text{self-referral}} = 0.8$ [$SD = .8$], $M_{\text{noReferral}} = 0.7$ [$SD = 0.7$], $p = .001$). Students who self-referred were more likely to endorse a past-year suicide attempt (6.6% among self-referral group, 3.1% among the no-referral group; $OR = 1.7$, $p = .02$) and not talking to anyone (formal or informal mental health supports) about their mental health in the past year (31.4% self-referrals, 21.9% no referral; $OR = 1.7$, $p < .001$). Students who self-referred were also more likely to hold a minoritized gender identity (6.9% self-referrals, 3.9% no self-referrals; $OR = 1.8$, $p = .012$). School staff ($N = 15$) noted that the self-referral process was helpful ($M = 3.87/5$, $SD = 1.27$), and approximately half of the students requesting support (53.7%) were not already engaged in school-based mental health support. Self-referral requests following school-wide screeners may be a useful strategy to identify students experiencing mental health distress without supports in place.

Impact and Implications

This study evaluated students' use of a single-item self-referral process following a school-wide anonymous screener of mental health and substance use. Students self-referring for mental health follow-up were more likely to be gender diverse, to experience high mental health symptoms, and to not talk with anyone about their mental health symptoms. This type of self-referral process may be one useful tool for schools to identify students who need more support and would engage with it when approached by staff but who are not part of the school mental health staff caseload already.

Keywords: adolescence, screening, self-referral, connection, staff need

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Adolescents have endorsed multifold increases in mental health symptom prevalence and severity over the past decade (Ahn-Horst & Bourgeois, 2024; Twenge et al., 2021). Even as rates of adolescent distress reach new heights, most adolescents who need mental health

treatment do not receive it (Racine et al., 2021; Uhlhaas et al., 2023). Schools are repeatedly called upon to serve as the prevention arm of a comprehensive and equitable youth mental health system given their high degree of contact with adolescents (Alegria et al., 2010;

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Duong et al., 2021; Love et al., 2019). Schools are uniquely positioned to implement prevention and early intervention practices, such as universal screening, to promote early identification and referral to treatment (Gopalan et al., 2010). These proactive mental health practices stand to intervene and remediate symptoms prior to their progression to clinical disorder and a higher need for care (Harrison et al., 2004). Evidence-supported procedures to triage students to the appropriate level of care must be available to schools to maximize the utility of universal screening and early symptom identification (Sekhar et al., 2019). The present study offers a preliminary evaluation of one such strategy—offering students the opportunity to self-refer for follow-up with a school mental health staff member upon completion of an anonymous mental health screener. We characterize the qualities of students who self-referred compared to those who did not when offered the opportunity to do so. We then describe school mental health staff feedback regarding this first attempt at implementing a student self-referral process.

Self-Referral as Part of Existing Systems of Support

When designing and testing new approaches to support students, it is important that those new approaches fit into the existing system. To that end, we conceptualize the self-referral as one component of the multitiered system of support, a framework used to organize student supports in schools. The multitiered system of support includes prevention and early intervention as components of a single-care continuum (McIntosh & Goodman, 2016). The multitiered system of support describes a strategic, stepped-care approach that provides combinations of interventions to target different levels of mental health severity and support easy transition between levels of care. In this system, Tier 1 (universal) supports are offered to all students, Tier 2 (targeted) supports are offered to students at-risk or with mild symptoms, and Tier 3 (treatment) supports are delivered to students with severe or diagnosable mental health presentations (Fletcher & Vaughn, 2009; Moore et al., 2019). The goal of self-referrals as implemented in the present study is to serve as a bridge from the universally administered survey to additional early or supportive intervention for students who may not otherwise connect to school-based supports. Successful implementation of earlier Tiers of support should reduce the burden on later Tiers by addressing problems early, reducing both the draw on mental health resources and the distress experienced by young people.

Self-Referral as a Low-Burden Strategy for Sustainable Support

It is critical that new components designed to be part of this school-based mental health system are as low burden as possible to support scalability and long-term sustainability (March et al., 2022). Although many students could benefit from low-intensity treatments that focus on prevention and early intervention (Bennett et al., 2019; Schleider & Weisz, 2017; van Doorn et al., 2021), schools are often limited in their capacity to deploy such interventions due to low resources and a severe school mental health workforce shortage (Liu et al., 2023). In 2019, the average ratio of students to school psychologists was 1,211 to 1, more than double the recommended maximum ratio of 500 to 1 (National Association of School Psychologists, 2021). In 2022–2023, the average ratio of students to school counselors was 385 to 1, much higher than the (still very high) recommended maximum ratio of 250 to 1 (Rakestraw,

2024). With these high caseloads, school behavioral health staff understandably prioritize students with more severe symptoms, reducing their capacity to screen and identify students who might benefit from preventative care efforts. Therefore, to sustainably increase school behavioral health initiatives, it will be necessary to implement low-burden strategies for early identification, prevention, and triage while also coordinating with school mental health staff regarding their capacity and resource needs.

Potential Benefits of Self-Referral

Activating mental health care when an adolescent expresses interest may facilitate willingness to engage (Nahum-Shani et al., 2018), and school-wide screeners have been proposed as a promising potential bridge to services (Sekhar et al., 2019). To date, population-level surveillance of youth mental health has largely been accomplished through routine, anonymous survey administration (e.g., Youth Risk Behavior Survey, Monitoring the Future; Miech et al., 2023). These epidemiological studies offer information about mental health trends in the community, which allow critical insights into ongoing prevalence, new concerns, and psychiatric comorbidities. We propose that epidemiological surveys also offer an as-yet untested opportunity to connect students to mental health care because they facilitate widespread and regular contact with adolescents, they query symptoms of mental health that adolescents may not discuss in other contexts, and they promote disclosure through anonymity (Sekhar et al., 2019). We also propose that the self-referral aspect may offer an avenue into mental health support that both empowers adolescent autonomy and may help combat barriers to access, such as stigma and the mental health literacy required to establish care in some traditional mental health service structures. Motivated by the converging crises of youth mental health and staff burden, we developed and tested a self-referral procedure to partner with school-wide surveys of student mental health.

The Present Study

To support early identification and coordination of mental health support for students, we put forth one low-burden strategy: an opt-in mental health referral request form that accompanies large, anonymous school-wide surveys of mental health. We tested the application of self-referral procedures offered to students following the completion of an anonymous school-wide screener implemented in public middle and high schools across the state of Massachusetts, the Substance Use Risk Factors (SURF) Survey (Costello et al., 2025). To better understand how the self-referral process functions, we describe the students who opt in to mental health supports and the experience of school mental health staff in implementing this approach through the following research questions (RQs).

Aim 1: Describe the subset of surveyed students who self-refer for opt-in school-based mental health contact.

RQ1: Are students of certain gender, racial, or ethnic identities more likely to self-refer for follow-up with a school staff member?

RQ2: Do students who self-refer for follow-up with a school staff member endorse more psychological symptoms (depression, anxiety, psychoticlike symptoms, emotional reactivity,

inattention/hyperactivity, risk taking, lifetime substance use, and suicidal thoughts and behaviors) than students who do not self-refer?

RQ3: Are students who self-refer for follow-up with a school staff member more likely to be disconnected from supports (i.e., report they did not speak to anyone regarding their mental health over the past year)?

Aim 2: Explore school mental health staff perspectives on the self-referral process as a component of school mental health.

RQ4: Among school staff who enact student contact following self-referral, how helpful do they report it being and how much do they report interest in continuing to receive self-referrals through this process?

RQ5: What topics do students discuss when approached by school mental health staff following referral?

RQ6: What resources do school mental health staff report needing to better support this strategy in the future?

Method

Student Participants

The SURF survey was administered, including the self-referral procedure, according to procedures described by Costello et al. (2025) to students enrolled in 47 Massachusetts middle ($N = 3$), high ($N = 42$), and combined ($N = 2$) schools in fall 2023 (analytic sample $N = 16,236$). Schools were drawn from 41 school districts in rural, urban, and suburban areas from around the state and included 31 traditional public schools, four charter schools, two vocational-technical schools, one therapeutic day school, one arts-focused magnet school, and one private college preparatory school.

Student participants included 1,335 sixth graders (8.2%), 1,511 seventh graders (9.3%), 1,736 eighth graders (10.7%), 6,250 ninth graders (38.5%), 6,501 tenth graders (40.0%), 4,235 eleventh graders (26.1%), 3,511 twelfth graders (21.6%), and 37 students completing additional school to fulfill graduation requirements (0.3%). Mean age of the sample was 15.99 years ($SD = 1.38$ years). Student demographic data approximately map on to statewide student enrollment data collected by the Massachusetts Department of Elementary and Secondary Education (DESE) for the 2023–2024 academic year (Massachusetts Department of Elementary and Secondary Education, 2025). Regarding gender identity, the sample comprised 7,388 boys (45.5%), 7,512 girls (46.3%), 144 transgender boys (0.9%), 42 transgender girls (0.3%), 434 students of another gender (2.7%), 115 students who indicated they were “not sure” of their gender identity (0.7%), and 162 students who indicated they did not want to say their gender identity (1.0%). Regarding racial identity, the sample included 104 American Indian/Alaskan Native students (0.6%), 1,015 Asian students (6.3%), 1,372 Haitian/Black/African American students (8.5%), 58 Hawaiian/Pacific Islander students (0.4%), 242 Middle Eastern/North African students (1.5%), 1,528 multiracial students (9.4%), 1,787 students of other racial identities (11.0%), and 9,407 White students (57.9%). Of the sample, 4,734 students identified as ethnically Hispanic or Latino/a/x (29.2%).

Student Survey Procedures

Consent

Caregiver consent was obtained through an opt-out procedure distributed in students’ preferred language based on reported school need, in which caregivers were given the option to withdraw their child from the optional school-wide survey. Caregiver consent forms were distributed to caregivers at least 2 weeks prior to the SURF survey date, at least two different times, and via at least two different methods (e.g., email, telephone call, student/parent portal message, school newsletter). If caregivers did not opt their child out of participating (through a secure online form), passive consent for survey participation was assumed. Voluntary surveys were administered in students’ preferred language to all not-withdrawn students, with assent implied by survey completion. Participating schools and districts were aware of and in agreement with the opt-out and passive consent procedure. SURF survey and accompanying opt-out consent documents were available in Amharic, Arabic, Bengali, Brazilian Portuguese, Mandarin Chinese (simplified), Dari, English, Farsi, Filipino, French, Gujarati, Haitian Creole, Russian, Spanish, Turkish, Ukrainian, and Vietnamese.

Self-Referral

Responses were collected during school periods via REDCap, an HIPAA-compliant platform for electronic data capture hosted on internal Massachusetts General Brigham servers. At survey conclusion, students were offered the opportunity to indicate whether they would like to be connected to school-based mental health resources, using the following prompt (school ID is a unique identification number assigned to each student at the school):

Please click the box below if you would like for us to tell someone at your school that you are interested in talking about your mood, emotions, or behaviors. Some students find this helpful. ***This is voluntary – meaning, it is completely your choice! If you click the box below, we will ONLY share your school ID. No information from the survey will be shared (for example, your answers to questions about mood or substance use).***

Students were informed that the requests are not monitored in real time and presented with local and national mental health resources. Students who selected “yes” were categorized as those requesting referral; those who did not affirmatively check the box were categorized as those not requesting referral. Within 48 hr, school staff members received a list of students who expressed interest in mental health referral. The school staff member who was to receive the list and personally follow up with self-referred students was determined in advance by school administration and school mental health staff. Staff roles included nursing staff, adjustment counselors, vice principals, social workers, and school counselors housed within individual schools who participated in the survey. All procedures were approved by Massachusetts General Brigham’s Institutional Review Board. For more information regarding survey procedures, see Costello et al. (2025).

Staff Sample

In February 2024, following the SURF survey administration and the self-referral process, school mental health staff were offered an

optional survey to provide feedback regarding their experience implementing the referral request process. School mental health staff ($N = 15$) from a subset of 14 schools completed brief quantitative and open-ended items. Per staff members' self-identified (write-in) role in school, the sample consisted of five school adjustment counselors, three school nurses, three counselors/guidance counselors, and one social worker.

Measures: Student Report

Demographics

Students self-reported age, gender identity, racial identity, and Hispanic/Latino/a/x ethnicity.

Depression and Anxiety Symptoms

The Patient Health Questionnaire–four-item version (Kroenke et al., 2009) assessed the extent to which students experienced symptoms of depression and anxiety over the past 2 weeks on a scale of 0 (*not at all*) to 3 (*every day*). This measure has been validated with adolescents, with total score thresholds: less than 2 = *normal*, 2–5 = *mild*, 5–8 = *moderate*, and 8–12 = *severe* (Löwe et al., 2010). Internal consistency for the Patient Health Questionnaire–four-item version was good in this sample (Cronbach's $\alpha = .88$).

Emotional Reactivity

The 21-item Emotional Reactivity Scale (ERS; Nock et al., 2008) assessed dimensions of emotional persistence, sensitivity, and intensity of arousal on a 5-point Likert-type scale describing the extent to which emotional experiences (e.g., “I tend to get emotional very easily”) sound “like them” (0 = *not at all like me*, 4 = *completely like me*). The ERS yields three subscales: persistence (four items, such as “When something happens that upsets me, it's all I can think about for a long time.”), sensitivity (10 items, such as “I tend to get emotional very easily.”), and intensity of arousal (seven items, such as “My moods are very strong and powerful.”). This questionnaire has demonstrated strong internal consistency and validity with adolescent samples (Nock et al., 2008). Internal consistency for the ERS was excellent in this sample ($\alpha = .97$).

Psychoticlike Symptoms

The Adolescent Psychotic-like Symptom Screener (APSS; Kelleher et al., 2011), a seven-item screener, assessed for lifetime experience of visual and auditory hallucinations, paranoia, grandiosity, delusions of control, mind reading, and delusions of reference using the scale 0 = *no*, *never*, 0.5 = *maybe*, and 1 = *yes*, *definitely*. Sum scores indicated the degree of syndromal psychotic symptoms (range = 0–7, *clinical cutoff* = 2). Internal consistency for the APSS was good in this sample ($\alpha = .82$).

Suicidal Thoughts and Behaviors

Students answered 0 = *no* or 1 = *yes* to four questions regarding the past year: self-harm (“Did you hurt yourself on purpose without trying to kill yourself?”), suicidal thoughts (“Did you ever have thoughts about killing yourself [ending your life]?”), plans for suicide (“Did you ever think about how you would kill yourself?”),

and suicidal behavior (“Did you try to kill yourself?”). All students, regardless of their responses, received the following information about resources: “If you are having thoughts or feelings of suicide, please know there are people who can help. Here are some numbers you can use 24 hr a day, 7 days a week to talk to someone who cares. Crisis Text Line: 741,741. National Suicide Prevention Lifeline: 9-8-8. Please also make sure to talk to a trusted adult if you ever feel like you cannot keep yourself safe or need extra support.”

Symptoms of Inattention and Hyperactivity

A 10-item questionnaire assessed symptoms of inattention and hyperactivity following criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (American Psychiatric Association, DSM-5 Task Force, 2013). Students responded to items (e.g., “I have trouble paying attention in school”) on a 4-point Likert-type scale from 1 (*not at all*) to 4 (*always*). Mean scores reflected the degree of symptoms. Internal consistency for the attention-deficit/hyperactivity disorder (ADHD) measure was excellent in this sample ($\alpha = .91$).

Lifetime Substance Use

Students reported on whether they had ever drunk at least one full drink of alcohol, used cannabis, smoked a cigarette, or used a vape for nicotine using the scale 0 = *no* and 1 = *yes*.

Past-Month Substance Use

If students indicated *yes* to lifetime use of alcohol, cannabis, or nicotine, detailed follow-up questions were administered regarding past 30-day use of the relevant substance because these are the most commonly used substances in adolescence (Miech et al., 2023). Students were asked, “In the past 4 weeks, (on average) how often did you use [substance],” and were instructed to respond using the scale: 0 = 0 times, 1 = 1 time, 2 = less than once per week, 3 = at least 1 day per week, 4 = 2–3 days per week, 5 = 4–6 days per week, or 6 = every day.

Risk-Taking

Students responded to “How often do you ... get a real kick out of doing things that are a little dangerous?” and “like to test yourself by doing something a little risky?” (National Survey on Drug Use and Health; Vaughn et al., 2021) using the scale 1 = *never*, 2 = *seldom*, 3 = *sometimes*, and 4 = *always*. Items were summed to create a summary score. Internal consistency for the risk-taking measure was good in this sample ($\alpha = .85$).

Disconnection From Support

Students were asked whether they had spoken with 10 formal (e.g., counselors, therapists) and informal (e.g., peers, family members) supports (adapted from the Actual Help-Seeking Questionnaire; Rickwood et al., 2005). This study evaluated the degree of students' overall disconnection using a single true/false item from the scale “I have not talked with anyone about my mood or feelings from the past year.”

Measures: Staff Feedback

School mental health staff indicated how helpful they found the mental health referral process using a 5-point Likert-type scale (1 = *not at all helpful*, 5 = *extremely helpful*). They also reported on a 5-point Likert-type scale regarding whether they would like to continue receiving this information in the future (1 = *definitely not*, 5 = *definitely yes*). Staff used a sliding 0%–100% scale to estimate the proportion of referred students not previously engaged in school-based mental health care and the proportion of referred students who they successfully contacted after receiving the list of students requesting support.

Staff selected all that applied from a list of major topics discussed by students who had requested mental health referral, including alcohol use; vaping or other nicotine use; cannabis (marijuana) use; other drug use; feeling down, depressed, or hopeless (symptoms of depression); feeling nervous, anxious, or on edge (symptoms of anxiety); fidgeting, excessive talking, or difficulty paying attention, following instructions, staying organized, or doing things quietly (symptoms of attention-deficit/hyperactivity disorder); thoughts about hurting themselves or ending their own life (suicidal thoughts); stressful life events; relationships with peers; relationships with family members; school concerns; and/or other (write-in available).

They then selected three priorities from a list of possible resources to improve this strategy in the future, including a list of external referral sources, more mental health training for current staff, expanded peer support programs, mental health education in school curriculum, a list of self-driven resources to offer students (i.e., apps, workbooks), clearer pipeline to out-of-school resources, consultation from mental health professionals, more details on the mental health symptoms reported by students on the survey, access to online/telehealth resources, increased education to guardians, more mental health staff, more office/coordinator staff, financial support, and other (write-in available). Staff were also invited to offer open-ended feedback regarding helpfulness and resources needed for the referral request process. Given that open-ended feedback was brief and provided by a small sample, this feedback is provided alongside related quantitative analyses to aid in interpretation but was not systematically analyzed.

Data Quality Assurances

Data filters were applied such that records were not included if they did not pass two attention check questions and if they were not at least 60% complete (suggesting students did not attend to the survey, lost connection at some point, or were otherwise significantly unlikely to have encountered the opportunity to request mental health referral at the conclusion of the survey). Filtering removed 9,273 records, and of these records 4,309 (46.4%) completed 0% of the survey, suggesting that internet connectivity issues may have interrupted the student's capacity to engage with the test record after it was created. In these cases, a second record would be created and administered to the student. Of the remaining filtered records (completion >0%), mean survey completion was $M = 24.0\%$ ($SD = 12.5\%$). Of the remaining records that comprised the analytic sample ($N = 16,236$), survey completion was $M = 91.9\%$ ($SD = 4.9\%$).

Missing Data

Students were instructed to respond to as much or as little of the survey as they were willing to complete. As a result, there is a degree of missingness present for each outcome-of-interest, ranging from 2.2% to 25.0% for questions administered to all participants (i.e., nonbranched questions). Past-month substance use was a follow-up question administered to all students who endorsed lifetime substance use, and among this sample, there was no missing entries (see Table 1). Although this missingness is comparable to that reported in similar epidemiological survey studies (e.g., Eekhout et al., 2012; Perkins et al., 2018), results are interpreted with missing data as a considered limitation.

Analytic Plan

Group differences in demographic and mental health symptoms were evaluated through independent t tests comparing the subset of students who self-referred for mental health follow-up versus those who did not. For categorical variables, chi-square difference tests were performed to assess group differences. When significant differences ($p < .05$) or trends ($p < .07$) were detected, odds ratios (ORs) were calculated to quantify the magnitude of the likelihood of a characteristic in question being present in the self-referring group compared with the not self-referring group. All analyses were conducted in R Version 4.3.2 (R Core Team, 2021) using all available data, which has been recommended for epidemiological studies with a similar degree of missingness (Perkins et al., 2018).

Table 1
Missingness by Variable

Variable	<i>N</i> missing (%)
Single-item variable	
Grade	358 (2.2)
Age	350 (2.2)
Gender identity	421 (2.6)
Racial identity	705 (4.3)
Ethnicity	358 (2.2)
Suicidal thoughts and behaviors: self-harm	2,602 (16.0)
Suicidal thoughts and behaviors: thoughts	2,570 (15.8)
Suicidal thoughts and behaviors: method	2,581 (15.9)
Suicidal thoughts and behaviors: attempt	2,583 (15.9)
Lifetime alcohol use	1,216 (7.5)
Lifetime nicotine vape use	1,411 (8.7)
Lifetime cannabis use	1,585 (9.8)
Past-month alcohol use	0 (0)
Past-month nicotine vape use	0 (0)
Past-month cannabis use	0 (0)
Total scale scores	
Depression/anxiety (PHQ4 total score)	2,522 (15.5)
Psychotic symptoms (APSS total score)	2,957 (18.2)
ADHD total score	3,553 (21.8)
Emotional reactivity (ERS total score)	4,059 (25.0)
Risk-taking score	3,620 (22.3)
Help seeking (AHSQ item)	350 (2.2)

Note. Past-month substance use was only queried as a follow-up question to students who endorsed lifetime use. No missingness was observed in this subset of participants. Scales used to assess degree of symptoms are presented in parentheses, where relevant. APSS = Adolescent Psychotic-like Symptom Screener; PHQ-4 = Patient Health Questionnaire–four-item version; AHSQ = Actual Help-Seeking Questionnaire; ERS = Emotional Reactivity Scale; ADHD = attention-deficit/hyperactivity disorder.

Results

Research Question 1: Are Students of Certain Gender, Racial, or Ethnic Identities More Likely to Self-Refer for Follow-Up With a School Staff Member?

In this sample, 468 (2.9%) students requested mental health referral, approximately 10 students per school surveyed ($M = 10.0$, $SD = 15$; $Mdn = 5$, range = 0–91). Requesters were more likely to hold a minoritized gender identity (6.9% requesters, 3.9% nonrequesters; $OR = 1.8$; see Table 2). No other significant demographic differences were observed between students who requested a mental health referral and those who did not.

Research Question 2: Do Students Who Self-Refer for Follow-Up With a School Staff Member Endorse More Psychological Symptoms (Depression, Anxiety, Psychoticlike Symptoms, Emotional Reactivity, Inattention/Hyperactivity, Risk Taking, Lifetime Substance Use, and Suicidal Thoughts and Behaviors) Than Students Who Do Not Self-Refer?

Requesters, in comparison to nonrequesters, endorsed more symptoms of depression and anxiety, $M_{\text{requesters}} = 3.7$ ($SD = 3.8$), $M_{\text{non-requesters}} = 3.0$, ($SD = 3.3$), $p = .0001$; psychoticlike symptoms, $M_{\text{requesters}} = 1.1$ ($SD = 1.6$), $M_{\text{non-requesters}} = 0.9$ ($SD = 1.4$), $p = .0004$; emotional reactivity, $M_{\text{requesters}} = 24.4$, ($SD = 23.7$), $M_{\text{non-requesters}} = 20.8$, ($SD = 20.8$), $p = .001$; and symptoms of inattention/hyperactivity, $M_{\text{requesters}} = 0.8$, ($SD = 0.8$), $M_{\text{non-requesters}} = 0.7$, ($SD = 0.7$), $p = .001$; see Table 3. For screeners that also

incorporate diagnostic thresholds, requesters were also significantly more likely than nonrequesters to surpass thresholds at each step. Requesters were more likely to report symptoms of depression and anxiety at each level (OR for mild, moderate, and severe symptoms = 1.2, 1.5, and 1.6, respectively; all $ps < .03$). Requesters were also more likely to surpass the threshold for psychoticlike experiences and early risk for psychosis on the APSS ($OR = 1.4$, $p = .002$). Requesters were more likely to endorse a past-year suicide attempt (6.6% requesters, 3.1% nonrequesters; $OR = 1.7$).

Post hoc multilevel linear mixed-effects models (for continuous outcomes) and generalized linear mixed-effects models with a logit link function (for binary outcomes) were conducted to account for clustering of students within schools. Effects were consistent in direction across all cases and increased in statistical significance in some cases (see Supplemental Materials for output and interpretation).

Research Question 3: Are Students Who Self-Refer for Follow-Up With a School Staff Member More Likely to Be Disconnected From Supports (i.e., Report They Did Not Speak to Anyone Regarding Their Mental Health Over the Past Year)?

Requesters were more likely to report not discussing mental health with anyone over the past year than nonrequesters (31.4% requesters, 21.9% nonrequesters; $p < .0001$; $OR = 1.7$). Post hoc multilevel analyses nested by school affirmed that interested students reported slightly higher odds of disconnection from other supports ($t = 4.08$, $p < .001$), with minimal between-school variation ($SD_{\text{school}} = 0.05$, $SD_{\text{student}} = 0.41$).

Table 2

Demographic Characteristics of Students Self-Referring and Not Self-Referring Following Completion of Anonymous School-Wide Screener

Demographic characteristic	N of students self-referring (total N = 468)		N of students not self-referring (total N = 15,768)		Group comparison, p (OR)
	N	%	N	%	
Student age	$M = 16.0$ $SD = 1.2$		$M = 16.0$ $SD = 1.4$		.56
Student gender					.012 ($OR = 1.8$)
Boy/man/male	213	45.7%	7,342	46.8%	
Girl/woman/female	208	44.6%	7,451	47.5%	
Transgender male, transgender female, or another gender	32	6.9%	610	3.9%	
Do not want to say/not sure	13	2.8%	281	1.8%	
Student racial identity					.28
American Indian/Alaska native	3	0.7%	105	0.7%	
Asian	22	5.0%	1,015	6.6%	
Haitian, Black, or African American	42	9.6%	1,366	8.9%	
Hawaiian or Other Pacific Islander	1	0.3%	58	0.4%	
Middle Eastern or North African	10	2.3%	243	1.6%	
Multiracial	50	11.4%	1,508	9.8%	
White	270	61.8%	9,330	60.6%	
Another race/not listed	39	8.9%	1,766	11.5%	
Student ethnicity					
Hispanic/Latino/a	146	31.2%	4,588	29.6%	
Not Hispanic/Latino/a	314	68.3%	10,923	70.4%	

Note. Odds ratios presented for significant differences ($p < .05$) reflect the odds of characteristic for students who self-referred and those who did not. Age was trimmed to realistic values (9–24 years; 14 values removed). Significance of group differences for racial and ethnic identity was calculated using two categories: (a) students who identified race/ethnicity as White and not Hispanic/Latino/a and (b) minoritized and marginalized racial/ethnic groups. Significance of group differences for gender identity was calculated using two categories: (a) students who identified with a minoritized gender identity (transgender man, transgender woman, or another gender) and (b) students who identified with male/boy or female/girl. Percentages reflect the percentage of affirmative responses of total N responses for the category (may not sum to 100 due to rounding).

Table 3*Mental Health Symptoms Endorsed by Students Who Do and Do Not Self-Refer Following Completion of Anonymous School-Wide Screener*

Symptom	N of students self-referring (total N = 468)		N of students not self-referring (total N = 15,768)		Group comparison, <i>p</i> (OR)
	<i>N</i>	%	<i>N</i>	%	
Depression/anxiety (PHQ-4)					.0001
	<i>M</i> = 3.7		<i>M</i> = 3.0		
	<i>SD</i> = 3.8		<i>SD</i> = 3.3		
Mild symptoms (≥ 2)	278	59.8%	7,412	54.5%	.03 (OR = 1.2)
Moderate symptoms (≥ 5)	168	36.1%	3,675	27.2%	<.001 (OR = 1.5)
Severe symptoms (≥ 8)	89	19.1%	1,767	13.1%	.001 (OR = 1.6)
Psychoticlike symptoms (APSS)					.0004
	<i>M</i> = 1.1		<i>M</i> = 0.9		
	<i>SD</i> = 1.6		<i>SD</i> = 1.4		
APSS threshold surpassed (≥ 2)	115	25.1%	2,465	18.9%	.002 (OR = 1.4)
Emotional reactivity (ERS)					.001
	<i>M</i> = 24.4		<i>M</i> = 20.8		
	<i>SD</i> = 23.7		<i>SD</i> = 20.8		
Inattention/hyperactivity					.001
	<i>M</i> = 0.8		<i>M</i> = 0.7		
	<i>SD</i> = 0.8		<i>SD</i> = 0.7		
Risk taking					.57
	<i>M</i> = 3.9		<i>M</i> = 3.9		
	<i>SD</i> = 1.9		<i>SD</i> = 1.8		
Lifetime substance use (% yes)					
Alcohol	76	20.1%	2,893	15.0%	.06
Cannabis	49	10.5%	1,746	11.9%	.32
Vaped nicotine	57	12.3%	1,794	12.4%	.93
Past-month use frequency (among participants with lifetime use)					
Alcohol					.91
	<i>M</i> = 0.19		<i>M</i> = 0.19		
	<i>SD</i> = 0.74		<i>SD</i> = 0.71		
Cannabis					.89
	<i>M</i> = 0.24		<i>M</i> = 0.24		
	<i>SD</i> = 1.08		<i>SD</i> = 1.02		
Vaped nicotine					.65
	<i>M</i> = 0.27		<i>M</i> = 0.29		
	<i>SD</i> = 1.22		<i>SD</i> = 1.11		
Suicidal thoughts and behaviors					
Past-year self-harm	62	13.3%	1,506	11.2%	.2
Past-year suicidal ideation	89	24.8%	529	16.9%	.2
Past-year plan	62	13.2%	1,770	13.2%	.9
Past-year suicide attempt	31	6.6%	2,280	3.1%	.02 (OR = 1.7)

Note. Odds ratios presented for significant differences ($p < .05$) reflect the odds of characteristic for requesters versus nonrequesters. Percentages reflect the percentage of affirmative responses of total *N* responses for the category (may not sum to 100 due to rounding). Significance of group differences for past-month substance use frequency was calculated using mean score for the category. APSS = Adolescent Psychotic-like Symptom Screener; PHQ-4 = Patient Health Questionnaire–four-item version; ERS = Emotional Reactivity Scale.

Research Question 4: Among School Staff Who Contact Students Following Self-Referral, How Helpful Do They Report It Being and How Much Do They Report Interest in Continuing to Receive Self-Referrals Through This Process?

Feedback from school staff indicated that they found this approach generally neutral to helpful ($M_{\text{helpfulness}} = 3.87$, $SD = 1.27$, range = 1–5; see Table 4) and they would like to receive self-referral requests via this mechanism in the future ($M_{\text{continueReceiving}} = 4.47$, $SD = .84$, range = 3–5). Mental health staff noted 53.7% ($SD = 41.4\%$) of the students who self-referred were not already engaging

in school-based mental health care. Staff reported they were able to successfully follow up with most students who self-referred ($M = 92.93\%$, $SD = 23.1\%$).

Research Question 5: What Topics Do Students Discuss When Approached by School Mental Health Staff Following Referral?

Staff members endorsed an average of three topics they discussed with self-referred students ($M = 3.2$, $SD = 4.8$, range = 1–12). Students most often discussed topics related to mental health, life

Table 4*Staff Feedback Regarding Use of Self-Referral Process*

Variable	<i>M</i>	<i>SD</i>	Min	Max
Helpfulness (1 = not at all, 5 = extremely)	3.9	1.1	1	5
Like to continue receiving info (1 = definitely not-5 = definitely yes)	4.5	0.83	3	5
Referred students not known to school mental health (%)	53.7	41.4	0	100
Referred students contacted (%)	92.9	23.1	10	100

Note. *N* = 15. Min = minimum; Max = maximum.

events, school-related concerns, and problems with peers and family (see Table 5).

Research Question 6: What Resources Do School Mental Health Staff Report Needing to Better Support This Strategy in the Future?

When asked to indicate their top three priorities from among a list of possible resources, school staff endorsed interest in a clearer connection between school and external mental health resources, expanded peer support programs, and more mental health training for current staff (see Table 6).

Staff members also provided open-ended feedback. Staff emphasized the benefits of receiving information about students who were not known to the counseling staff. They noted key challenges, including interest in receiving the information as quickly as possible, as well as difficulties connecting students to care that is culturally responsive and offered in other languages. See Supplemental Table 2 for all open-ended responses.

Discussion

In response to the youth mental health crisis, schools are called upon to provide widespread behavioral health care. This study demonstrated that including a single-item follow-up to universal screening can support a student mental health self-referral process. In this sample, 2.9% of all students surveyed self-referred for staff follow-up (468 of 16,236). Students holding a minoritized gender identity were disproportionately likely to self-refer using this process. Students who self-referred were also more likely to endorse elevated mental health symptoms and indicate they have not discussed mental health with anyone over the past year. Post hoc analyses confirmed these findings after accounting for student nesting within different schools. School staff reported that in this first year of implementation, the referral process was generally helpful, identified some students not yet known to mental health staff as needing or wanting mental

health support, and led to conversations regarding mental health, social stressors, and substance use with referred students. Staff indicated their perceived resource priorities to facilitate this process moving forward, including a clearer connection between school and external mental health resources, expanded peer support programs, and more mental health training for current staff.

Ultimately, the present study indicates that some adolescents will anonymously self-refer and that those who self-refer appear to be more distressed and less likely to be connected to formal psychological supports. We propose that self-referral may function to intervene at multiple levels. At the individual level, some students may experience an opportunity to request and connect with mental health services that they need. At the school level, schools may become more aware of students in need and triage students to various levels of care based on the specific needs of each student, as outlined in the screening, brief intervention, and referral to treatment framework deployed by medical and other systems to identify individuals in need and titrate treatment to the appropriate tier of support accordingly (Mitchell et al., 2012). With a particular eye toward integrating research and practice for mental health prevention programming, the interactive systems framework (Wandersman et al., 2024) outlines the importance of reciprocal flow between practice proceedings and new research findings to iteratively hone a system that is responsive to need and maximizes efficiency of early prevention. Informed by these two frameworks, integrating self-referral into existing systems could both allow for improved triage to appropriate care and call for ongoing evaluation of student, provider, and school system needs.

As new strategies are developed to support student mental health in schools, it is critical to ensure that these strategies do not reinforce already-existing care inequities. In this sample, students holding a minoritized gender identity were significantly more likely to self-refer for follow-up. Gender-minoritized youth may experience identity-based discrimination by both individuals and systems, which has been linked to both disproportionately high rates of mental health symptoms and inequities in access to effective mental health care (Balsam et al., 2019; Casey et al., 2019). Adolescents often describe a lack of autonomy in seeking traditional counseling or therapy, due to barriers imposed by caregivers, costs, or logistics of accessing care—barriers that were particularly commonly endorsed among gender diverse youth (Ringle et al., 2024). Previous work has highlighted that stepped-care models that triage youth from screening to tailored care in schools may be particularly important supports for gender-minoritized youth who are less likely to access care elsewhere in their lives (Weinberg & McGrory Cooper, 2023). The overrepresentation of gender-minoritized students self-referring for connection to school mental health supports in the present study may suggest that, at least among these students who self-referred, school mental health staff are perceived as relatively supportive and safe to approach. However, although it is promising that some gender-minoritized students with elevated symptoms self-referred, most gender-minoritized youth with elevated symptoms did not self-refer. Even in communities wherein gender-minoritized youths may receive more tangible support, sociocultural stigma imparts a significant degree of stress and amplifies mental health symptoms (Hammack, 2018). Systemic changes must be made to better support these students, for example, formal education and acknowledgment of minoritized gender identities in education and improved training for providers (Hammack et al., 2022). Until a significant cultural

Table 5
Topics Discussed With Referred Students

Domain	Staff reporting topic, <i>N</i> (%)
Feeling nervous/anxious/on edge (symptoms of anxiety)	10 (66.7)
Feeling down/depressed/hopeless (symptoms of depression)	9 (60.0)
Stressful life events	8 (53.3)
School-related concerns	8 (53.3)
Problems with peers	7 (46.7)
Problems with family	6 (40.0)
Problems with alcohol use	5 (33.3)
Problems with vaping or other nicotine use	5 (33.3)
Inattention/restlessness/hyperactivity (symptoms of ADHD)	4 (26.7)
Suicidal thoughts	2 (13.3)
Problems with cannabis use	1 (6.7)
Problems with other drugs	1 (6.7)
Other (write-in)	0 (0.0)

Note. Topics discussed were queried using a “select all that apply” format, and thus, percentages will not sum to 100. Examples of resources described within each category are presented in parentheses, where relevant. ADHD = attention-deficit/hyperactivity disorder.

Table 6*Staff Resource Priorities to Facilitate Student-Requested Mental Health Referrals*

Resource	Identified as a top three priority, <i>N</i> (%)
Clearer connection to external mental health systems (pipeline to external referrals, consultation from mental health professionals, access to online/telehealth resources)	14 (93.3)
More comprehensive student-facing mental health resources (mental health education in curriculum, a list of self-driven resources to offer students [i.e., apps, workbooks])	8 (53.3)
More mental health training for current staff	6 (40.0)
Increased education for caregivers	6 (40.0)
Expanded peer support programs	4 (26.7)
More mental health staff	3 (20.0)
Financial support	2 (13.3)
More office/coordinator staff	1 (6.7)
More details on the mental health symptoms reported by students on the survey	0 (0.0)
Other (write-in)	0 (0.0)

Note. *N* = 15. Examples of resources described within each category are included in parentheses, where relevant.

shift happens, however, it will be key to continue to build and hold safe spaces for students holding minoritized gender identities. Finally, although we cannot overinterpret null results, we find no evidence that the self-referral method was disproportionately underutilized by students from minoritized racial or ethnic backgrounds.

It is key to note that this process identified only 3% of the sample that were interested in mental health follow-up. This highlights the important point that one-time self-referrals cannot and will not be a stand-alone solution to addressing students' mental health needs. Adolescents' mental health distress often goes undetected—and therefore, untreated—until symptoms escalate to a significant, disruptive degree (Kim et al., 2022). In the current sample, although the number of students requesting referral was relatively small compared to the entire study sample, that subset who did request referral were endorsing significantly more distress in combination with a higher likelihood of being completely disconnected from supports throughout the past year. Strategies such as the opt-in referral process may proactively identify students who are distressed, disconnected, and open to receiving supports while also offering students an opportunity to experience agency in requesting mental health care for themselves. Fostering autonomy and offering students a positive experience with responsive adults in mental health care may fundamentally shape a positive mental health culture within students and their school (Troy et al., 2022). Many previous successful methods to triage students from screening to care do so in response to the level of symptoms endorsed on screeners (Mullen et al., 2019). The approach described here differs in that it leverages an anonymous screener to provide immediate follow-up after students have been asked a series of questions about mental health symptoms when they may be feeling emotionally disrupted from responding to those questions or otherwise interested in discussing symptoms further with someone in their school. In line with maintaining student autonomy, students are informed that their survey responses are independent of the self-referral procedure, in part to protect their privacy as they participate in the epidemiological research study and in part to support their autonomy in making decisions about what to share with any given adult at school.

As indicated by staff members, students discussed a range of topics related to life stressors as well as symptoms of mental health distress and substance use, suggesting that they are willing and able

to engage with staff member follow-up several days after the self-referral requests were placed. Staff indicated that they were able to contact most students who requested referral and that about half of these students were not previously identified as needing support by the school mental health system. This could be seen as both a benefit and a challenge of the self-referral process because it invites an unknown number of students to self-identify as interested in further follow-up and then places the responsibility for that follow-up on the school mental health staff. In situations wherein students perceive that their self-referrals are not taken seriously by school staff (regardless of the reason, staff response does not occur in a timely and attentive manner), this could ultimately backfire and reinforce the belief that it is not safe or acceptable to share about mental health needs or request support (Rickwood et al., 2005). Schools implementing self-referrals need to be supported in responding to any number of student referrals (in the present study, up to 91 referrals in any one school). It is also important to interpret the current findings in context; Massachusetts consistently ranks in the top 5–10 states nationally for counselor and psychologist availability in schools (Procopis, 2022), and this study sample averaged one mental health counselor per 100 students (Vargas et al., 2025).

In addition to ensuring the staff have the power to carry out a high volume of student check-ins quickly following self-referral, sustainable school mental health practices need to be supported by tailored, stepped resources that can be deployed by school mental health staff as needed. Understandably, staff members also endorsed clearer referral pipelines, increased mental health staff and training, expanded peer supports, and more caregiver education would significantly improve their capacity to implement opt-in referrals following school-wide screeners. This reinforces other findings suggesting that school staff would prioritize more training as well as more comprehensive wraparound services outside of school (Liu et al., 2023). Although ongoing efforts to incorporate schools into a youth mental health system are building momentum and garnering further support, the bridges between school-based and community-based care are not sufficiently developed at this time. There is a need for structured, coordinated referral systems to a spectrum of community supports that offer students and families *choice* regarding the care they receive while not relying solely on the education system. Researchers can support the implementation of school-based mental

health supports by developing, testing, and packaging evidence-based screening and intervention protocols; creating and collaboratively revising procedures to support transitions of care for students who are identified as needing support or reentering a lower tier of support following intervention; and expanding community-based research efforts in the name of highlighting the needs of the staff members tasked with carrying out the critical daily support of students.

Constraints on Generality

The current work aimed to promote access to youth mental health support as one component of a larger mental health system, and as such, it is critical to acknowledge that community members' relationships to their mental health system will inevitably shape their willingness to engage with it. Students who are minoritized and experience ongoing provider bias or mistreatment (Lu et al., 2021), who have had a negative experience with mental health care in the past, or who fear punishment or retribution for self-referring for any reason may be reticent to self-refer. The present study must be interpreted with the understanding that we are only able to describe students who willingly opted in to the self-referral process, and we are unable to capture any information about the students who do not answer the survey questions. We also do not collect any information from students about why they do or do not self-refer, which may help bolster understanding of this process if incorporated into future studies. Additionally, as noted above, it is important to note that Massachusetts, where this study took place, consistently ranks in the top 5–10 states nationally for counselor and psychologist availability in schools (Procopis, 2022), and this study sample averaged one mental health counselor per 100 students (Vargas et al., 2025). Students in the present study might therefore be embedded in climates that are comparatively more supportive or higher resourced in terms of mental health care than students whose schools have fewer or no mental health staff available.

Limitations and Future Directions

Despite the potential value of this self-referral process, the process and the present study carry significant limitations we must acknowledge. Opt-in referrals require students to be attentive to the survey, trusting and motivated to request follow-up, and willing to engage with school staff once follow-up is initiated. Reticence to seek support is common among adolescents for many reasons—including limited knowledge of supports, downplaying of symptoms, stigma, and barriers to accessing care (Roberts et al., 2022). Although this study seeks to combat these barriers, it will be important to solicit student feedback regarding the use of referral procedures in the future, as well as comprehensive feedback from school staff that builds beyond the small subsample of willing responders described in the present study. Additionally, researchers have pointed out flaws in single-item approaches to assessing psychological constructs due to limited ability to assess the item's psychometric properties such as validity and reliability (Allen et al., 2022). We have made efforts to ensure all single-item questions included in this study are face valid and clear and indeed were selected to reduce participant burden, but we acknowledge that multi-item scales are often preferable.

Of course, the single-item self-referral question is limited in its reach, and it offers only one avenue by which a subset of students

can identify as needing support at one given point in time. Other studies may evaluate the impact of replacing or augmenting this approach with an always-available request line, more frequent school-wide check-ins, or other creative approaches to referral. Notably, effects in this study were modest, and it is unlikely that data are missing truly at random (i.e., the sample who willingly completes measures about mental health is likely a selected sample). Therefore, replication with different and larger samples is needed to draw conclusions about the use of this referral mechanism. It will also be key to extend this work longitudinally to understand students' resource engagement and subsequent mental health symptoms following school staff members' approaching self-referred students, as well as potential changes in referral request rate over time.

Conclusion

Efforts toward combating the youth mental health crisis may require creative application of multiple approaches to supporting youth mental well-being. Opt-in referrals are, of course, not a comprehensive solution. However, in its first year of implementation, this approach identified a small subset of students who may experience mental health symptoms, but not be captured by traditional mental health care approaches. Incorporating initiatives such as referral requests into a comprehensive school mental health system may ultimately benefit both students and practitioners by facilitating early contact, normalizing communications about mental health, and offering students a positive experience with mental health providers in school. More work is needed to confirm the preliminary benefits of this approach and more clearly characterize how small, light-touch interventions such as the one presented here may fit (or not fit) into a comprehensive, school-based mental health system for youth.

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