Mental Health Trust: An Analysis of African-American Apprehension Following the Overreach of Executive Power

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ABSTRACT

African American adolescents represent one of the largest groups of underrepresented populations in the United States mental health care system. Despite this, they remain among the least studied populations across the literature. This study examined the extent to which the expansion of executive power during the early phases of the COVID-19 pandemic eroded trust in mental health support services among African-American teenagers. Drawing from patterns of historical discrimination alongside patterns of modern policy failure, the purpose of this research was to situate adolescent mistrust within a broader framework of systemic inequity. Using a mixed-methods approach, this study combines a retrospective survey administered to African American teenagers in rural Georgia who engaged in pediatric mental health care during the years 2019-2022, combined with over twenty peer-reviewed studies on healthcare access, democratic backsliding, and institutional discrimination.

The findings suggest that federal policy during COVID-19 disproportionately impacted Black communities and increased perceived mistrust, drawing parallels to historical apprehension. This limited patient-provider relationships, and a lack of local inclusion was a key driving factor, along with apprehension of the political status quo. This study addresses a critical gap by centering the first-hand experiences of African-American adolescents. Ultimately, this study addresses a critical scholarly gap by centering the lived, firsthand experiences of African American adolescents. Moving forward, policymakers must prioritize equitable healthcare reforms grounded in rebuilding institutional trust, a foundational yet frequently overlooked element in pediatric mental health outcomes.

Keywords: mental health, adolescents, COVID-19, democratic backsliding, discrimination

INTRODUCTION

Although the United States maintains one of the world's most extensive healthcare infrastructures, African-American communities, particularly adolescents, continue to experience disproportionately low levels of trust in mental health services. Existing research consistently identifies mistrust as a central barrier to care, with a Brookings Institution study finding that more than half of African Americans report a low to moderate level of trust in the US healthcare system. Among adolescents, these levels are even lower, suggesting that distrust may begin forming earlier than previously examined and may shape engagement with healthcare systems.

While scholars widely attribute this mistrust to systemic inequalities, the COVID-19 pandemic introduced a new dimension: the rapid expansion of executive power and centralized decision-making. Federal responses, though designed for efficiency, often bypassed local institutions, and when federal agencies implemented emergency responses, they often overlooked the specific needs of marginalized communities (Bowen et al). As cited in the International Journal of Environmental Research and Public Health, renowned for medical policy analysis, *mental health services* -encompassing not only psychiatric care but also crisis hotlines, school-based counseling, etc.- became increasingly strained, exposing and, in many cases, exacerbating preexisting disparities [1]. Emerging research suggests that these centralized responses may have disproportionately impacted African-American communities. For example, according to a meta-analysis by Dr. Szaflarski and Dr. Baudry, health policy analysts at the University of Michigan, pediatric psychiatric hospitals serving predominantly African American populations were significantly more likely to experience rejected requests for additional staffing compared to

hospitals in majority-white areas [2]. Political science scholarship further argues that the expansion of executive authority during COVID potentially intensified structural inequalities. Highlighting this view, political science researcher Dr. Edgell at the University of Alabama contends that the reliance on broad, top-down decision-making disproportionately harmed communities facing structural inequities. As a result, the United States federal government often bypassed local autonomy, impacting marginalized communities. In this context, *executive power* refers to policies enacted by the federal government (ie: the CARES Act of 2020 or the American Rescue Plan), or orders issued by the president, including those administered through agencies such as the Department of Health and Human Services [3]. Despite these insights, a critical gap remains in the literature. Existing studies tend to examine historical mistrust, structural inequities, or pandemic policy responses in isolation, without addressing how these factors interact at the level of individual experience. This gap is particularly pronounced for African-American adolescents, a population whose perceptions of institutional trust are actively forming and who remain underrepresented in both quantitative and qualitative research.

To address this gap, the purpose of this study is to evaluate how perceived minority exclusion associated with the overreach of executive power during the early phases of COVID is associated with trust in mental health support services in the US for African American teenagers in rural Georgia. By centering first-hand experiences within a broader structural framework, this study contributes to a more nuanced understanding of how healthcare trust is formed and potentially rebuilt among underserved populations.

LITERATURE REVIEW

Historical Discrimination

To understand the contemporary relationships that African American teenagers have with the US medical system, it is necessary to examine the historical mistreatment of African Americans in healthcare institutions. The historical discrimination of African Americans in healthcare has greatly shaped their relationship with medical institutions. For instance, the Tuskegee Syphilis Study, in which African American men were deliberately left untreated to study the progression of the disease, remains one of the clearest examples of medical exploitation and continues to shape community perceptions of healthcare [3]. Specifically in psychiatric care, forced institutionalization and underfunded mental health programs have contributed to multigenerational wariness of healthcare initiatives. Additionally, younger African-American immigrants and refugees face unique challenges. Many often arrive in the United States with undiagnosed health conditions due to the limited amount of medical infrastructure present within their home nations.

Over multiple generations, these inequities contribute to cyclical mental health disparities. For instance, a study by the National Institutes of Health found that third-generation African Americans experienced higher rates of mental health challenges compared to first- and second-generation populations, suggesting that historical injustices have persisted across generations [4]. However, while current research recognizes the long legacy of unequal treatment, it does not examine how historical discrimination interacts with contemporary executive decisions, such as those made during COVID-19, to impact adolescents specifically. This limitation underscores the need to investigate mistrust among younger populations who face both historical and newly emerging structural challenges.

Abuse of Federal Power during COVID-19

The early phases of COVID-19 saw unprecedented levels of federal authority expanding. In a meta-analysis conducted by a professor of Economics at the Erasmus School of Economics in the Netherlands, emergency powers granted to the executive branch of the United States government enabled swift responses to COVID; however, they also created conditions conducive to overreach and inequitable resource allocation. For example, judicial reviews during this time indicate that federal authorities frequently sided with institutional and corporate priorities, often at the expense of vulnerable populations such as African Americans. This concentration of power for the sake of speed had concrete consequences for mental health services. In mental health services specifically, federal policy prioritized technological and material supplies over human-resource support, despite clear evidence that adolescent psychiatric services were severely understaffed [5].

Policies implemented during COVID-19 frequently overlooked mental health support for minorities, exacerbating preexisting disparities. Exemplifying O'Donnell's claims, researchers who published in the Latin American Lancet journal found that female discrimination became more apparent in the implementation of healthcare policies between 2020 and 2023, further illustrating how gender- and race-based disparities became more pronounced [6]. By bypassing local governance structures and focusing on broad, uniform interventions, federal actions inadvertently intensified barriers to mental health access for historically marginalized groups. Even within this policy discussion, however, individual-level experiences have been undercovered. They do not explore how adolescents interpreted these policy failures or how executive decisions influenced their trust in the mental health services they rely on. As a result, the specific experiences of African American teenagers remain absent from the conversation.

Perception of Discrimination

Historically, political environments have significantly influenced trust in medical systems. As contextualized by professors of Political Science at the University of California at Irvine, during the Reagan Era, policies such as the Reform and Control Act of 1986 promoted dignity and more equitable access to healthcare, fostering trust in medical institutions. In contrast, contemporary policies like the National Day of Remembrance for Americans Killed by Illegal Aliens contributed to hostility, which indirectly reduces the willingness to trust governmental institutions [7]. For African American adolescents, perceived discrimination is essential as it is closely linked to medical mistrust. Research conducted at Yale Medical School shows that experiences of bias correlate with a 25% increase in mistrust toward healthcare systems, particularly in psychiatric care. Patient-provider relationships are central to building trust, yet negative experiences can discourage future engagements with mental health services [8]. The COVID-19 pandemic intensified these challenges. Patient-provider relationships are essential, but negative encounters, such as microaggressions or dismissal of mental health concerns, can discourage adolescents from seeking care in the future.

Lack of Quantitative Data on African American Teens

Despite extensive literature on systemic inequities in healthcare, research on African American teenagers remains sparse. As the National Research Council in the United States explains, most studies focus on adult populations or aggregate minority groups without disaggregating by age. Quantitative data that examine first-hand experiences of African American teens in accessing mental health services are thus particularly limited [9]. Echoing this claim, Dr. Amelia Fiske, a human ethics expert, states that existing datasets often overlook younger populations, who are most likely to shape their political environments. She argues that existing datasets often overlook younger populations because researchers tend to prioritize adults who are easier to recruit and perceived as more reliable narrators.

This lack of data hinders the ability of policymakers to design effective interventions, thus increasing the potential of exacerbating mistrust amongst African American teenagers [10]. Addressing this gap is essential for understanding how executive overreach during the COVID-19 pandemic specifically affected trust in mental health services among African-American teenagers. The null hypothesis states that levels of minority exclusion through the overreach of executive power had no bearing on government trust levels amongst African American adolescents. The research hypothesis is that as levels of minority exclusion increased, the levels of government trust decreased. By highlighting both historical patterns and contemporary policy impacts, this study situates its research within the broader context of systemic inequities and this underexplored population.

METHODS

The researcher employed a mixed-method correlational design to examine the relationship between perceived minority exclusion and trust in mental health services among African-American adolescents during the COVID-19 pandemic. A mixed-methods approach was chosen because it allowed for the integration of quantitative data, which identifies patterns in levels of trust, with qualitative data, which provides contextual insight into participants' lived experiences. This design is appropriate for research involving trust, as trust is both quantifiable and deeply contextual. A correlational framework was used because the study seeks to identify associations between variables rather than establish causation. Additionally, given the ethical and logistical

implications of experimental manipulation in this context, a correlational design provided the most feasible and appropriate framework.

A survey was chosen as part of the method because, unlike individual in-person interviews, which are constrained by access and locality, surveys allowed the researcher to gather a larger volume of responses across southern Georgia. Given the time and financial constraints on the researcher, studying southern rural Georgia was the most feasible population for the researcher, as they had prior connections that uniquely allowed them to access African American teenagers predisposed to mental health conditions. Furthermore, the use of a meta-analysis helped to justify trends seen in the survey, contributing more to the legitimacy of the research.

To get the most responses and thus have the most accurate data, the coverage of this study focused on twenty African-American high school students in southern rural Georgia who either received help for their mental health or had interacted with a mental health provider during COVID (2019-2022). Inclusion criteria required that participants identify as African-American, be enrolled in high school, and have had at least one interaction with a mental health provider. A non-probability convenience sampling method was used due to accessibility constraints and the challenges of recruiting minors for research involving mental health. While this sampling method enabled access to relevant and underserved populations, it introduced potential selection bias, as participants were more likely to have prior engagement with mental health systems. Furthermore, while this method introduces limitations related to generalizability, it is commonly used in exploratory and qualitative research involving hard-to-reach populations. The researcher both anticipated and utilized twenty individuals, as this sample size was similar to Chu's study, in which they utilized twenty sample participants, too. The researcher was put in contact with the participants through a national mental health non-profit, and all participants and their parents gave their consent via permission forms (Appendix A). Furthermore, data were collected using a retrospective survey instrument administered through Google Forms. This platform was utilized to make the form and send it out, as it was an accessible instrument for both the researcher and the participants (Appendix B). Additionally, all participants were in contact with the researcher via email, allowing easy communication between the researcher and the participants. The design of the survey was based on a foundational study done by Kristen A Chu, PhD, a clinical psychology researcher at the University of California, Los Angeles, on the impact of COVID-19 on family mental health. This study is grounded in institutional trust theory, which posits that individuals' willingness to engage in systems such as healthcare is shaped by perceived fairness, representation, and responsiveness within those institutions. According to this framework, trust is not formed solely through individual interactions but also through broader perceptions of systemic legitimacy, particularly among historically marginalized communities. This framework is particularly relevant for African American adolescents whose healthcare environments, the researcher posited, are influenced by both lived experiences and historical discrimination. Similarly, prior research conducted by Chu utilized retrospective data to assess how mental health interventions during COVID-19 affected family experiences. In order to study this, the researchers also asked twenty participants to retrospectively answer a questionnaire assessing how psychological interventions and treatment strategies during COVID-19 impacted the lives of families. The survey conducted in this study followed this design; thus, the researcher followed a similar scope as Chu and asked the participants retrospectively about their experiences with mental health as a familial unit during COVID [11]. The survey consisted of three sections.

The first section featured quantitative questions that had the participants answer on a ten-point Likert scale. The wide scale improved the validity of the results by decreasing the likelihood of participants providing an inaccurate representation of their views. The use of a ten-point scale was inspired by Chu's study, in which they used a numerical ranking system of 1-10 to describe feelings towards mental health providers (1 being the strong feelings of dislike and 10 being strong feelings of trust) [11]. In the first section, participants were asked about the degree to which they trusted the United States healthcare system and whether they felt included under said system. The primary variables were defined and operationalized as follows. Independent variables included perceived minority inclusion, measured through Likert scale responses assessing the extent to which participants felt represented, included, and considered in healthcare systems and decision-making processes. The dependent variable then was trust in mental health services, operationalized through participant ratings of trust in government and healthcare providers, as well as qualitative expressions of confidence, skepticism, and

disengagement. The supporting variables included reported barriers to access (ie, transportation, cost, telehealth availability) and interpersonal experiences with providers (ie, dismissal versus validation).

In the next section of the survey, categorical selection was utilized in which participants were asked to select statements on healthcare trust that resonated with them. These statements were chosen by examining the NIH mental health standards to find topics that are in alignment with the values people prioritize in care. The topics of inquiry in this section were "whether physicians respect privacy/ prioritized personal information protection", "accessibility to telehealth during COVID/ transportation barriers", and "exclusion from decision-making at a local level/ skepticism around new rules."

Finally, the last section of questions was open-ended and asked participants to give anecdotes about their experiences if they received mental health treatment during COVID. This was to fill the lack of qualitative data, as described in the National Research Council, and determine how African-American teens viewed the future of the system. At the end of the survey, participants were asked about their demographic information, as well as whether they would be willing to be interviewed and if they would like to be updated on the research being conducted. There was also an answer box that prompted participants to express any other statements they wanted to make that weren't included in the scope of the survey. All responses from the survey were automatically recorded in Google Forms and exported into a spreadsheet. This was included to inform both future research and potentially explain trends in experiences. Furthermore, before analysis, the data were reviewed for completeness and consistency. Responses with missing data were accounted for in limitations, and categorical coding was used to organize the open-ended questions. Quantitative and qualitative data were summarized in individualized sheets for each participant. Quantitative data were analyzed using Data Classroom, and descriptive statistics, including frequency distributions and clustering patterns, were calculated to identify trends in participant responses. Relationships between these variables, such as perceived minority inclusion and trust in government, were assessed through scatterplot analysis and visual trend identification. Due to the limited sample size, inferential statistical tests were not conducted. Instead, findings were interpreted as associational patterns rather than statistically significant relationships. For the qualitative analysis, these data were analyzed using a thematic coding process, though a formal intercoder process couldn't occur due to the single-researcher design. To further enhance reliability, the coding process was conducted through multiple rounds of review to ensure consistency in the application of themes across responses. Firstly, all responses were read in full to identify recurring ideas. Next, responses were categorized into three primary domains. Firstly, accessibility of mental health services. Secondly, provider interaction experiences (dismissal vs validation). Thirdly, autonomy and transparency in treatment. These responses were grouped into these domains to evaluate how these experiences shaped perceptions of trust among rural adolescent African Americans. After seeing these sub-themes, responses within each domain were further analyzed to examine patterns in frequency, tone, and contextual meaning. This process allowed the researcher to move beyond simple categorization and identify how specific experiences contributed to broader perceptions of trust and exclusion. To enhance reliability, the coding process was conducted iteratively, with responses reviewed multiple times to ensure consistency in how the themes were applied. Any ambiguous responses were re-evaluated in the context of the surrounding data to maintain coherence across categories. To further strengthen the validity of the findings, qualitative themes were compared with quantitative trends to identify points of convergence and divergence. This triangulation allowed patterns observed in numerical data to be explained through participant narratives, enhancing the overall interpretative depth of this study.

The second part of this method involved statistical analysis from previous studies on democratic backsliding and its implications for healthcare. *Democratic backsliding* is the process through which laws are not held to the highest levels of accountability, thus eroding due process. The purpose of this was to collect data and streamline the process of assessing how democratic backsliding has affected the trust of African American teenagers as it pertains to mental health services. The researcher based this portion of the method on a previous study conducted by Dr. Chu. Because the objectives of both studies were similar in nature, the researcher decided to model part of the study based on this. However, instead of using statistical analysis on both the pre- and post-surveys, the researcher simply decided to do the post-surveys in 2026 to minimize any potential bias in the question types created for the initial part of the method. Additionally, doing a pre-survey would prove to be difficult, as COVID-19 at the time of this paper was too old for many participants to properly recall.

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Similar to Chu's study, the researcher compiled over fifty research papers. Then, based on relevance to the correlation between trust and willingness to "comply" with the medical system, the researcher narrowed those down to twenty sources to examine. As done in Chu's research, the analysis was split into two phases. Firstly, factors related to governmental mistrust were examined. In the second part, the analysis focused on active participation and perceived mistrust. Finally, using essential sufficiency and trying to depict the full phenomenon at hand, the researcher abstracted the main themes and findings of the study.

RESULTS

Survey and Discussion

The survey yielded results from students from over 20 different high schools across the state of Georgia. The respondents were all from rural areas with an uneven gender distribution of 65% male and 35% female. The ethical IRB board approved this research. The majority of the survey results can be seen in Figures 1, 2, and 3. The results from the end section of the survey, where participants were asked to add any other comments about their mental health journey, will be included with the results of the interview because the results were both quantitative and qualitative in nature, and thus were analyzed in that manner.

Figure 1 depicts the results of the section that asked the participants how much they felt minorities were included in medical discussions and what their level of trust in the government (current administration) was on a ten-point scale. As one can see from the figure below, the majority of responses clustered between 3 and 8 on the minority inclusion scale, with government trust scores most commonly falling between 3 and 6. A modest positive association was observed between the two variables, though the relationship was not strong, suggesting that inclusion may be a contributing factor in trust formation. This aligns with the institutional trust theory, though the variability in responses indicates that inclusion alone does not fully account for trust, pointing to the influence of additional factors such as interpersonal relationships.

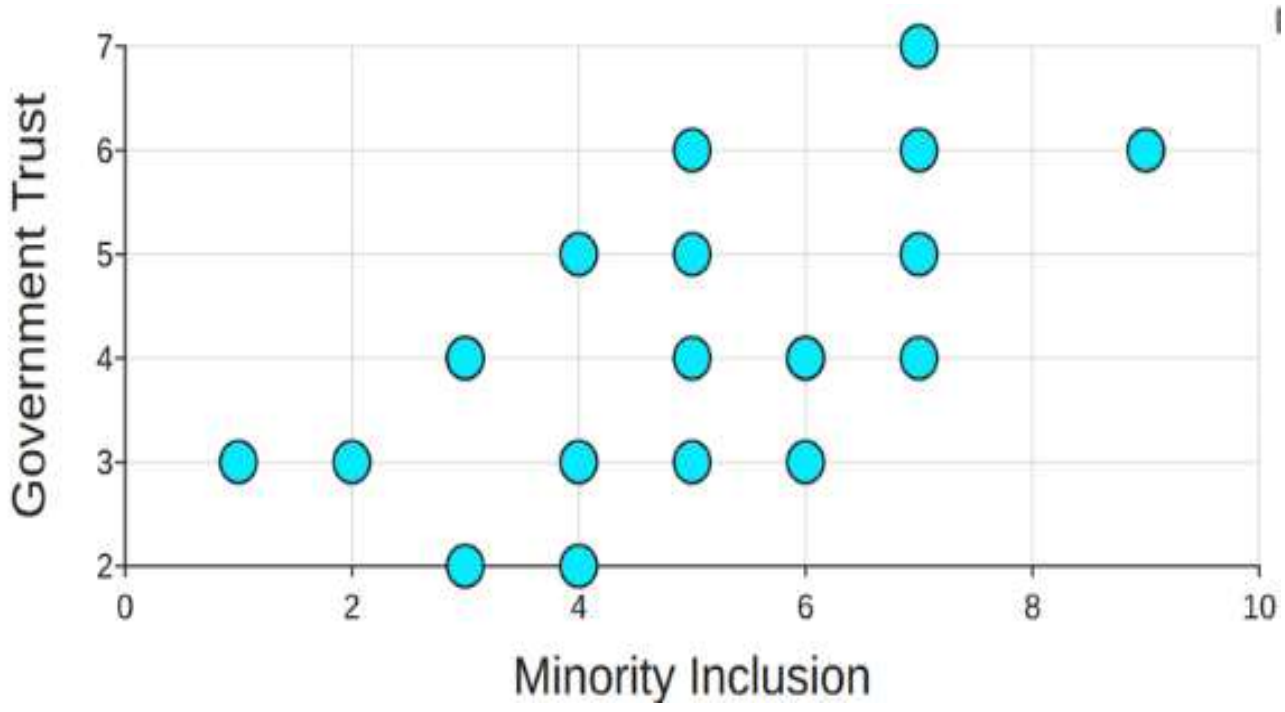

Figure 1

Figure 2 displays the results from the section where participants rated both their level of minority inclusion and their level of primary care physician trust. As one can see in the figure below, the relationship between these two variables was unclear, with responses distributed broadly across both scales. For instance, the most common levels of physician trust clustered around 4-6 on a ten-point scale, as explained in the previous section. However, minority inclusion at these levels ranged from 3 to 7, showing a weaker correlational relationship. This shows

that while it is important for African American adolescents to feel included in medical conversations, medical inclusion alone likely isn't the only factor that shapes trust in the government.

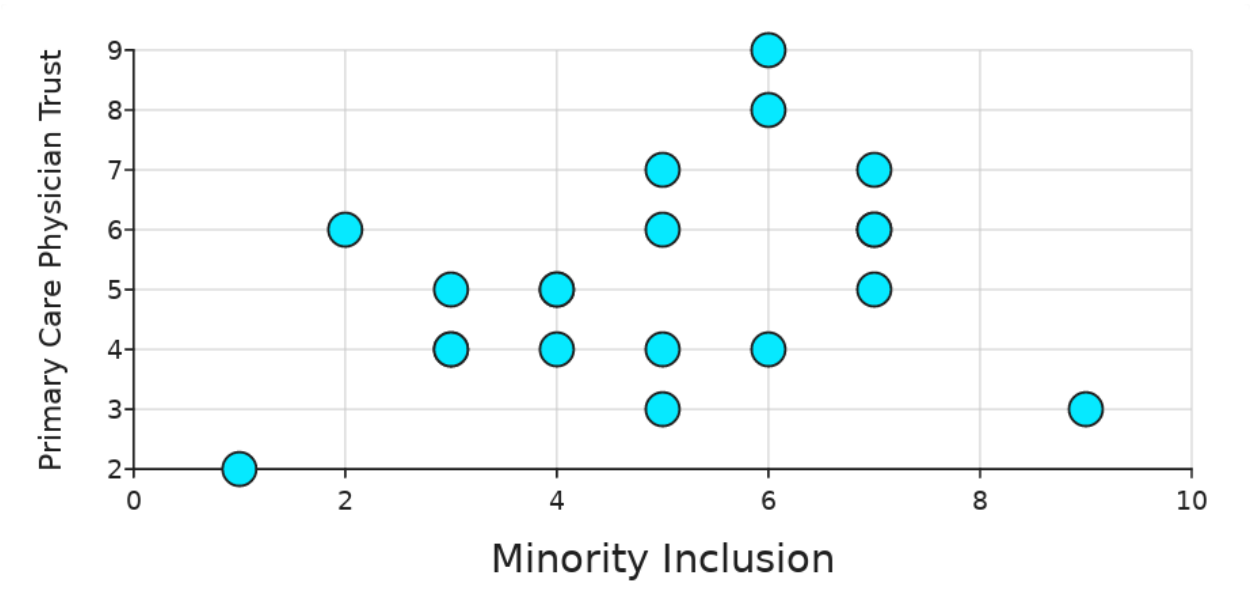

Figure 2

Finally, Figure 3 shows the results for participants' levels of trust in their primary care physician and in the government. As can be seen in the figure below, no clear correlation was found between these two variables, with responses scattered widely across both axes. The lack of a clear relationship between minority inclusion and physician trust suggests that independent physician relationships may operate independently of broader institutional perceptions. However, adolescents who reported lower trust levels in the government may still maintain moderate to high levels of trust in their physicians, indicating that positive interpersonal relationships can partially offset broader systemic mistrust. Moreover, this figure complicates the assumption that improving systemic inclusion alone will uniformly increase trust across all levels of healthcare. This aligns with existing research, which frames structural and interpersonal relationships as separate discussions when shaping inclusion going forward (Nanaw et al).

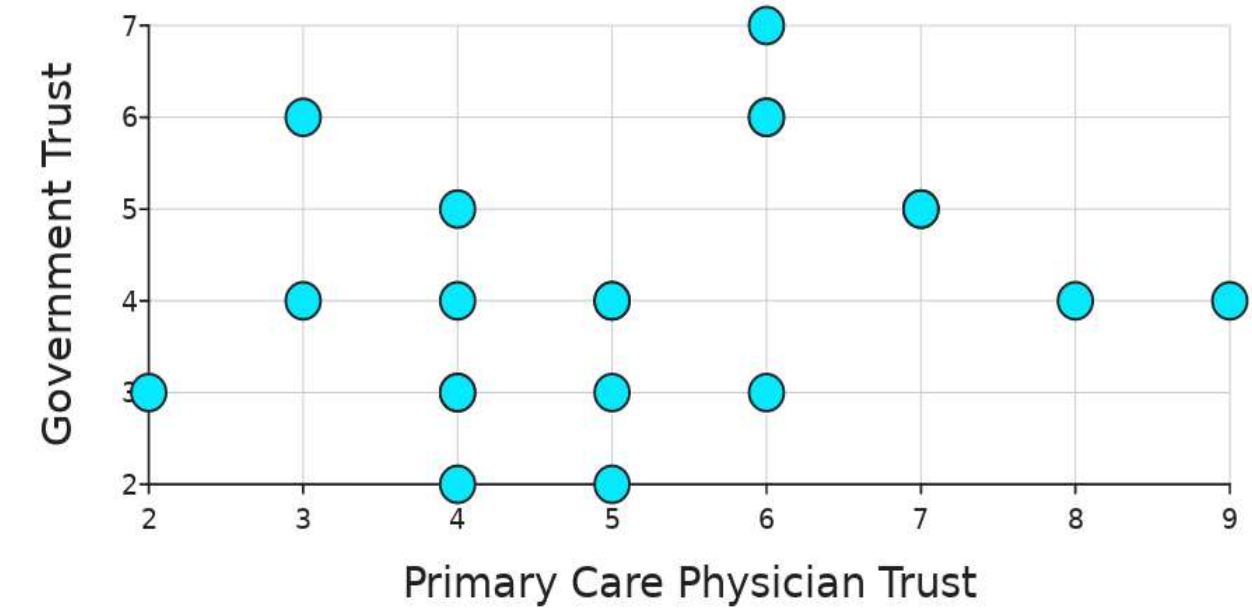

Figure 3

Qualitative Data and Discussion

Nearly 80% of participants decided to answer the qualitative questions present in the survey.

The first trend discussed will be those found in the domain, which includes participants' past experiences with mental health care accessibility. To start, the number of times that participants reported difficulty accessing mental health services was nearly twice the number of times that participants reported having straightforward access. Of those mentions of difficulty, just under 40% were followed by a qualifying statement that then included a "but" construction, such as noting long wait times for an appointment, "but I eventually got seen," or carried a resigned tone, such as "I just stopped trying after a while." These statistics did not include mentions of school-based or community resources accessed outside of traditional clinical settings. 30% of participants reported seeking mental health support from non-clinical sources, such as school counselors, community centers, or online platforms.

The second trend discussed was the dismissal of certain experiences or feelings of discomfort. Nearly 50% of participants who answered the qualitative questions described an instance in which their concerns were minimized and invalidated by a healthcare provider or authority figure. A recurring pattern within these responses was often the underplaying of experiences (ie, consistent linkages to stress) or the referral to another more advanced specialist or type of medication. Representative of this sentiment was one participant who stated: "he [his primary care mental health provider] told me my trauma was probably just stress and I needed to exercise more." The other spectrum of those who felt dismissed was more drastic, with one participant recounting that "she said I didn't seem depressed enough to need medication." The other 50% of participants in this domain offered a contrasting experience, with participants describing providers who listened attentively and followed up on concerns raised in previous appointments.

Finally, the third trend revealed was a lack of transparency and autonomy in mental healthcare. The topic participants indicated that they wished they had more agency over treatment planning at 38%, medication decisions at 22%, and being informed about their diagnosis at 19%. However, they mentioned nearly as frequently as any specific lack of autonomy was the broader sentiment that participants did not wish for a particular change so much as they wished to have been treated as an active participant in their own care throughout the process. One participant, reflecting on feeling excluded from decisions about their own treatment, captured this as "it felt like things were being told to me, not being told along with me," highlighting the continued trend of medical isolationism.

DISCUSSION

Implications, Limitations, and Future Research

The most significant limitations of this study concern the boundaries of the findings in terms of scope. To begin with, this study establishes that rural minority high school students in Georgia report meaningful barriers to mental health access and moderate to low feelings of inclusion in medical discussions, but do not identify the specific mechanisms driving these patterns. The qualitative trends of difficulty accessing care, dismissal within clinical settings, and a lack of transparency and autonomy all provide contextual description, but there was no clear location of causation. Secondly, the smaller sample size and distribution limit how broadly these findings can be generalized. Because the survey was distributed within a specific set of rural Georgia communities and yielded a gender skewed respondent pool, the results reflect the experiences of a particular subset of the target population at a particular moment in time. They should not be assumed to represent the experiences of minority youth in urban or suburban Georgia, in other Southern states with different healthcare landscapes, or in rural communities with meaningfully different racial or socioeconomic compositions. Additionally, the absence of a comparison group, such as white rural Georgians of the same age or urban minority Georgians, means that it is not possible to determine from this data alone whether the barriers reported are specific to the intersection of race and rurality or whether one of those factors carries more explanatory weight than the other. Thirdly, the study's reliance on self-reported data introduces the possibility that responses were shaped by social desirability, the particular political climate at the time of data collection, or recall inaccuracies among participants reflecting on older experiences.

These limitations occurred due to a lack of academic resources and the fact that the researcher had a limited timeframe of eight months, thus being unable to expand the study in duration. These factors limit the reliability of both the quantitative and qualitative responses, and mean that the trends identified should be understood as patterns warranting further investigation rather than definitive conclusions.

Additionally, bias from self-reported data could have manifested in heightened exaggerations of experiences. Furthermore, the researcher, having worked in mental health advocacy, was inclined to believe that heightened levels of mistrust existed. In an effort to minimize this bias, however, the questions were structured using neutral, non-leading language to ensure that the results were grounded in real-world experiences.

Future research should design studies capable of testing causal relationships. For instance, a comparative study examining minority youth in rural versus urban Georgia, insurance status, household income, or poverty rates, could begin to isolate whether geographic or racial identity is a stronger predictor of felt exclusion and access difficulty. Research that interviews providers alongside patients would allow for a more complete picture of where the disconnects between institutional intent and lived patient experience actually occur, and would help determine whether dismissiveness in clinical settings reflects inadequate training, unconscious bias, systemic time pressure, or some combination of these.

This study extends existing research by identifying the barriers that exist; however, the cause behind these factors requires a larger academic discussion. This study further builds on existing research by demonstrating that mistrust among African American adolescents in rural areas is not solely a product of historical discrimination or structural inequality, but is actively a process being shaped by lived experience. While prior literature often isolates structural factors such as healthcare access or policy inequities, this study places physician-patient relationships as an essential element in the conversation of psychiatric medical mistrust. When viewed through the lens of institutional trust theory, these findings suggest that perceptions of systemic exclusion weaken baseline trust in healthcare systems, while interpersonal interactions with providers either reinforce or mitigate these perceptions.

This kind of dual-perspective design would also allow researchers to assess whether providers in rural Georgia believe themselves to be culturally competent and whether that self-assessment aligns with what their patients report. Because the qualitative data in my study pointed to inclusion as a level of trust, future policy-focused research should examine the specific effects of consciously increasing levels of trust and whether those behavioral changes are perceived and valued by minority patients. This research would give practitioners, administrators, and state health policy makers the evidence-based information needed to justify directing limited resources toward culturally responsive care training in underserved rural areas rather than treating it as an optional professional development add-on. This study showed that for rural minority African American teenagers in southern Georgia, most, across both quantitative and qualitative methods, did not feel included in accessing mental health care. As African American communities face more barriers to accessing mental health care than the system acknowledges, they are frequently dismissed when they do reach a provider, and they often feel invisible to the institutions meant to support their well-being. Thus, it is important to take these documented patterns and build a new system of medical trust where personal experiences are at the forefront of interpersonal and systemic change.

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Appendix A Consent Forms:

1. Introduction and Purpose of the Study
You are being invited to take part in a research study about how African American teenagers feel about mental health services in the United States, especially during the early phases of COVID-19. This study is looking at whether government actions and messages during COVID affected trust in mental health support. The purpose of this study is to understand your experiences and thoughts so that we can learn how to make mental health services better for teenagers like you.

2. Description of the Research
If you agree to participate in this study, you will be asked a series of questions assessing your comfort level with the US healthcare system. This questionnaire will be administered over Google Forms and can be done at your own convenience. All identities will remain anonymous during publication, and the study is estimated to take around 15-20 minutes to complete.

3. Subject Participation
We estimate that 20 participants who are African American teenagers will enroll in this study. Participants must be between the ages of 14-18, and have some experience or familiarity with mental health resources. Additionally, a parental figure and/or guardian must agree to allow the participant to engage in this study.

4. Potential Risks and Discomforts
There are no known risks. However, some questions may make you feel uncomfortable or bring up personal thoughts or feelings. If you feel upset, you have the right to remove consent at any time during this process. To do so, simply email the lead researcher.

5.) Potential Benefits

Your responses can help researchers, schools, and healthcare providers better understand how African American teenagers feel about mental health services. This may help improve support services and outreach programs for other teenagers in the future.

Statement of Consent

I, _____, give my permission to participate in this research study. I understand that my participation is voluntary, that I can skip questions or stop at any time, and that my responses will be kept private. I also understand the purpose of the study, what I will be asked to do, and the potential risks and benefits.

Participant Name (Printed): _____
Participant Signature: _____
Date: _____

Parent/Guardian Consent (if participant is under 18):
I, _____, permit for my child to participate in this study. I understand the purpose, procedures, risks, and benefits.

Parent/Guardian Name (Printed): _____
Parent/Guardian Signature: _____
Date: _____

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Appendix B Google Form questionnaire:

1. Name (first, last)

2. Email

3. Race

4. Gender Identity

5. Year in school

6. Educational level of parents and/or guardians

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7. Have you or a member of your family ever contracted COVID? If so, describe the intensity of the experience.

8. Any previous mental health diagnosis/ history?

9. How would you describe your level of trust in doctors, counselors, or mental health programs during COVID? Has that changed since then? If so, how?

10. When you think about mental health services today, what would make you feel safe and willing to use them?

11. Click all that apply

a.) I trust mental health professionals to respect my privacy.

b.) I believe mental health providers treat people like me fairly.

c.) I feel confident that a counselor would understand my concerns.

d.) I worry that mental health professionals would judge me because of my race.

e.) I believe seeking help from a mental health professional would lead to helpful results.

Mark only one oval.

1	2	3	4	5
◯	◯	◯	◯	◯

12. Click all that apply

Check all that apply.

- [ ] Mental health services were easy to find during the early months of COVID.
- [ ] I had access to online or teletherapy options when I needed them during COVID.
- [ ] Cost made it difficult for me or my family to get mental health care during COVID.
- [ ] Transportation or technology barriers prevented me from getting care.
- [ ] I knew where to go (school, clinic, hotline) if I needed mental health help.

13. Click all that apply

Check all that apply.

- [ ] Government decisions during early COVID felt excessive or unfair to me or my community.
- [ ] I felt excluded from decisions about public health during COVID.
- [ ] The actions of local/state leaders during COVID made me less likely to trust health institutions.
- [ ] I felt the government prioritized other groups over Black teens during COVID.
- [ ] News about emergency rules or executive orders made me skeptical of official health advice.

14. Of any of these questions, please elaborate if you have had any negative experiences.

15. On a scale of 1-10, how much do you trust the US government?

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

16. On a scale of 1-10, how much do you trust your primary care physician?

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

17. On a scale of 1-10, how do you think the US ranks in minority inclusion in healthcare?

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

18. Recall one positive interaction that you've had since COVID-19 ended with a mental healthcare provider? Was race or politics discussed?

19. Recall one negative interaction that you've had since COVID-19 ended with a mental healthcare provider? Was race or politics discussed?

20. On a scale of 1-10, how scared are you right now of the political status quo?

Mark only one oval.

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

21. What is the rationale behind your answer?

Appendix C Quantitative and Qualitative Results.

3. Race: Black/African American
4. Gender Identity: Female
5. Year: 10th
6. Parent Education: College Degree

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 3
12. Barriers: Cost, wait time, access issues.
12b. Beliefs: Mixed trust, some concern about judgment.

13. Government Factors: Felt excluded, skeptical.
14. Negative Experience Elaboration: He told me my trauma was probably just stress and I needed to exercise more.
15. Trust Government (1-10): 3

16. Trust Doctor (1-10): 7
17. Minority Inclusion (1-10): 6

18. Positive Interaction: My provider listened and followed up.
19. Negative Interaction: He told me my trauma was probably just stress and I needed to exercise more.

20. Fear (1-10): 9
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: It took months to find help, but I eventually got seen.
Autonomy: I wish I had more say in treatment planning.

3. Race: Black/African American
4. Gender Identity: Male
5. Year: 11th
6. Parent Education: High School

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 4
12. Barriers: Cost, wait time, access issues.
12b. Beliefs: Mixed trust, some concern about judgment.

13. Government Factors: Felt excluded, skeptical.
14. Negative Experience Elaboration: She said I didn't seem depressed enough to need medication.
15. Trust Government (1-10): 3

16. Trust Doctor (1-10): 5
17. Minority Inclusion (1-10): 4

18. Positive Interaction: They remembered previous concerns and made me feel heard.
19. Negative Interaction: She said I didn't seem depressed enough to need medication.

20. Fear (1-10): 6
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: I tried, but I stopped trying after a while.
Autonomy: Medication decisions weren't explained.

3. Race: Black/African American
4. Gender Identity: Male
5. Year: 11th
6. Parent Education: College Degree

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 4
12. Barriers: Cost, wait time, access issues.
12b. Beliefs: Mixed trust, some concern about judgment.

13. Government Factors: Felt excluded, skeptical.
14. Negative Experience Elaboration: They said it was just stress and didn't take it seriously.
15. Trust Government (1-10): 3

16. Trust Doctor (1-10): 7
17. Minority Inclusion (1-10): 4

18. Positive Interaction: My provider listened and followed up.
19. Negative Interaction: They said it was just stress and didn't take it seriously.

20. Fear (1-10): 5
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: It was hard to schedule, but I eventually got an appointment.
Autonomy: It felt like things were being told to me, not told along with me.

3. Race: Black/African American
4. Gender Identity: Female
5. Year: 10th
6. Parent Education: Some College

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 4
12. Barriers: Cost, wait time, access issues.
12b. Beliefs: Mixed trust, some concern about judgment.

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20. Fear (1-10): 7
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: It took months to find help, but I eventually got seen.
Autonomy: I wish I had more say in treatment planning.

3. Race: Black/African American
4. Gender Identity: Male
5. Year: 11th
6. Parent Education: College Degree

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 2
12. Barriers: Cost, wait time, access issues.
12b. Beliefs: Mixed trust, some concern about judgment.

13. Government Factors: Felt excluded, skeptical.
14. Negative Experience Elaboration: She said I didn't seem depressed enough to need medication.
15. Trust Government (1-10): 4

16. Trust Doctor (1-10): 6
17. Minority Inclusion (1-10): 5

18. Positive Interaction: My provider listened and followed up.
19. Negative Interaction: She said I didn't seem depressed enough to need medication.

20. Fear (1-10): 8
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: I tried, but I stopped trying after a while.
Autonomy: Medication decisions weren't explained.

3. Race: Black/African American
4. Gender Identity: Male
5. Year: 10th
6. Parent Education: College Degree

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8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 3
12. Barriers: Cost, wait time, access issues.
12b. Beliefs: Mixed trust, some concern about judgment.

13. Government Factors: Felt excluded, skeptical.
14. Negative Experience Elaboration: They said it was just stress and didn't take it seriously.
15. Trust Government (1-10): 4

16. Trust Doctor (1-10): 8
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20. Fear (1-10): 6
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: I tried, but I stopped trying after a while.
Autonomy: Medication decisions weren't explained.

3. Race: Black/African American
4. Gender Identity: Female
5. Year: 12th
6. Parent Education: Some College

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 4
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Autonomy: Medication decisions weren't explained.

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20. Fear (1-10): 6
21. Rationale: Concern about political and healthcare uncertainty.

Access Detail: Access was straightforward.
Autonomy: I wish I had more say in treatment planning.

3. Race: Black/African American
4. Gender Identity: Male
5. Year: 11th
6. Parent Education: College Degree

7. COVID Experience: Family member had moderate COVID.
8. Mental Health History: Some anxiety/stress.
9. Trust During COVID: Decreased, slightly improved after.
10. Safety Factors: Transparency and being listened to.

11. Access (1-5): 3
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15. Trust Government (1-10): 5

16. Trust Doctor (1-10): 8
17. Minority Inclusion (1-10): 6

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Access Detail: Access was straightforward.
Autonomy: It felt like things were being told to me, not told along with me.

3. **Race:** Black/African American
4. **Gender Identity:** Male
5. **Year:** 12th
6. **Parent Education:** Some College

7. **COVID Experience:** Family member had moderate COVID.
8. **Mental Health History:** Some anxiety/stress.
9. **Trust During COVID:** Decreased, slightly improved after.
10. **Safety Factors:** Transparency and being listened to.

11. **Access (1-5):** 4
12. **Barriers:** Cost, wait time, access issues.
12b. **Beliefs:** Mixed trust, some concern about judgment.

13. **Government Factors:** Felt excluded, skeptical.
14. **Negative Experience Elaboration:** They remembered previous concerns and made me feel heard.
15. **Trust Government (1-10):** 4

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