Bridging the Need-to-Access Gap: Examining Parents who Perceive a Need for Their Youth to Receive Mental Health Services

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BRIDGING THE NEED-TO-ACCESS GAP: EXAMINING PARENTS WHO PERCEIVE A NEED FOR THEIR YOUTH TO RECEIVE MENTAL HEALTH SERVICES

by

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A Thesis submitted to the Faculty of the Graduate School, Marquette University, in Partial Fulfillment of the Requirements for the Degree of Master of Science

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ABSTRACT
BRIDGING THE NEED-TO-ACCESS GAP: EXAMINING PARENTS WHO PERCEIVE A NEED FOR THEIR YOUTH TO RECEIVE MENTAL HEALTH SERVICES

Alexandra Bowling, B.A.
Marquette University, 2024

Parents often act as gatekeepers to their children and adolescents receiving mental health services. Youth help-seeking models propose that three parent-focused factors (perceptions of their youth’s illness profile, predisposing characteristics, and enabling resources) impact each stage of the help-seeking process: problem recognition (i.e., perceived needers), decision to seek help (i.e., treatment intensers), and service selection and utilization (i.e., treatment utilizers). Research is needed that examines how the above factors relate to parents getting “stuck” in the help-seeking process (i.e., do not become treatment utilizers). The current study investigated whether predisposing characteristics (i.e., family and demographic characteristics, mental health attitudes and beliefs) predict parents’ location in the help-seeking pathway. Parents (N=186; 25.8% Black or African American, 25.3% Hispanic or Latino, 15.6% Asian) were recruited via Amazon’s Mechanical Turk and completed online self-report questionnaires. Results demonstrated that White parents are more likely than both Black/African American and Asian parents to be perceived needers when compared to treatment intensers or treatment utilizers. Additionally, parents are more likely to be treatment utilizers than perceived needers as parental self-efficacy increases and perceived irrelevance of treatment decreases. Results suggest a need to both empower parents to seek youth mental health services and to address structural inequities in order to bridge the need-to-access-gap for youth mental health care.
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Introduction

Youth’s mental health needs are significant and well-established but have been inadequately addressed. Mental health disorders are common among children and adolescents, with an estimated prevalence rate of 25% (for a review, see Merikangas et al., 2022). Fortunately, effective, evidence-based treatments for child and adolescent mental health disorders exist (for a review, see Pina et al., 2019 & Weisz et al., 2017), and have long-lasting benefits to the youth and families who receive them (e.g., Ginsburg et al., 2014; Wolk et al., 2015). Conversely, untreated mental health disorders in youth are associated with adverse health, academic, social, and psychological outcomes (e.g., Green et al., 2005; Lee et al., 2011; Pompili et al., 2012). Oftentimes, the negative impact of poor mental health early in life extends into adulthood (e.g., Ford et al., 2007), creating a heavy economic burden for society (e.g., Prince et al., 2007). These detrimental impacts of mental health problems on youth, their families, and society as a whole highlight the importance of youth participation in mental health services. However, less than half of youth who could benefit from existing mental health treatments access these services (e.g., Merikangas et al., 2022).

Given that a substantial percentage of psychologically distressed youth are not receiving the mental health care they need, efforts to improve treatment access and engagement are essential. An examination of the help-seeking process for youth mental health problems offers several opportunities to enhance access and engagement with these services. Typically, youth rely upon their parents to recognize that services are needed and to take the lead on seeking care (Hassett et al., 2018; Logan & King, 2001). In this way, parents act as gatekeepers to their children and adolescents receiving mental health services, and so understanding their impact on the entire help-seeking process is especially important.
Help-seeking for youth mental health problems

Researchers have developed various help-seeking models in order to understand determinants of mental health utilization and the help-seeking process. Current models capturing what determines use of services originate from models focusing on physical health. One of the most influential service utilization frameworks was developed by Andersen (see Andersen, 1995; Andersen & Newman, 1973), who was one of the first to consider the impact of societal norms (e.g., legislation, values or beliefs about funding care) on individual influences (e.g., a person’s predisposition to use services, symptoms, and ability to access services). Andersen’s model was an improvement from previous theories that largely focused on individual predictors of utilization in isolation, ignoring society’s influence on such individual determinants. Andersen proposed that three overarching factors determine health care utilization: 1) illness profile (i.e., clinical and perceived need), 2) predisposing characteristics (i.e., demographic characteristics, family characteristics, mental health attitudes or beliefs), and 3) enabling resources (i.e., social networks, health insurance, accessibility or availability of services, and healthcare or organizational policies). However, Andersen’s model, and similar utilization models, implicitly suggest that help-seeking always leads to service utilization, disregarding help-seeking as a dynamic process that facilitates or hinders treatment use. To provide a more nuanced understanding of the cognitive decision-making processes that precede obtaining mental health services, as well as their determinants, Goldsmith and colleagues (1988) modified and expanded upon Andersen’s framework to posit that illness profile variables, predisposing characteristics, and enabling resources impact individuals’ movement through three help-seeking stages for mental health services: 1) problem recognition (i.e., recognition of having a mental health problem), 2) decision to seek help for distress, and 3) service selection and utilization (i.e.,
informal support or formal mental health services). Research has consistently supported this help-seeking pathway and its influences for adults (e.g., Bonabi et al., 2016; Twomey et al., 2015). Figure 1 presents a model that conglomerates existing theories regarding the mental health help-seeking pathway.

**Figure 1**

*Current Help-Seeking Models*

These help-seeking frameworks have been adapted to specifically consider youth mental health help-seeking. Notably, child-focused models incorporate an ecological systems perspective to acknowledge the influence of children’s proximal social environments (e.g., parents) on the youth mental health help-seeking pathway (e.g., Cauce et al., 2002; Eiraldi et al., 2006; Logan & King, 2001; Srebnik et al., 1996). In particular, *parent* perceptions of their youth’s illness profile (e.g., perceived need), their predisposing characteristics (i.e., family and demographic characteristics, and mental health attitudes and beliefs), and enabling resources (e.g., accessibility of youth mental health services) impact each step of the help-seeking process (i.e., parents’ recognition of their youth’s mental health problems, decision to seek help, and attempt to seek and secure related care). While the above set of parental factors (i.e., illness
profile, predisposing characteristics, and enabling factors) are proposed to impact each stage of the youth help-seeking process, research has mostly focused on these factors’ relationships with the end result of help-seeking: service utilization. Current literature lacks specificity regarding which factors are most relevant for each point in the help-seeking process. By understanding the impact of parental factors on each stage of youth mental health help-seeking, stakeholders can more readily identify and support parents based on where they are in this process. In particular, the impact of these parental factors on parents’ ability to move past recognition of a child’s mental health need may be especially important, given that parents who recognize a problem often decide to seek and eventually utilize mental health related services (e.g., Mojtabai & Olfson, 2008; Sayal et al., 2010; Teagle, 2002).

**Importance of parents’ perceived need in accessing youth mental health care**

The first step in the help-seeking process, parental recognition of a mental health need, is heavily influenced by the illness profile, which consists of clinical need and perceived need (Cauce et al., 2002; Srebnik et al., 1996). *Clinical* need is defined as whether children objectively experience clinically significant levels of distress. *Perceived* need, on the other hand, is parents’ subjective perception about whether youth mental health care is needed (Cauce et al., 2002; Srebnik et al., 1996). Although related, clinical need and perceived need are different; without a perceived need, clinical need may not be enough to promote parents’ help-seeking and service utilization (Bussing et al., 2003). In this way, perceived need is a crucial component of parental problem recognition.

Despite the proposed role of both *clinical* and *perceived* need in the help-seeking pathway, previous research has primarily focused on *clinical* need’s impact on help-seeking and treatment access. Clinical need (e.g., more severe, persistent psychopathology or externalizing
symptoms) is known to predict parents’ mental health help-seeking and service use for youth (e.g., Fehr et al., 2020; Merikangas et al., 2011; Thurston et al., 2015). Less research has examined parents’ perceived need. Nonetheless, a small body of literature has identified that parents’ perceived need is related to problem recognition and help-seeking intentions (e.g., McGinnis et al., 2022; Teagle, 2002; Thuston et al., 2015), as well as service utilization (e.g., Ezpeleta et al., 2002; Wu et al., 1999; Zahner & Daskalakis, 1997). In fact, Zahner and Daskalakis (1997) found parents’ perceived need to be a stronger predictor of youth service utilization than demographic (e.g., child age, gender, or race and ethnicity; parents’ education and occupation) or clinical (parent report of child’s psychopathology) characteristics.

Accordingly, parents perceiving a need appears to be a key step in the youth help-seeking process.

Some parents, however, do not move past perceiving a mental health need for their child and either do not decide to seek or are unable to obtain services. Thus, parents perceiving a mental health need is a necessary but perhaps not sufficient step for accessing youth mental health services. It is imperative that research identifies how to support and empower parents who perceive a need but are not successful in utilizing the needed mental health care services. Figure 2 presents modified versions of youth help-seeking models to highlight where parents may or may not advance in the help-seeking pathway after perceiving that their children need mental health help. Three potential scenarios are depicted: 1) treatment utilizers: some parents who recognize a mental health problem decide to seek help and eventually utilize youth mental health services; 2) treatment intenders: other parents who recognize a problem may decide to seek help but do not end up utilizing youth mental health services; and 3) perceived needers: an additional
set of parents may recognize a mental health problem but neither decide to seek help nor utilize youth mental health services.

**Figure 2**

*Stuck Points in Help-Seeking Among Parents who Perceive a Need*

These scenarios highlight how parents who perceive a need for their youth to receive mental health help are not guaranteed to seek out mental health services. Predisposing characteristics (e.g., demographics, mental health beliefs) may have the strongest impact on belonging to the *perceived needers* group, as certain individual- and family-level attributes (e.g., being male, low family income, having negative attitudes toward mental health services) might increase the likelihood of parents deciding to seek help (i.e., the second step in the help-seeking process). On the other hand, parents in the *treatment intenders* group may be mostly impeded from utilizing services due to enabling factors that are more external in nature (e.g., availability or cost of services). Importantly, structural barriers and systemic issues likely impact all stages of parents’ help-seeking for youth mental health problems. For example, mental health interventions were generally created by and for White, upper class individuals, such that
differences in language and culture as well as mistrust in the healthcare system might impede youth mental health care help-seeking and utilization by parents from historically marginalized backgrounds (e.g., lower income, racial/ethnic minority; Alvidrez et al., 2010; Thompson, Bazile, & Akbar, 2004). While these factors warrant careful consideration and intervention (e.g., via policy change), the current study aims to identify parent- and family-level characteristics that are related to the process of seeking help for youth mental health problems with the goal of informing strategies to specifically empower parents who may need support in accessing mental health care for their youth. The sections below describe the current literature on such predisposing characteristics’ association with the youth help-seeking process.

**The role of parents’ predisposing characteristics in help-seeking process**

Parents’ predisposing characteristics are posited as one of three sets of factors to impact the youth help-seeking process. One aspect of this set of factors includes parents’ demographic characteristics, such as age, gender, race and ethnicity, level of education, and psychopathology. Predisposing characteristics also consist of family characteristics, which includes parents’ marital status as well as family size and income level. Mental health attitudes and beliefs – such as parents’ stigmatization of and knowledge about mental health and treatment – are also part of parents’ predisposing characteristics. An understanding of how parents’ predisposing characteristics relate to decisions to seek help and service utilization can help the field understand which parents may need support in seeking or accessing youth mental health services, and how to best support them. To date, help-seeking research has mostly compared *treatment utilizers* to those who have not used services, ignoring the distinction between *perceived needers* and *treatment intenders*. The unique role of predisposing characteristics on parents getting “stuck” in the *perceived needers* or *treatment intenders* groups is not yet understood.
Predisposing characteristics among parents with perceived need but no service utilization

A review of the literature identified only five studies that specifically examined parents who do not utilize mental health services after perceiving that their youth would benefit from such services (perceived needers; Brown et al., 2014; Carlone & Milan, 2020; Fehr et al., 2020; Owens et al., 2002; Thompson & May, 2005). A majority of these studies focused on how child characteristics (e.g., child age, psychopathology severity, and presence of internalizing behavior problems or anxiety disorders; Brown et al., 2014; Fehr et al., 2020; Thompson & May, 2006) differentiated parents who reported a perceived need but no service utilization from parents who had utilized services and/or parents who reported no perceived need and no use of services. However, three of these studies also evaluated parents’ demographic and family characteristics. One of two articles examining family income level found parents with low-to-moderate income levels to have a higher risk of perceiving a need but not utilizing services than parents with higher income levels (Brown et al., 2014; Thompson & May, 2006). Neither education levels nor family structure (e.g., single-parent) were related to parents perceiving a youth mental health need but not using services (Brown et al., 2014; Fehr et al., 2020; Thompson & May, 2006).

In addition, three of the articles about parents who reported a perceived need but no treatment utilization examined mental health attitudes or beliefs, as well as enabling characteristics (e.g., logistical barriers). Owens and colleagues (2002) found that, compared to parents who had previously accessed youth mental health services, parents who perceived a need but had not accessed related services were more likely to endorse barriers related to perceptions about mental health problems (i.e., thought problems were not serious enough or could be handled on their own) as well as structural barriers (e.g., location of services, not knowing where to obtain services). This article did not find the two parent groups to differ on barriers related to
perceptions about mental health services (e.g., stigma, thought treatment would not help, not knowing whom to trust; Owens et al., 2002). A second study found stigma and parent-reported barriers to care (e.g., issues with transportation) did not distinguish parents who had previously obtained treatment from those who reported a perceived need but no service utilization (Fehr et al., 2020). The third article examined parents’ reflective functioning, or their ability to understand and reflect their child’s mental states, finding that mothers who felt their child needed but were not currently using mental health services felt less certainty about their reflective functioning when compared to mothers who were currently utilizing youth mental health services (Carlone & Milan, 2020).

In sum, few studies have examined predisposing characteristics among parents who report a perceived need but have not utilized mental health treatments. More research is needed in this area, given that help-seeking models propose that predisposing characteristics have an important role in the entire help-seeking process. It is possible that these characteristics differentiate perceived needers from parents who have moved further in the help-seeking process (i.e., are treatment intenders or treatment utilizers). Importantly, the above studies did not assess parents’ help-seeking intentions; thus, it is possible that some parents who were treatment intenders were incorrectly classified as perceived needers.

**Parents’ predisposing characteristics related to help-seeking intentions for youth**

Given the limited research on the impact of parent factors on service utilization after parents perceive a youth mental health need, consideration of how parents’ predisposing characteristics impact movement to the second (i.e., decision to seek help) and third (i.e., selection/utilization of services) steps of youth mental health help-seeking could be relevant for identifying which parents are more likely to need support in accessing services. In particular,
parental help-seeking intentions have been described as a prerequisite for deciding to and seeking help (Morwitz & Munz, 2021). So, an understanding of how parent factors are related to their help-seeking intentions (i.e., willingness and ability to seek help, if needed; Turner, 2012) could help elucidate which parents are likely to be treatment intenders, and how to support perceived needers into becoming treatment intenders. Parents with positive help-seeking intentions have been found to be more likely to access youth mental health services than parents with more equivocal help-seeking intentions (Oh & Bayer, 2015).

Regarding parents’ demographic and family characteristics, mothers (Thurston et al., 2015; Thurston et al., 2017; Turner & Mohan, 2016) and those with higher education levels (Thurston et al., 2015) have been found to be more willing to seek youth mental health services. Race and age have, so far, not been found to directly predict parents’ intentions to seek youth mental health services (Turner et al., 2015; Thurston et al., 2017). However, parents’ ethnicity may moderate the relationship between stigma and help-seeking intentions, such that Latinx parents who reported more stigma have been found to be less likely to seek treatment; this interaction was not found for White or Black parents (Turner et al., 2015). Additionally, parents with their own mental health service use history had similar help-seeking intentions when compared to parents with no service use history (Turner, 2012; Turner & Mohan, 2016).

Parents’ mental health beliefs related to youth mental health treatment may also help explain parents’ youth help-seeking intentions. For example, mothers more willing to seek youth mental health services reported greater stigma toward help-seeking than those less willing (Murry et al., 2011), though some studies have found stigma to have no impact on help-seeking intentions (Dempster et al., 2013; Turner & Mohan, 2016). Of note, all of the above studies examined help-seeking intentions on a continuum, ignoring the possibility that their samples
likely consisted of *perceived needers* and those with no perceived need. Likewise, the studies did not compare *treatment intenders* to *treatment utilizers*. A clearer understanding of if and how parents’ predisposing characteristics relate to their help-seeking intentions will inform efforts to increase help-seeking intentions among parents who perceive a need for youth mental health services as well as increase youth service utilization among both the *perceived needers* and *treatment intenders*.

**Predisposing characteristics related to parents’ youth mental health service utilization**

An examination of predisposing characteristics related to parents’ service utilization may elucidate who may be more or less likely to seek help, given that most of the literature has examined factors related to this step in the help-seeking process. Parents’ demographic characteristics show some promise in explaining how far parents proceed in the help-seeking process. For example, racial and ethnic minority groups experience higher unmet service needs, even after controlling for insurance and socioeconomic status (e.g., Broman, 2012). Also, while research has not identified the impact of parental gender on mental health service utilization, mothers may be more likely to seek services than fathers, given that adult women use services more often than men (Mojtabai et al., 2002; Narrow et al., 2000; Olfson et al., 2002).

Furthermore, in some studies, parents’ psychopathology and history with adult mental services have been associated with youth mental health help-seeking and service utilization (Godoy et al., 2014; Wu et al., 1999; Zimmerman, 2005). Last, parents with a high school degree or greater may be more likely to have accessed youth mental health services than those with no high school degree (Coker et al., 2009). However, other studies have not found an association between service utilization and parents’ psychopathology/service use history (Sayal et al., 2010; Teagle et al., 2002; Wu et al., 2001) or education levels (Zwaanswijk et al., 2005).
Family characteristics, a second aspect of predisposing characteristics, can also help researchers understand which parents may be more likely to utilize youth mental health services. Although one study found that youth from middle-income families were significantly less likely to receive mental health services than those from low- and high-income families (Cohen & Hesselbart, 1993), most research has not found a relationship between family income and youth mental health service utilization (Coker et al., 2009; Sawyer et al., 2007; Shivram et al., 2009; Wu et al., 2001; Zimmerman, 2005). Additionally, research is mixed on whether single-parent households have a significant (Sourander et al., 2001; Zahner & Daskalakis, 1997) or nonsignificant (Sawyer et al., 2007; Zwaanswijk et al., 2005) relationship with parents’ likelihood of accessing youth mental health services. Last, even though number of children has mostly been found to be unrelated to youth service utilization (Shivram et al., 2009; Zimmerman, 2005; Zwaanswijk et al., 2005), one study found that youth who had received mental health services had significantly fewer siblings than those who did not (Jensen et al., 1990). Given the mixed literature regarding parent and family demographics’ relationship with youth treatment utilization, these factors may have a more meaningful role on earlier stages in the help-seeking process (i.e., recognition of a problem and deciding to seek help).

Parents’ mental health attitudes and beliefs have been found to relate to youth mental health treatment utilization. Parents with positive attitudes and greater knowledge related to mental health and services are more likely to seek and engage in mental health care for their youth (e.g., Gerdes et al., 2014). Specifically, stigma regarding mental health problems and treatment, or concerns about how others would perceive needing or seeking mental health care, has been commonly reported as discouraging parents from seeking and utilizing such services (Cohen et al., 2012; Flink et al., 2013; Gerdes et al., 2014; Murry et al., 2011; Sayal et al., 2010).
Another less-explored attitude impacting parents’ help-seeking and service utilization is their perceived relevance of treatment to their child’s mental health needs; parents with lower perceived relevance may be less likely to engage with youth mental health services (Chacko et al., 2017; Kadzin, 2000; Stevens et al., 2006). Research on the impact of parents’ knowledge of youth mental health is even more limited; while parents’ knowledge of youth mood disorders has been found to predict the number of youth mental health services utilized (Mendenhall, 2012; Mendenhall &Frauenholtz, 2013), studies have yet to examine the impact of parents’ knowledge of youth mental health problems on initial service utilization. Additionally, parents’ self-efficacy about their abilities to seek youth mental health services has been proposed to predict parents obtaining such services (Reich et al., 2004), although this concept has not been empirically tested. The above studies on factors related to treatment utilization indicate that further research is needed to understand when and under what circumstances predisposing characteristics play a role in the youth help-seeking process. In particular, it is possible that these characteristics distinguish perceived needers from parents who go further along in the help-seeking process (i.e., treatment intenders or treatment utilizers).

**Current study**

The current study builds upon previous research investigating youth mental health help-seeking by specifically focusing on parents who believe their children need mental health services but have not utilized them. Findings fill a notable gap in the literature, as most studies have focused on identifying factors related to the last step in the help-seeking process: service utilization. Uniquely, this study examined how parents’ predisposing factors differentiate parents’ position in the help-seeking process (i.e., perceived needers, treatment intenders, treatment utilizers). Although predisposing characteristics are well-established predictors of
youth mental health service utilization (for a review, see Ryan et al., 2015), research has yet to fully examine the extent to which these factors predict parents’ ability to move from recognizing a problem to deciding/intending to seek help to utilizing services.

As parents’ perceived need is necessary but not sufficient for parents to utilize youth mental health services, the first aim of the study was to identify parents who may be more likely to not engage with the youth mental health care system when they perceive it to be needed. Specifically, this study examined whether perceived needers (i.e., parents who recognize a mental health problem in their children but neither decide to seek help nor utilize youth mental health services) can be distinguished from treatment intenders (i.e., parents who recognize a problem and decide to seek help, but do not end up utilizing youth mental health services) and treatment utilizers (i.e., parents who recognize a mental health problem, decide to seek help, and utilize youth mental health services) via parent and family demographic characteristics (i.e., parent gender, race/ethnicity, educational level, relationship status, mental health service use history, household or family income, and number of children). Overall, it was hypothesized that parents with more “privileged” demographics (e.g., White, above average family income levels) and those who identify as a woman and/or having a previous service use history would be more likely to get further in the help-seeking process (e.g., be in the treatment utilizer or treatment intender group versus the perceived needer group) than males, those with no service use history, and those from traditionally marginalized backgrounds (e.g., racial and ethnic minority, below average family income levels). Parents’ education levels, parent relationship status, and number of children in the household were not hypothesized to predict overall group membership.

Moreover, the current study examined whether modifiable parent-based factors predict parents’ position in the youth mental health help-seeking process, in order to identify possible
targets for promoting parents’ help-seeking and service utilization. In particular, parents’ mental health attitudes and beliefs (e.g., knowledge and perceptions regarding youth mental health and related services) can be more readily targeted by researchers and clinicians than parent/family demographic characteristics (e.g., parent education, family income) and structural issues (e.g., cost and availability of services) without government intervention (e.g., via policy or legislation). For example, psychoeducation programs focused on promoting mental health help-seeking have been found to increase knowledge and positive attitudes toward mental health- and related-services as well as the likelihood of service use among youth and parents (Aguirre Velasco et al., 2020). The results of the proposed project have implications for enhancing youth treatment engagement by informing identification of who and what parent programs should primarily target.

Thus, the second aim of this study was to discern parent mental health attitudes and beliefs that could be targeted in programming to improve mental health care access for youth in need. To do so, the study examined how perceived needers differ from treatment intenders and treatment utilizers in terms of child mental health knowledge, self-efficacy in recognizing and supporting children with mental health problems, stigmatization of mental health and treatment, and perceived irrelevance of treatment. Overall, it was expected that parents with greater child mental health knowledge and self-efficacy, as well as lower levels of stigmatization and perceived irrelevance of treatment, would be most likely to get furthest in the help-seeking process. Specifically, we hypothesized that parents with greater knowledge of youth mental health, greater self-efficacy, lower stigmatization, and lower perceived irrelevance of treatment would have a greater likelihood of being a treatment utilizer and a treatment intender than a perceived needer.
Method

Participants

The study used archival data from an online survey examining parents’ knowledge of youth mental health and treatment. For the primary study, inclusion criteria were: parent or primary caregiver of youth between the ages of 4-17 years old; aged 18 or older; live in the United States; and fluent in the English language. Participants who completed the survey in less than one third of the overall median completion time (Mdn duration = 22.36 minutes) were removed (n = 29), resulting in a final sample of N = 299 parents.

To examine the above research questions, the proposed study used data from a subsample of parents (N = 186) that consists of perceived needers (n = 27; 14.5%), treatment intenders (n = 36; 19.4%), and treatment utilizers (n = 123; 66.1%). This subsample excluded parents whose children never used mental health services and who did not perceive their children to need them (n = 111), as well as parents who did not complete the PATPSI Help-Seeking Intentions subscale (n = 2). Table 1 includes demographic information about the current sample of parents. For this subsample, the mean age of parents was 39.17, (SD = 7.47), and most were female (65.6%) and married (58.6%). The distribution of parents’ racial and ethnic identities were as follows: 29.0% White, 25.8% Black or African American, 25.3% Hispanic/Latino, 15.6% Asian, 2.7% multiracial,1.1% biracial, and 0.5% Native American or Alaska Native. The median household income fell between $60,000 and $69,000. Almost half of the parent participants had a Bachelor’s degree (42.5%) and two children in their household (44.1%). A majority of the parents reported current or past mental health service use for themselves (57.0%).
### Table 1

**Parents’ Demographics Characteristics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Perceived needers (n = 27)</th>
<th>Treatment intenders (n = 36)</th>
<th>Treatment utilizers (n = 123)</th>
<th>Total (N = 186)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
<td>M (SD) or n (%)</td>
</tr>
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<td>Age</td>
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<td>37.00 (6.12)</td>
<td>40.20 (7.73)</td>
<td>39.17 (7.47)</td>
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<td>Gender</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Female</td>
<td>14 (51.9%)</td>
<td>27 (75.0%)</td>
<td>81 (65.9%)</td>
<td>122 (65.6%)</td>
</tr>
<tr>
<td>Male</td>
<td>12 (44.4%)</td>
<td>9 (25.0%)</td>
<td>40 (32.5%)</td>
<td>61 (32.8%)</td>
</tr>
<tr>
<td>Transgender Male</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>Non-binary</td>
<td>1 (3.7%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>2 (1.1%)</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>2 (7.4%)</td>
<td>9 (25.0%)</td>
<td>43 (35.0%)</td>
<td>54 (29.0%)</td>
</tr>
<tr>
<td>Black or African American</td>
<td>10 (37.0%)</td>
<td>8 (22.2%)</td>
<td>30 (24.4%)</td>
<td>48 (25.8%)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>4 (14.8%)</td>
<td>12 (33.3%)</td>
<td>31 (25.2%)</td>
<td>47 (25.3%)</td>
</tr>
<tr>
<td>Native American or Alaska Native</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>Asian</td>
<td>10 (37.0%)</td>
<td>4 (11.1%)</td>
<td>15 (12.2%)</td>
<td>29 (15.6%)</td>
</tr>
<tr>
<td>Biracial</td>
<td>0 (0%)</td>
<td>1 (2.8%)</td>
<td>1 (0.8%)</td>
<td>2 (1.1%)</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1 (3.7%)</td>
<td>2 (5.6%)</td>
<td>2 (1.6%)</td>
<td>5 (2.7%)</td>
</tr>
<tr>
<td>Parent service use history</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently or previously used</td>
<td>8 (29.6%)</td>
<td>16 (44.4%)</td>
<td>82 (66.7%)</td>
<td>106 (57.0%)</td>
</tr>
<tr>
<td>Have not used</td>
<td>19 (70.4%)</td>
<td>20 (55.6%)</td>
<td>41 (33.3%)</td>
<td>80 (43.0%)</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than HS degree</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>HS diploma/GED</td>
<td>2 (7.4%)</td>
<td>4 (11.1%)</td>
<td>9 (7.3%)</td>
<td>15 (8.1%)</td>
</tr>
<tr>
<td>Some college, no degree</td>
<td>4 (14.8%)</td>
<td>11 (30.6%)</td>
<td>22 (17.9%)</td>
<td>37 (19.9%)</td>
</tr>
<tr>
<td>Associate degree</td>
<td>2 (7.4%)</td>
<td>5 (13.9%)</td>
<td>20 (16.3%)</td>
<td>27 (14.5%)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>15 (55.6%)</td>
<td>11 (30.6%)</td>
<td>53 (43.1%)</td>
<td>79 (42.5%)</td>
</tr>
</tbody>
</table>
## Graduate or professional school

<table>
<thead>
<tr>
<th>Income Range</th>
<th>4 (14.8%)</th>
<th>5 (13.9%)</th>
<th>18 (14.6%)</th>
<th>27 (14.5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$20,000</td>
<td>1 (3.7%)</td>
<td>2 (5.6%)</td>
<td>6 (4.9%)</td>
<td>9 (4.8%)</td>
</tr>
<tr>
<td>$20,000-$29,000</td>
<td>1 (3.7%)</td>
<td>4 (11.1%)</td>
<td>10 (8.1%)</td>
<td>15 (8.1%)</td>
</tr>
<tr>
<td>$30,000-$39,000</td>
<td>3 (11.1%)</td>
<td>1 (2.8%)</td>
<td>17 (13.8%)</td>
<td>21 (11.3%)</td>
</tr>
<tr>
<td>$40,000-$49,000</td>
<td>2 (7.4%)</td>
<td>5 (13.9%)</td>
<td>10 (8.1%)</td>
<td>17 (9.1%)</td>
</tr>
<tr>
<td>$50,000-$59,000</td>
<td>1 (3.7%)</td>
<td>5 (13.9%)</td>
<td>6 (4.9%)</td>
<td>12 (6.5%)</td>
</tr>
<tr>
<td>$60,000-$69,000</td>
<td>2 (7.4%)</td>
<td>6 (16.7%)</td>
<td>17 (13.8%)</td>
<td>25 (13.4%)</td>
</tr>
<tr>
<td>$70,000-$79,000</td>
<td>10 (37.0%)</td>
<td>7 (19.4%)</td>
<td>16 (13.0%)</td>
<td>33 (17.7%)</td>
</tr>
<tr>
<td>$80,000-$89,000</td>
<td>2 (7.4%)</td>
<td>0 (0%)</td>
<td>5 (4.1%)</td>
<td>7 (3.8%)</td>
</tr>
<tr>
<td>$90,000-$99,000</td>
<td>2 (7.4%)</td>
<td>3 (8.3%)</td>
<td>6 (4.9%)</td>
<td>11 (5.9%)</td>
</tr>
<tr>
<td>$100,000-$149,000</td>
<td>2 (7.4%)</td>
<td>2 (5.6%)</td>
<td>16 (13.0%)</td>
<td>20 (10.8%)</td>
</tr>
<tr>
<td>$150,000+</td>
<td>1 (3.7%)</td>
<td>1 (2.8%)</td>
<td>14 (11.4%)</td>
<td>16 (8.6%)</td>
</tr>
</tbody>
</table>

## Marital status

<table>
<thead>
<tr>
<th>Status</th>
<th>15 (55.6%)</th>
<th>21 (58.4%)</th>
<th>74 (60.2%)</th>
<th>110 (59.1%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (3.7%)</td>
<td>4 (11.1%)</td>
<td>14 (11.4%)</td>
<td>19 (10.2%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>0 (0%)</td>
<td>1 (2.8%)</td>
<td>1 (0.8%)</td>
<td>2 (1.1%)</td>
</tr>
<tr>
<td>Separated</td>
<td>9 (33.3%)</td>
<td>6 (16.7%)</td>
<td>14 (11.4%)</td>
<td>29 (15.6%)</td>
</tr>
<tr>
<td>Never married</td>
<td>2 (7.4%)</td>
<td>4 (11.1%)</td>
<td>19 (15.4%)</td>
<td>25 (13.4%)</td>
</tr>
</tbody>
</table>

## Number of children

<table>
<thead>
<tr>
<th>Age Range</th>
<th>4 (14.8%)</th>
<th>5 (13.9%)</th>
<th>18 (14.6%)</th>
<th>27 (14.5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>9 (33.3%)</td>
<td>17 (47.2%)</td>
<td>49 (39.8%)</td>
<td>75 (40.3%)</td>
</tr>
<tr>
<td>2</td>
<td>13 (48.1%)</td>
<td>15 (41.7%)</td>
<td>54 (43.9%)</td>
<td>82 (44.1%)</td>
</tr>
<tr>
<td>3</td>
<td>4 (14.8%)</td>
<td>4 (11.1%)</td>
<td>13 (10.6%)</td>
<td>21 (11.3%)</td>
</tr>
<tr>
<td>4</td>
<td>1 (3.7%)</td>
<td>0 (0%)</td>
<td>4 (3.3%)</td>
<td>5 (2.7%)</td>
</tr>
<tr>
<td>5</td>
<td>0 (0.0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>6</td>
<td>0 (0.0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>More than 6</td>
<td>0 (0.0%)</td>
<td>0 (0%)</td>
<td>1 (0.8%)</td>
<td>1 (0.5%)</td>
</tr>
</tbody>
</table>

## Procedure

The original study was approved by Marquette University’s Institutional Review Board.

Participants were recruited from Amazon’s Mechanical Turk (MTurk), an online survey platform where workers are paid to complete tasks. Upon accessing the survey, participants were shown
an information sheet that explained the study’s purpose and their rights to confidentiality and to withdraw from participation. Participants who confirmed their interest in participating were asked a question screening for inclusion criteria. Those who confirmed they met criteria were presented with the full survey battery. After completing the survey, participants received a code to receive $4.25 in compensation via the MTurk online payment process. Identifying information, including participants’ IP addresses, was not collected.

Measures

Demographic form

Parents completed a series of questions to report demographic information about themselves, their family, and their children, including: parent gender (male, female), race/ethnicity (Asian; Black/African American; Hispanic/Latino; White), and educational level (some college or less; Associates degree or more); household or family income (less than $60,000; $60,000 or greater), number of children (1 child; 2 children; 3 or more children), and relationship status (married or living with partner; single, separated, divorced, or widowed). For analyses, demographics were collapsed into categories, with their levels listed above.

Service use history and perceived need

Parents were asked whether they and/or any of their children had currently, previously, or never received mental health services or a mental health diagnosis. Parents who indicated that one of their children was currently or had previously received mental health services were categorized as treatment utilizers. Parents who indicated none of their children had ever received mental health services were asked if they perceived their children needed such services (“Do you think any of your children needed or would have benefited from help for emotional, behavioral, or social difficulties?”). Those who indicated “yes” to this question were retained in the dataset.
and categorized as either *perceived needers* or *treatment intenders* (see additional information below). Parents who replied “no” to this question were not included in the current study.

**Parental Attitudes Towards Psychological Services Inventory (PATPSI; Turner, 2012)**

The PATPSI is a 21-item questionnaire that assesses parents’ attitudes toward outpatient mental health services. Each item was rated on a Likert scale (*0* = *strongly disagree* to *5* = *strongly agree*). The PATPSI consists of three subscales: Help-Seeking Attitudes, Help-Seeking Intentions, and Stigmatization. For the current study, the Help-seeking Intentions (5 items; e.g., “If I believed my child were having a mental breakdown, my first decision would be to get professional help”) and Stigmatization (sum of 8 items; e.g., “I would not want others (friends, family, teachers, etc.) to know if my child had a psychological or behavior problem”) were used. Higher scores for Help-Seeking Intentions indicate greater tendency to seek mental health services, while higher Stigmatization scores indicate greater concern about how others might perceive them, should they find out they were seeking professional psychological help. Turner and Mohan (2016) found good internal consistencies for the PATPSI subscales (Cronbach’s alpha = .76 for Intentions and .84 for Stigmatization). Internal consistency for the current study was found to be good (Cronbach’s alpha = .76 for Intentions and .88 for Stigmatization).

The Help-Seeking Intentions subscale was used to categorize parents who reported no child service use history but a need for mental health related help into the *perceived needers* and *treatment intenders* groups. Specifically, parents were categorized as *treatment intenders* if they, on average, selected “agree” or “strongly agree” for the Help-Seeking Intentions items.

**Mental Health Literacy Test (MHLT; Gamarra, 2021)**

The MHLT is a 40-item true/false measure that assesses parents’ knowledge of youth mental health problems (e.g., “Children with depression may present as irritable, rather than
sad”). Higher MHLT scores indicate a greater number of correct items (range from 0 to 40). Gamarra (2021) found the MHLT to have good internal consistency (Cronbach’s alpha = .83). Internal consistency for the current sample was found to be good (Cronbach’s alpha = .82).

**Parental self-efficacy (PSE)**

The PSE is a 6-item measure that was developed for the original study to assess the degree to which parents believe they could recognize (e.g., “I would know if my child was struggling with a mental health issue”) and support (e.g., “If my child was struggling with a mental health issue, I would know how to help them feel better myself”) children with mental health issues. The first five items were rated on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). The sixth item on the scale asked parents to rate their overall confidence in being able to help their child if they were struggling with a mental health issue (scale of 0 = *not at all confident* to 5 = *extremely confident*). In the current study, the first five items were summed to measure parental self-efficacy. Higher scores are indicative of greater belief in one’s ability to recognize and support their child’s mental health. Internal consistency for this study was found to be good (Chronbach’s alpha = .71)

**Barriers to Treatment Participation Scale – Expectancies (BTPS-E; Kazdin et al., 1997; Murphy, 2005)**

The BTPS-E is a 44-item questionnaire that assesses expected barriers families may experience during treatment, as well as the role these barriers play in participation and completion of mental health services for youth. Items were rated on a 5-point Likert scale (1 = *totally disagree* to 5 = *totally agree*). The BTPS-E includes four subscales: Stressors and Obstacles That Compete With Treatment, Perceived Irrelevance of Treatment, Treatment Demands and Issues, and Problematic Relationship With the Therapist. For the purposes of the proposed analyses, only the Perceived Irrelevance of Treatment subscale (8 items; e.g., “I will
probably lose interest in coming to sessions”) will be utilized. All items on this scale were averaged to calculate the scaled score. Higher scores are indicative of greater expectations for barriers to interfere with treatment participation. Previous research demonstrated good internal consistencies for the BTPS-E total and subscales (lowest Cronbach's alpha = .85; Nanninga et al., 2016). Internal consistency for this study was found to be excellent (Cronbach’s alpha = .89 for Perceived Irrelevance of Treatment).

Data analysis plan

Aim One: Identify parents who may be more likely to not engage with the youth mental health care system when they perceive it to be needed

To understand what demographics differentiate perceived needers from treatment intenders and treatment utilizers, a multinomial logistic regression was performed through SPSS NOMREG to examine how membership to the three parent groups may be predicted by parent service use history and/or diagnostic status (yes or no), gender (female or male), race/ethnicity (Black/African American or Hispanic/Latinx or Asian or White), education level (some college/less or Associate’s degree/greater), family income (less than $60,000 or $60,000 and greater), number of children (1 child or 2 children or 3+ children), and relationship status (living with partner or widowed/divorced/separated/never married). Odds ratios for significant demographic predictors were examined to understand the extent of their impact on group membership.

Aim Two: Identify parent mental health attitudes and beliefs that could be targeted in programming to improve mental health care access for youth in need

A multinominal logistic regression examined how membership to the perceived needers, treatment intenders, and treatment utilizers groups may be predicted by parents’ child mental health knowledge, parental self-efficacy, stigmatization, and perceived irrelevance of treatment.
Odds ratios for significant modifiable predictors were examined to understand the extent of their impact on group membership.
Results

Preliminary analyses

Several preliminary analyses were conducted to ensure the data’s accuracy. All modifiable predictors (i.e., knowledge of youth mental health problems, parental self-efficacy, stigmatization, and perceived irrelevance of treatment) were examined for normality by evaluating skewness and kurtosis in the total sample. Data was considered acceptable if skewness is between -2 to +2 and if kurtosis is between -7 and +7 (Tabachnick & Fidell, 2013); all continuous predictor variables were found to be normally distributed.

Assumptions regarding outliers and multicollinearity were assessed prior to running the multinomial logistic regressions. Outliers for discrete variables were assessed via examining the expected frequencies for each pair of predictors; as less than 20% of the cells had frequencies less than 5, no categorical outliers were removed. Outliers for continuous variables were identified using standardized residuals (the difference between the actual and predicted probabilities); standardized residuals larger than 3.0 or smaller than -3.0, are considered an outlier (Tabachnick & Fidell, 2013). As none of the residuals fell outside this range, outliers for the continuous variables were not evident. Pearson correlations (see Table 2) were used to evaluate multicollinearity. Correlations between the modifiable predictors in the total sample fell below the 0.7 cutoff (Tabachnick & Fidell, 2013; \( r = .14 \) to \( .61 \)). Thus, collinearity was not indicated, and all predictors were retained.
Table 2

Correlations of Predictor Variables Among Total Sample

<table>
<thead>
<tr>
<th>Predictor</th>
<th>M (SD)</th>
<th>Possible range</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Knowledge of child mental health</td>
<td>31.61 (5.47)</td>
<td>0-40</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Parental self-efficacy</td>
<td>19.13 (3.01)</td>
<td>5-25</td>
<td>.14</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Stigmatization</td>
<td>10.46 (7.63)</td>
<td>0-40</td>
<td>-.30**</td>
<td>-.28**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>4. Perceived irrelevance of treatment</td>
<td>1.82 (.77)</td>
<td>1-5</td>
<td>-.25**</td>
<td>-.24**</td>
<td>.61**</td>
<td>-</td>
</tr>
</tbody>
</table>

**p < .01

Aim 1: Identify parents who may be more likely to *not* engage with the youth mental health care system when they perceive it to be needed

A multinomial logistic regression was performed to create a model of the relationship between the demographic characteristic predictor variables (gender, race/ethnicity, education level, family income, relationship status, number of children, and parent service use history) and membership in the three group classifications (*perceived needers, treatment intenders, and service utilizers*). The *perceived needers* group was used as the reference category. Family and demographic predictors of membership in each of the groups are presented in Table 3. There was a good model fit (discrimination among groups) based on the seven family and demographic predictors, $\chi^2(210, N = 175) = 174.38$, $p = .97$, using a deviance criterion. The fit between the model containing only the intercept and data improved with the addition of the predictor variables, $\chi^2(20, N = 175) = 37.25$, Nagelkerke $R^2 = .233$, $p = .01$. 
Table 3

*Multinomial Logistic Regression of Demographic Variables Predicting Membership in Three Parent Help-Seeking Groups*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Treatment utilizers vs. perceived needers</th>
<th>Treatment intenders vs. perceived needers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Gender (reference: female)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0.720</td>
<td>[0.27, 1.93]</td>
</tr>
<tr>
<td>Race/ethnicity (reference: White)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black/African American</td>
<td>0.085</td>
<td>[0.01, 0.73]</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>0.216</td>
<td>[0.02, 2.12]</td>
</tr>
<tr>
<td>Asian</td>
<td>0.060</td>
<td>[0.01, 0.55]</td>
</tr>
<tr>
<td>Education (reference: Associates or greater)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college or less</td>
<td>0.899</td>
<td>[0.26, 3.12]</td>
</tr>
<tr>
<td>Income (reference: $60,000+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$60,000 or less</td>
<td>1.409</td>
<td>[0.46, 4.30]</td>
</tr>
<tr>
<td>Relationship status (reference: Married or living with partner)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed, divorced, separated, never married</td>
<td>0.378</td>
<td>[0.12, 1.16]</td>
</tr>
<tr>
<td>Number of children (reference: 1 child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 children</td>
<td>0.499</td>
<td>[0.16, 1.55]</td>
</tr>
<tr>
<td>3 or more children</td>
<td>0.599</td>
<td>[0.14, 2.66]</td>
</tr>
<tr>
<td>Parent treatment and diagnosis history (reference: service use/diagnosis history)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No history with service use or diagnosis</td>
<td>0.389</td>
<td>[0.12, 1.28]</td>
</tr>
</tbody>
</table>

*Note: OR = Odds Ratio. *p < .05
Detailed analysis of the findings according to the three help-seeking groups showed that, in particular, parents’ race/ethnicity made significant, unique contributions to the prediction of overall group membership, $\chi^2 (6) = 15.03, p = .02$. Specifically, parameter estimates revealed that Black/African American (Wald = 5.07, $p = .024$) and Asian (Wald = 6.12, $p = .013$) parents were less likely than White parents to be in the treatment utilizers group ($\%$Black/African American = 25.2, $\%$Asian = 12.6, $\%$White = 36.1) than the perceived needers group ($\%$Black/African American = 38.5, $\%$Asian = 38.5, $\%$White = 7.7). Hispanic/Latino parents were not more or less likely than White parents to be in the treatment utilizers group ($\%$Hispanic/Latino = 26.1, $\%$White = 36.1) compared to the perceived needers group ($\%$Hispanic/Latino = 15.4, $\%$White = 7.7, Wald = 1.73, $p = 0.188$). In addition, Black/African American (Wald = 4.14, $p = .042$) and Asian (Wald = 4.34, $p = .037$) parents were less likely than White parents to be in the treatment intenders group ($\%$Black/African American = 24.2, $\%$Asian = 12.1, $\%$White = 27.3) than the perceived needers group ($\%$Black/African American = 38.5, $\%$Asian = 38.5, $\%$White = 7.7). Hispanic/Latino parents were not more or less likely than White parents to be in the treatment intenders group ($\%$Hispanic/Latino = 36.4, $\%$White = 27.3) compared to the perceived needers group ($\%$Hispanic/Latino = 15.4, $\%$White = 7.7, Wald = 0.56, $p = .453$).

The odds ratio (OR) calculations of the model showed that, relative to White parents, the likelihood for being a treatment utilizer compared to a perceived needer was lower among Black/African American (OR = .085) and Asian (OR = .060) parents. The likelihood of belonging to the treatment intenders group, when compared to the perceived needers group, was lower for Black/African American (OR = .091) and Asian (OR = .072) parents, relative to White parents.
Aim Two: Identify parent mental health attitudes and beliefs that could be targeted in programming to improve mental health care access for youth in need

A multinomial logistic regression was performed to create a model of the relationship between the mental health attitudes and beliefs predictor variables (knowledge of youth mental health problems, stigmatization, perceived irrelevance of treatment, and parental self-efficacy) and membership in the three group classifications (perceived needers, treatment intenders, and treatment utilizers). The perceived needers group was used as the reference category. Mental health attitudes and beliefs predictors of membership in each of the groups are presented in Table 4. There was a good model fit (discrimination among groups) based on the four mental health attitudes and beliefs predictors, $\chi^2(356, N = 184) = 299.09, p = .99$, using a deviance criterion. The fit between the model containing only the intercept and data improved with the addition of the predictor variables, $\chi^2(8, N = 184) = 23.44$, Nagelkerke $R^2 = .145$, $p = .003$.

Table 4

Multinomial Logistic Regression of Parent Mental Health Values and Beliefs Variables Predicting Membership in Three Parent Help-Seeking Groups

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Treatment utilizers vs. perceived needers</th>
<th>Treatment intenders vs. perceived needers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Knowledge of child mental health</td>
<td>1.00</td>
<td>[0.92, 1.10]</td>
</tr>
<tr>
<td>Parental self-efficacy</td>
<td>1.17</td>
<td>[1.02, 1.35]</td>
</tr>
<tr>
<td>Stigmatization</td>
<td>0.98</td>
<td>[0.91, 1.06]</td>
</tr>
<tr>
<td>Perceived irrelevance of treatment</td>
<td>0.48</td>
<td>[0.23, 0.98]</td>
</tr>
</tbody>
</table>

Note: OR = Odds Ratio. *p < .05

Detailed analysis of the findings according to the three help-seeking groups showed that none of the individual predictors had significant associations with overall group membership (ps
>.05 for knowledge of youth mental health problems, parental self-efficacy, stigmatization, and perceived irrelevance of treatment. Parameter estimates revealed that, as self-efficacy (Wald = 4.86, \( p = .027 \)) scores increased, parents were more likely to be in the treatment utilizers than the perceived needers group. As perceived irrelevance of treatment scores increased, parents were less likely to be treatment utilizers than perceived needers (Wald = 4.02, \( p = .045 \)). None of the predictors were significantly related to the treatment intenders group with perceived needers as the reference category.

The OR calculations of the model with perceived needers as the reference category showed that, for every one unit increase in parental self-efficacy, parents were 1.173 times more likely to be in the treatment utilizers group. Additionally, for every one unit increase in perceived irrelevance of treatment, parents were 0.479 times more likely to be in the treatment utilizers group when compared to the perceived needers group.
Discussion

The current study adds to the literature by examining whether predisposing characteristics (i.e., family and demographic characteristics, mental health attitudes or beliefs) predict whether parents perceived a need for mental health treatment (i.e., perceived needers), had intentions to seek treatment (i.e., treatment intenders), or had accessed treatment for their children (i.e., treatment utilizers). Findings showed that parents' race/ethnicity made a significant, unique contribution to the prediction of parents’ location in the help-seeking process, while other demographic variables (i.e., gender, education level, family income, relationship status, number of children, and parent service use history/diagnostic status) did not appear to play a significant role. Moreover, none of the predictors related to mental health attitudes and beliefs (i.e., knowledge of youth mental health problems, parental self-efficacy, stigmatization, and perceived irrelevance of treatment) had significant associations with overall group membership or differentiated treatment intenders from perceived needers. However, parents were more likely to be treatment utilizers than perceived needers as parental self-efficacy increased and perceived irrelevance of treatment decreased; stigma and knowledge of youth mental health problems did not differentiate these two parent groups. Taken together, results suggest that characteristics related to demographics and mental health attitudes and beliefs have some utility in understanding parents’ progression through the help-seeking process.

Race/ethnicity and advancement through the help-seeking process

Only one demographic characteristic – parents’ race/ethnicity – identified parents most likely in need of support to access and use youth mental health treatment. Results are consistent with research showing that racial and ethnic minorities have inequitable access to mental health services, especially when compared to White individuals (e.g., Alvidrez et al., 2010; Broman,
2012; Merikangas et al., 2011). In particular, White parents were more likely than both Black/African American and Asian parents to be a treatment intender or treatment utilizer when compared to a perceived needer. Social stressors, particularly structural and systemic racism, actively contribute to ethnic/racial mental health disparities (e.g., Alegría et al., 2015). Indeed, current youth help-seeking models emphasize the importance of enabling resources, such as transportation and health insurance, for moving through the process (e.g., Cauce et al., 2002; Eiraldi et al., 2006; Logan & King, 2001; Srebnik et al., 1996). Help-seeking, however, might be qualitatively different among people of different backgrounds. For instance, research has demonstrated that many Black/African American individuals might seek help from informal providers (e.g., church leaders, mentorship programs; Vázquez & Villodas, 2019). Similarly, Asian individuals of various ethnicities might seek care from medical professionals due to stigmatization and shame associated with mental health (e.g., feeling like a burden; Yang et al., 2020). Interestingly, Hispanic/Latino parents were similarly as likely as White parents to make it further in the help-seeking process (i.e., similarly likely to be a treatment intender or treatment utilizer compared to a perceived needer). These results are inconsistent with prior research demonstrating that mental health disparities negatively impact Hispanic/Latino individuals (e.g., Broman, 2012; Merikangas et al., 2011). Perhaps Hispanic/Latino parents’ barriers to movement between the help-seeking steps can be better predicted by the ethnic identity’s interaction with other cultural and contextual characteristics (e.g., race, language preference, citizen status, cultural values). For example, it may be that Hispanic/Latino parents who experience more acculturative stress (e.g., primarily speak Spanish) are more likely to become “stuck” within the help-seeking process due to a cultural mismatch between available services and preferred methods of treating youth mental health. Or, as symptoms are often expressed or described
somatically, perhaps many Hispanic/Latino parents are more likely to take their youth to a pediatrician to address physical complaints. Additionally, mental health disparities among racial and ethnic minorities, including Hispanic/Latino populations, might be better understood by considering how parents with marginalized identities often fear or do not trust health providers (e.g., De Silva et al., 2020). Overall, the impact of parents’ racial identity on their point in the help-seeking process demonstrates a need for structural and systemic changes within the mental health care system. To reduce disparities that are influenced by social determinants of health (i.e., ethnicity/race), mental health services need to be: affordable (e.g., higher reimbursement for providers, sliding scale fees), accessible (e.g., providing transportation, services in commonly used places like schools, churches, doctor’s offices, virtually), available (e.g., increase number of trained, racially and ethnically diverse providers), and acceptable (e.g., train providers to provide culturally responsive care; see Arredondo, 2019).

**Perceived treatment relevance and self-efficacy’s influence on advancement through the help-seeking process**

Findings suggest that parents’ mental health attitudes and beliefs (e.g., perceived treatment relevance, self-efficacy in identifying and helping youth mental health problems) can be helpful in distinguishing parents with a perceived need for treatment but no intentions to seek services (i.e., perceived needers) from parents who have utilized services (i.e., treatment utilizers). Consistent with prior research, parents’ likelihood of having utilized youth mental health services increased as their perceived relevance of treatment increased (Chacko et al., 2017; Kadzin, 2000; Stevens et al., 2006). Conceptually, this finding is not surprising: parents who do not think mental health treatment will help their child may view such treatment as a waste of time and money. Consequently, parents who realize that their child is struggling may not necessarily move past that initial stage in the help-seeking process. By examining perceived
needers and treatment intenders separately and in addition to treatment utilizers, this study’s results do not refute but rather build upon Owen and colleagues’ (2002) finding that parents with a perceived need but no treatment utilization (i.e., perceived needers and/or treatment intenders) do not differ from treatment utilizer parents on thoughts about treatment helpfulness. These differences in results demonstrate that beliefs about treatment relevance may be especially important in distinguishing parents at the beginning of the help-seeking process (i.e., perceived needers) from those at the end (i.e., treatment utilizers). Turning to self-efficacy, parents in the present study were more likely to have used services (versus not having moved past perceiving a need) when their self-efficacy in recognizing and supporting youth mental health problems increased. Again, this finding makes sense: parents who do not believe they have the ability to notice that their child is struggling and/or know how to get professional help may view it as a waste of time to even attempt to seek services for their child when they think it may be needed. While researchers have proposed that this form of self-efficacy influences help-seeking (Reich et al., 2004), this study was the first to test and confirm this theory. Accordingly, these results suggest that parents may be less likely to move from the initial step (i.e., perceiving a need for services) to the final step (i.e., utilizing services) of help-seeking if they believe that a) treatment would not be helpful for children or b) they cannot recognize and/or support children with mental health issues.

Thus, to best support parents who perceive their children need mental health services, stakeholders (in particular: researchers, clinicians, and policymakers) should prioritize dispelling misconceptions about youth mental health services. Dissemination efforts, such as parent psychoeducational workshops, online marketing campaigns, and pamphlets at pediatricians’ offices, are needed that bolster parents’ confidence in supporting youth with mental health needs.
via increasing parents’ understanding of how mental health treatment works and helps youth, and via including information about where and how to seek related services. More generally, results highlight a need for research to examine parents’ help-seeking in a nuanced manner, as was done for this study. To better understand the impact of parents’ mental health attitudes and beliefs on health help-seeking and treatment utilization for youth, future research needs to examine parents’ various “stuck points,” potentially breaking down the steps between perceived need and treatment utilization even further (e.g., searching for providers/clinics, contacting providers/clinics about availability).

**Identifying parents likely to need help-seeking support via parent and family demographic characteristics**

The current findings suggest that parent and family demographic characteristics (e.g., gender, education level, family income, relationship status, number of children, and parent service use history) may not play a significant role in parents’ advancement through the help-seeking pathway. These results, however, are not completely consistent with prior research. Other studies have found household income (Brown et al., 2014; Coker et al., 2009; Sawyer et al., 2007; Shivram et al., 2009; Thompson & May, 2006), parents’ relationship status (Brown et al., 2014; Fehr et al., 2020; Sourander et al., 2001; Sawyer et al., 2007; Thompson & May, 2006), and parents’ history of mental health diagnoses or treatment (Godoy et al., 2014; Turner, 2012; Turner & Mohan, 2016; Wu et al., 1999; Zimmerman, 2005) to have mixed predictive ability on parents’ progression through the help-seeking process. Consequently, demographic characteristics’ role may be more complex than a linear association and require more nuanced research to better understand their associations. For one, the importance of cost of services on help-seeking may be better examined via families’ distance from the federal poverty level, as it takes into account the number of people in a household (HealthCare.gov, 2022). Moreover, the
impact of family on parents’ help-seeking might be better understood by measuring indicators of family dynamics (e.g., parental conflict; Ryan et al., 2015) instead of its composition or type. The mostly non-significant findings for demographic characteristics also illustrate a need to consider such predisposing characteristics within larger contexts of sociocultural values and norms (e.g., within neighborhood, school, country).

**Predicting parents’ likely position in the help-seeking process via mental health attitudes and beliefs**

Stigmatization and knowledge of child mental health and treatment did not predict parents’ progress through the help-seeking pathway, which is surprising given that mental health attitudes and beliefs have been proposed as significant facilitators and barriers to youth mental health care utilization. The study’s non-significant findings for stigmatization are consistent with prior research’s inconsistent findings on its relationship to help-seeking intentions (Dempster et al., 2013; Murray et al., 2011; Owens et al., 2002; Turner & Mohan, 2016). However, mental health attitudes and beliefs potentially impact help-seeking in ways that were not explored in this study. For instance, as stigmatization of mental health and treatment is known to impact treatment utilization (Cohen et al., 2012; Flink et al., 2013; Gerdes et al., 2014; Murry et al., 2011; Sayal et al., 2010), perhaps it is a significant factor during the early stages of help-seeking (i.e., influences whether parents perceive a need for treatment). Similarly, given that knowledge of child mental health and treatment did not predict parents’ location in the help-seeking process, perhaps that knowledge is a precursor to parents’ perceiving a need at the outset of help-seeking. Additionally, stigmatization and knowledge of child mental health may influence where or from whom treatment is utilized (i.e., informal supports family or clergy, collateral services like school counselors, or formal mental health services like psychologists or psychiatrists), and not whether any mental health-related treatment was sought (Cauce et al., 2002). As a result,
clinicians need to be cognizant that parents who initiate treatment for their youth may or may not have mental health and treatment stigmatization, and/or poor knowledge of youth mental health.

**Treatment intenders as a help-seeking “stuck point”**

The present study was able to differentiate parents who perceive a need for treatment but have not made it to the end of the help seeking process (i.e., *perceived needers*) from those who have “made it to the end” (i.e., *treatment utilizers*) via certain mental health attitudes and beliefs. However, in contrast with the proposed hypotheses, these mental health characteristics were not useful in distinguishing *treatment intenders* (i.e., endorsed an intention or willingness to seek services) from *perceived needers*. These non-significant results indicate that the predisposing characteristics examined (i.e., demographics and mental health attitudes and beliefs), with the exception of parents’ race/ethnicity, may not play a role in parents’ movement from perceiving a need to developing intentions to seek help, or their movement from developing intentions to seek help to utilizing treatment. Additional research is needed to explore characteristics and circumstances that may be uniquely salient to this *treatment intenders* group. For example, perhaps enabling resources (e.g., affordability or availability of youth mental health services) are more influential in determining whether parents decide to seek services or move past deciding to seek services. *Treatment intenders* may be hindered from becoming *treatment utilizers* due to a lack of health insurance or inability to find a mental health provider without a long waitlist. Similarly, *perceived needers* who do not have health insurance may not believe services to be a potential, viable option and may, thus, not develop into a *treatment intender*. Furthermore, the current study’s non-significant findings for *treatment intenders* suggest that this categorization may not have adequately captured a help-seeking “stuck point.” That is, parents who endorsed intentions to seek help might or might not have previously attempted to access services for their
youth, and consequently might be differentially impacted by predisposing factors (and enabling resources, as discussed above).

**Limitations and future directions**

These findings should be considered within the context of some important limitations. First, given the study’s cross-sectional research design, results do not elucidate if parents’ predisposing characteristics (in particular, perceived treatment relevance and self-efficacy in recognizing and supporting youth mental health problems) precede their perceptions of need or service utilization. Importantly, treatment utilizers’ mental health attitudes and beliefs pre-accessing services may not be reflected in the study’s data. That is, it is possible that their mental health attitudes and beliefs changed (e.g., became more positive) as a result of their youth receiving mental health services. A treatment utilizer parent, for example, may have endorsed lower parental self-efficacy scores if they had been assessed when the parent initially perceived a need for such services; their beliefs in their ability to notice and help children with mental health problems may have been enhanced by “successfully” doing so for their youth. To determine a causal relationship and its direction, future research should longitudinally assess parents’ mental health attitudes and beliefs, as well as their progression through the help-seeking pathway.

Future studies could also improve upon measuring youth help-seeking processes. The study’s operationalization of help-seeking intentions is imperfect, as responses to various intention-related questions were averaged to measure intentions binarily. While this dichotomous split defined those with help-seeking intentions as those who, on average, agreed or strongly agree with intention-related items (e.g., “If my child were to experience a psychological or behavior problem, I would get professional help if I wanted to”; “If I believed my child were having a mental breakdown, my first decision would be to get professional help”), this
operationalization may not perfectly map on assessing whether a person does or does not have intentions to seek help. On the other hand, perceived need was measured via one item (“Do you think any of your children needed or would have benefited from help for emotional, behavioral, or social difficulties?”). Additional research should utilize a more comprehensive approach to assessing whether parents are in the perceived needers or treatment intenders stage, perhaps by using interviews with parents to understand their unique and dynamic experiences. In addition, prior research has indicated a need to assess perceived need for multiple, distinct services (e.g., psychological therapy, medical doctor, minister; Vázquez et al., 2021). Given that parents turn to various forms of support for youth mental health problems (e.g., Reardon et al., 2017), future research should examine the relationship between predisposing characteristics and advancement through the help-seeking process for various providers.

Furthermore, this study’s sample was an improvement from previous studies’ though its examination of the youth help-seeking pathway among a sample of diverse parents, though there is still room for improvement. While the sample size for each help-seeking group was considered sufficient for the multinomial logistic regressions, a larger sample size would have increased confidence in the results’ accuracy. In particular, greater representation of parents across demographics’ subcategories (e.g., Asian or bi/multiracial, men, low income, no high school degree) might have revealed that these characteristics can be helpful in determining parents’ likely point in the youth help-seeking process. Moreover, mental health attitudes and beliefs were positively skewed, though acceptable for data analysis. If more parents with very negative or inaccurate perceptions about child mental health and treatment had been included, it is possible that more perceived needers and treatment intenders would have been represented, and/or that stigmatization and knowledge of youth mental health would have emerged as
important to parents’ advancement through youth help-seeking. Regardless of these limitations, this study is one of the first to suggest that perceiving a need for mental health care is necessary but not enough for parents to access youth mental health services, and that this nuance can be better understood by considering predisposing characteristics’ associations.

Conclusion

In an effort to improve youth mental health treatment access and utilization, the current study examined predisposing characteristics’ utility in determining parents’ likely position in the youth mental health help-seeking process. Results demonstrate that some demographic characteristics and mental health attitudes can be used to identify parents who may be more likely to not engage with the youth mental health care system when they perceive it to be needed. For one, racial and ethnic minority parents are likely most in need of support to access treatment after they recognize a need. Social determinants of health actively marginalize racial and ethnic minority parents from accessing mental health care for youth in need. As a result, addressing structural inequities (e.g., lack of insurance, availability of services) are necessary to ensure access to mental health services once parents perceive it to be needed. At the same time, efforts to increase service utilization need to prioritize fostering parents’ perceived relevance of treatment and self-efficacy to notice and help youth mental health problems. In conclusion, we must empower parents to seek youth mental health services and address structural inequities in order to bridge the need-to-access-gap for youth mental health care.
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