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The Impact of School-Based Health Centers on Ethnic Minority Adolescents' Awareness, Perception, and Utilization of Mental Health Services

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Capstone Research Project

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Abstract

This study explored the impact of School based health centers on the awareness and perception of mental health and services on students of ethnic minority populations. It also explored the impact of the use School based health centers on further utilization of mental health services beyond the School based health center. The purpose of the study was to gain insight on the effectiveness of this School based health center at addressing the barriers faced by the ethnic minority population to seeking, engaging, and being satisfied with mental health treatment. Three ethnic minority students, aged 17-18, participated and completed an eight-item Likert-scale survey regarding client's perception and awareness of mental health pre and post use of the School based health center. The School based health center helped improve perceptions of mental health, counseling and therapy.

The Impact of School-Based Health Centers on Ethnic Minority Adolescents' Awareness, Perception, and Utilization of Mental Health Services

In the United States, one in five adolescents experience symptoms of significant emotional distress, and nearly one in 10 are emotionally impaired (Knopf, Park & Mulye, 2008). Most diagnosable mental health disorders occur in adolescence; nearly half of the disorders begin by the age of 14, and increases to three-fourths by the age of 24. The most common diagnoses amongst the adolescent population are depression, anxiety, substance use, and attention deficit hyperactivity disorder (Knopf, et al., 2008). Merikangas et al. (2010) found that 58% of students, in their sample of adolescents, had at least one diagnosis, which consisted of mood, substance, behavior, and/or anxiety disorders. Twenty four percent of adolescents had two disorders, 11% had three disorders, and seven percent met the criteria for four to five disorders. Of the many adolescents with significant mental health symptoms and diagnosable disorders, only 15-20% received services (Bains, 2014).

Bignall, Jacquez and Vaugh, (2014) found that different ethnic groups attributed mental health illness to different factors. African Americans and Hispanics usually attributed spirituality and normalization, whereas, whites rarely did, but attributed illness to experienced trauma. Asian Americans attributed illness to a range of factors, such as, personal characteristics, environment, family, and normalization.

The prevalence of mental illness was higher in communities that faced multiple prejudices and disadvantages within society. Amongst those communities were African Americans and other ethnic minority populations (Knifton, 2012). Adolescents, from families with low socioeconomic statuses, disproportionately experienced mental health issues (Knopf et

al., 2008). These communities often faced trauma, racism, acculturation challenges, and adverse social circumstances. The prevalence of mental health illness was similar across ethnic groups, but the differences were associated with the willingness to seek and utilize treatment (Bignall et al., 2014). In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that less than 10% of African Americans and Hispanics utilized outpatient mental health services. The low rate of utilization of school based health centers, utilization of SBHCs mental health services, barriers to utilizing SBHC mental health services warrant additional research.

Literature Review

Fewer than half of the general population, with diagnosable mental health disorders, sought or received treatment for their illness (Sickel, Seacat & Nabors, 2016). African Americans, Hispanics, and Asians received mental health treatment significantly less than their white counterparts (Bains, 2014; Cummon & Druss, 2010). Wade et al. (2008) reported that 25% of African Americans and 22% of Hispanics, who had a diagnosable mental health illness and were in need of treatment, failed to get it, in comparison to 13% of white Americans. Existing research (e.g., Amaral, Geierstanger, Soleimanpour, & Brindis, 2011; Keeton, Soleimanpour, & Brindis, 2012) studied the utilization of mental health services amongst ethnic minority groups, particularly African Americans. Research revealed that, despite the many areas of one's life that are affected by mental health illnesses, individuals omitted, delayed, and prematurely ended treatment. Reports also showed that minority ethnicities and racial backgrounds were underrepresented in mental health research, likely due to their underutilization of mental health services (Sickel, Seacat & Nabors, 2014). They were, however, overrepresented in the corrections system; in 2003, more than 15,000 children with mental health disorders were held in detention centers, which were found to be a problematic, passive alternative to treatment (Wade

et al., 2008). The most common researched and addressed barriers to mental health treatments were structural barriers, such as, socioeconomic status, lack of insurance, transportation, and/ or access (Wade et al., 2008). School-based health centers have been implemented as a solution to those barriers.

School based Health Centers

School-based health centers (SBHCs) were designed and implemented to address the unmet mental and physical health needs of underserved adolescent populations. According to the 2014-2015 National Assembly on School Based Health Care census, over 50% of SBHCs were in urban locations (Wade et al., 2008). Over 70% of students in a school that housed a SBHC, were of minority ethnic and racial backgrounds (Keeton, et al., 2012). These schools, with a large population of students of racial and ethnic populations, were amongst the priority populations in which SBHCs were placed (in an effort to bridge the gap between these students and health care). In addition to bridging the gap between students and health care, and likely the primary motive behind SBHCs, was the effort to reduce health care expenses as a result of frequent emergency department visits for non- emergencies, and inpatient stays. According to the 2014-2015 National Assembly on School-Based Health Care census, access to preventative and treatment services in schools can also address stigma, noncompliance, and inadequate access to the service outside of the school setting (Wade et al., 2008).

There was a range of results in reports on the use of SBHCs and who utilized them most. In one study of student utilization of SBHCs, it was found that 29% of their respondents utilized the SBHC, and a significantly lower percentage used the SBHC mental health services (Amaral, Geierstanger, Soleimanpour, & Brindis, 2011). Of the seven ethnicities recorded from the sample, African Americans, Pacific Islanders, and American Indians utilized the service the

least. Asian Americans utilized it the most, followed by Hispanics/Latinos. Another study reported the contrary, with African Americans being more likely to utilize services compared to their counterparts (Bain, 2014). Amaral et al. (2011) reported that SBHCs attracted students with severe mental health concerns and met the needs that would have otherwise gone unmet. It was also noted that treatment-seeking behavior was more directly linked to students who lacked insurance and/or on public assistance.

Utilization of SBHCs mental health services

As previously mentioned, SBHCs often provide first time exposure to mental health treatment for all students, especially those of ethnic minority populations. These usually, harder-to-reach populations are more likely to receive mental health services at SBHCs than at community health network facilities (Amaral et al., 2011). Juszczack et al. (2003) noted, through the comparison of utilization patterns of minority adolescents between SBHCs and services at Community health networks (CHN), that SBHCs attracted harder to reach populations. Some research also posited that students of ethnic minority populations utilized the SBHC services more than their Caucasian peers, and that Caucasians utilized community outpatient services more (Husky, Kanter, Mcguire, & Olfson, 2012; Juszczack, Melinkovich & Kaplan, 2003). In general, adolescents were more likely to seek services if they had easy access to an ambulatory care setting; thus, they were likely to utilize the SBHC at their schools versus any other outpatient settings (Bains, 2014; Parasuraman & Shi, 2014). SBHC were found to address several structural barriers.

Barriers to utilization of mental health services

There are many barriers associated with the reported low utilization of mental health services amongst the ethnic minority groups. As previously mentioned, low socioeconomic

status, often linked to the lack of insurance, transportation, and general access to treatment, are the most evident and only scratch the surface of the problem (Wade et al., 2008; Smedley, Stith & Nelson, 2003). Richman, Kohn-Wood and Williams (2007) believed that limitations to accessing services weren't the only explanation for ethnic minorities' underutilization of services. Differences in access cannot completely explain disparities in utilization of mental health services. Experiences of discrimination, racial identity and stigmas are a few other barriers that can provide insight into the underutilization of services. They also believed the other factors including perceptions and attitudes towards mental health treatment, though there is limited research on this.

Stigmas. Amongst the many barriers to the utilization of mental health treatment, stigmas' regarding mental health seems to be the most prominent, beyond structural barriers. Mental health concerns are a global health issue regarding the associated stigma and discrimination that inhibits the utilization of service (Knifton et al., 2009). There are two categories of stigma, public stigma and personal or self -stigma. Public stigma refers to the impact of negative stereotypes, and self-stigma refers to the internalization of public stigma (Corrigan, Kuwabara & O'Shaughnessy, 2009). Stigma usually involves a combination of inaccurate knowledge and negative attitudes (Knifton et al., 2010).

Mental health stigmas (MHS) can be a result of a social cognitive process and is a broad concept that is internationally known to be impactful in many different life domains. Research shows that treatment-seeking attitudes are directly linked to MHS (Sickel et al., 2016; Sickel et al., 2014). Not only does MHS influence a decrease in treatment seeking behaviors and ultimately the utilization of treatment, but also can increase mental health symptoms and decrease the ability to cope (Sickel et al., 2014). The researchers noted that MHS is an attitudinal

barrier and seems to be directly related to variables such as age, ethnicity, race, and the severity of an illness (Sickel et al., 2014). The National Alliance on Mental Illness reported that stigmas about mental health within the African American population often restrict their willingness to seek and engage in treatment (NAMI). It was also found that African Americans reported greater stigma than others.

Attitudes and Perceptions. Attitudes toward seeking mental health treatments are multifaceted, including acknowledging the need for help, stigmas associated with treatment, openness to receive treatment, and the belief in the professional's ability to help (Masuda, Anderson, & Edmonds, 2012). Cai and Robst (2015) gathered, from self-reports, that African Americans' attitudes were more positive toward seeking treatment prior to using it, but after utilization of the services their attitudes became less positive. This may indicate a lack of satisfaction in the treatment received. There were differences, however, in the perceived need for and effectiveness of treatment that could account for this. They also found that African Americans and Hispanics often disagreed with the diagnosis given to them by professionals, and instead provided a rationale as to the reasons for their symptoms (Cai & Robst, 2015). Others noted that stigmas regarding mental health were increased for any groups that are perceived to behave in contradiction to social norms (Gonzalez, Alegría, Prihoda, Copeland, & Zeber 2011). This could link back to the over-pathologizing of minority behaviors when compared to the majority culture.

These factors help to explain some of the racial and ethnic differences in the perception and use of mental health treatment. Similar results were found in the study by Gonzalez et al. (2011), who hypothesized that comfort-talking with a professional, and greater belief in efficacy in treatment, would generate stronger links to mental health care. The findings did not support

their hypothesis that comfort-talking with a professional would be associated with greater uses of mental health care. It was found, however, that greater belief in efficacy of treatment was associated with greater use.

Racial Identity. As previously mentioned, racial identity can have an impact on one's willingness to utilize services. Racial identity is a part of self-concept, which focuses on the cultural and ethnic lenses an individual, views the world (Sellers, Copeland-Linder, Martin & Lewis, 2006). Identity can inform beliefs about interactions, and expectations of treatment. Richman, Kohn-Wood amd Williams (2007) explored the effects of race, racial identity, and discrimination on mental health utilization. Results showed that past discrimination and identity variables were more important to African Americans' utilization of mental health services, than variables such as educational level or income. Richman, et al. (2007) found that African Americans with high racial identity, who have experienced discrimination, reported a lower willingness to utilize mental health services than those with lower racial identities. Ultimately, African Americans were less likely to trust in a mental health professional. The history of oppression faced by the African American community evidently continues to have an impact on the trust placed in the healthcare system (Breland-Noble, 2004). Adolescence is a vulnerable point in human development, and predisposed mistrust due to discrimination further complicates things (Bains, 2014). These findings have shown the importance of looking beyond the structural barriers, and looking further into individual, social, and cultural variables in relation to the utilization of mental health services.

Shame. Shame and embarrassment are individual barriers that inhibit the utilization of treatment. Individuals, especially adolescents, fear what others will think of them for engaging in therapy, even if that means not seeking the help needed (Thomas, Bazile & Akbar, 2004).

Shame and other stigmatizing behaviors are likely to be more prevalent in ethnic minority communities; it can be attributed to cultural beliefs and cultural differences (Knifton et al., 2010). Cultural rules such as keeping and resolving family issues within the family, and the belief that African Americans must maintain a strong identity and not show weakness, are amongst a few that inhibit treatment seeking. Stigmas surrounding mental health associate mental health issues as being "crazy, a weakness, or having deficit", and therefore seeking mental health treatment is not ideal, as it would mean something is wrong with the person (Thomas, et al., 2004). Therefore, there is a need to implement an educational task to combat these stigmas.

Lack of Knowledge. Amongst the African American community, many lack knowledge and a clear understanding of mental health (Wade et al., 2008). Lack of information regarding mental health symptoms, treatment locations, and knowing when to seek treatment presents as another barrier to service utilization (Thompson, et al., 2004). Racial and ethnic disparities are present in the treatment of internalizing disorders such as depression, anxiety, and post-traumatic stress disorder in contrast with externalizing disorders such as oppositional defiant disorder and attention deficit hyperactivity disorder, which are easily recognized. The problem for ethnic minorities in addressing internalizing disorders is often the lack of ability to recognize the symptoms (Merikangas et al., 2011). Education on mental health is important for this population. Kisker and Brown (1996) also found that the use of SBHCs can address some of these barriers and can increase student's knowledge of health and health care services.

Addressing the barriers

It is important that researchers and clinicians identify ways to diminish these barriers to adequate mental health treatment. The earlier an individual seeks treatment the better the chance

of recovery and minimizing self-destructive behaviors (Sickel et al., 2014). To deliver appropriate mental health services it is important to identify and address the barriers that hinder utilization, so that efforts to engage ethnic minority populations is strengthened (Maulik, Mendelso, & Tandon, 2010). It is believed that SBHCs offer an ideal pathway to overcome these barriers so that students utilize the available services (Bains et al., 2014).

In response, to meet the interpersonal and socio-cultural, and structural needs of ethnic minority populations' systemic barriers need to be addressed as well. Policy reforms, such as the Affordable Care Act, were passed in 2010, making health care attainable for all Americans. To ensure that mental health care was as accessible as other health care the Mental Health Parity and Addiction Equity Act were passed. Since, organizations, such as American Psychological Association and American Counseling Association, implemented changes to address issues of diversity, including changes to ethical codes, to include guidelines for culturally sensitive behavior and practices (Smith, 2015).

Student reported benefits. In addition to numerical data reporting the use of SBHCS, self-report is also important to take into consideration, when evaluating the perceived benefits of SBHCs. Bains et al. (2014) found, through interviewing, some students reported benefits of SBHCs. Students indicated that they liked that they could go and talk to someone and not keep it bottled up, they also liked being able to see a counselor within the same day in which they needed to talk. Overall, the students valued the perception that the counselor was always available, even if they had to wait a little while. Maulik, Mendelso, and Tandon (2010) also reported an increased use of school-based mental health services amongst the African American youth population involved in their study, likely due to the ease of access to treatment. Santelli, Kouzis, and Necomer (1996) noted that students were generally accepting of SBHCs within their

schools. The rate of acceptance differed between physical and mental health. Given a favorable experience, trust in services at the SBHC would increase use and use of the SBHC has the potential to increase trust in all mental health services.

Rationale

There seems to be an abundance of existing research on the utilization of school-based mental health services. Research has been consistent in reporting the ability of School-based health centers on reaching populations that would have otherwise not sought or had access to mental treatment. Research also showed, prior to and with the access of SBHCs, these populations preferred the SBHC over community mental health services. Little is known, however, on the impact of SBHCs on students of minority populations' awareness and perception of mental health. There is also little to no research on the SBHCs impact on student's willingness to utilize mental health services in their community once they no longer have access to the SBHC. Research on these dynamics is necessary in understanding the long-term impacts of SBHCs in addition to the excess research on the immediate impact of SBHCs.

Method

Participants

There were three participants, which represented 7% of the ethnic minorities, who completed an intake or were admitted for treatment. Ethnic minorities represented over 80% of the students receiving mental health treatment at the SBHC. All participants completed each of the eight items on the Likert-scale survey, two of which requested demographic information.

Of the three participants, one was African American and two were Hispanic students, one was 17 years old and two were 18 years old. There were two females and one male. These participants were recruited based on their age and ethnic minority group, as reported in their

electronic medical records (EMR), as well as their participation in mental health treatment at the SBHC. Two primary therapists at the SBHC examined their caseload for participants who fit the demographics, as reported in their EMR, sent the lists to the SBHC program manager, who then compiled their addresses and parent/guardian names. This information was used to distribute recruitment letters and consent forms to the students and/or their parent/guardian. Participants were compensated with earbuds for participating in the study

Materials

The survey was developed by the researcher to gather specific information needed for this study. It was in part, influenced by a local health care agency Perception of Care survey (see Appendix). The survey consisted of two demographic questions and six statements with Likert-type scale responses. The survey questions and statements sought to identify if the participation in the SBHC mental health service influenced participants' awareness of and views on mental health services, and willingness to utilize mental health service beyond the SBHC.

Procedure

Students under the age18 years old, enrolled in the SBHC, as well as admitted or at the time, undergoing intake, who fit the demographics as reported in their EMR were mailed a recruitment letter and consent form for their parents/guardians to review and sign. Students 18-19 years old were handed a sealed envelope from their primary therapist, which contained a recruitment letter and informed consent. Upon handing the students the sealed envelope, the primary therapists were given a script to say: "Our counseling intern is conducting a research study that you may qualify for. Review this and return it to her if you are interested in participating". Students who returned with the signed consent form were directed to submit it to the researcher.

At this time, the researcher and participant decided on a designated time to meet in the conference room of the SBHC to conduct the survey, and tried to avoid meeting with participants during their core academic classes. The researcher provided the participant with a hall pass to meet on the agreed day and time. When participants arrived during the designated time, they met individually with the researcher to learn about the study, provided written assent and completed the survey, the entire process took about ten minutes. To maintain students' confidentiality, the assent form requested that participants did not provide any self-identifying information, such as, the name of their therapist, their names, or date of birth on the survey. To safeguard from coercion or undue influence, researcher did not include in this research, my own clients.

Participants were instructed to hand the survey into the researcher upon completion. Anyone who participated in the study, even those who decided not to complete the survey once they began, were compensated with earbuds from the researcher. Giveaways were provided by the school based health center. The participants were then given a pass to return to their scheduled room.

Results

The mean and percentage were calculated for each the six Likert-scale items. The mean was *one* for each item, due to the small sample size. Percentages represented the amount of participants who selected a particular response on the survey. Participants' perception/views of mental health are reported in Table 1. Participants' awareness of mental health and services are reported in Table 2. Participants' willingness to engage in further mental health treatment is reported in Table 3. There were no significant findings.

Discussion

The results of this research study were used to gain insight on the effectiveness of the school based health center's mental health at addressing structural barriers, stigmas, and cultural upbringings that present as barriers to treatment. These results provide insight to the school based health center's behavioral health providers, regarding their impact on the perception, awareness, and further utilization of mental health services of their clients of ethnic minority populations. To understand the impact, the Likert-type scale survey was designed to gather information about the participants' experiences prior to and during treatment at the SBHC.

For this research, "perception" was defined and explained to participants as their personal view, belief, or thought about something. "Views" was used in synonymy with "perception". "Awareness" was defined and explained as their understanding or knowledge of something. The purpose of this research study was to gain insight into the impact of SBHCs mental health services on the perceptions, awareness, and willingness to further utilize mental health services beyond the SBHC on its students of ethnic minority populations.

The most significant finding was that all participants reported that engaging in therapy at the SBHC had a positive impact on their perception of mental health. These findings support previous research (Santelli, Kouzis & Necomer, 1996). As aforementioned, SBHCs were implemented to address the unmet mental and physical health needs of underserved adolescent populations; this study has supported that a SBHC effectively addressed the needs of these three underserved youth.

Perception of mental health and treatment prior to use of SBHC

Negative attitudes towards and perceptions of mental health have consistently been identified as a barrier to treatment for ethnic minority populations. These attitudes and perceptions are often influenced by public stigmas that then encourage self–stigma (Corrigan,

Kuwabara & O'Shaughnessy, 2009). Of the three participants, each one denied hearing negative things about mental health, counseling, and therapy. All three participants also denied having personal negative views about mental health, counseling, and therapy. These findings were significant in that they refuted that of previous research, as stigmas and perceptions of mental health and treatment were one of the main barriers to ethnic minorities seeking, receiving, and being satisfied with treatment. With these findings, it decreases the likeliness that these participants have succumbed to or been affected by public or self stigmas regarding mental health and treatment, eliminating this as barrier for this sample.

Awareness of mental health and treatment prior to use of SBHC

Awareness and knowledge of mental health diagnoses and symptoms were another identified barrier to the ethnic minority population seeking and utilizing mental health treatment. All three participants reported having some awareness and knowledge of mental health and services prior to treatment. One participant reported that, prior to beginning mental health counseling in the school based health center, she/he knew *very much* about mental health, such as depression, anxiety, sleep disorders, stress, trauma, etc. Two participants reported that they knew *some* about mental health. These findings also refute awareness of mental health as a barrier to these participants seeking and receiving treatment.

Perception of mental health and treatment post use of SBHC

Since using the school based mental health counseling service, all three participants reported that they *strongly agreed* or *agreed* that their views about mental health, counseling, and therapy improved. Thus, the use of the SBHC mental health counseling service had a positive impact on their pre-existing views about mental health, counseling, and therapy, and supported previous research regarding the purpose and potential impact of SBHCs on the ethnic

minority population. However, participants reportedly, did not enter treatment with a negative perception of mental health and treatment, so the degree of the SBHC \impact is unknown, but was positive.

Awareness of mental health and treatment post use of SBHC

Since using the school based mental health counseling service, one participant reported that they knew *very much* about mental health, such as depression anxiety, sleep disorders, stress, trauma, "etc." One participant reported he/she were neutral, suggesting he/she did not learn more as a result of engaging in treatment. One participant reported he/she knew little, possibly for the same reason.

Impact of SBHC mental health treatment on further use beyond SBHC

Ultimately, the likeliness of continuing or utilizing mental health treatment once the SBHC is no longer accessible to the student due to graduating or transferring schools is likely the most significant finding of this study. Though the participants awareness and perception of mental both influence the willingness to seek and utilize mental health treatment beyond the school based health center. Given the accessibility of the school based health center, students are likely to utilize it more than outpatient settings. If students have a good experience with treatment, it will increase their willingness to continue services in the community. Santelli, Kouzis, and Necomer (1996) noted that students were generally accepting of SBHCs within their schools. Given a favorable experience, trust in services at the SBHC would increase use and use of the SBHC has the potential to increase trust in mental health services.

Since using the school based mental health counseling service, two participants reported that they are *very likely* or *likely* to utilize mental health services after high school, in their community if needed. These results indicated that the SBHC's mental health counseling service

was a positive experience that has impacted their willingness to further utilize mental health services. One participant was *neutral*, indicating that he/she did not feeling strongly one way or another about utilizing mental health services in the community after high school, indicating that the use of the SBHC's mental health counseling service was likely not a positive experience for them therefore discouraging them from further utilizing mental health services in their community beyond the SBHC, if needed.

Limitations

The first limitation of this study is the sample size. Of 44 students, who fit the study criteria, only three participated in the study, which does not allow for an adequate representation of the sample population. The requirement of parental consent for minors appeared to be a barrier for participation, as there were no participants from the list of minors, who were mailed the recruitment letter and informed consent forms. Also, only one of the two primary therapists provided a list of students, who fit the study criteria, to the SBHC program manager for recruitment, thus limiting the potential number of participants. Furthermore, an English version of the recruitment letter, informed consent form, and assent forms were distributed; it was likely English was not the first language of some of the parents who received them, limiting their ability to understand and permit their child to participate.

Finally, the researcher developed the instrument; therefore, the survey reliability and validity were unknown. Items on the survey could have been formulated differently. There also could have been additional items to obtain more information from the participants. Items that could have been included could have solicited feedback on treatment satisfaction, history of mental health treatment, and opinions on the services they are receiving or available to them in their SBHC.

Recommendations for further research

Future studies should explore a more promising method of obtaining participants, to increase the sample size, as it would yield representative results of the target population. Experimenting with another method of data collection, such as, a focus group or interviews might be beneficial. Finally, determining the reliability and validity of the instrument would lend more insight to the findings, as well as developing a new instrument to gather the same data.

Implications for counselors

School-based health centers are designed and implemented to address the unmet mental and physical health needs of underserved adolescent populations. According to the 2014-2015 National Assembly on School-Based Health Care census, over 50% of SBHCs were in urban locations. Over 70% of students in a school with a SBHC, were of minority ethnic and racial backgrounds (Keeton, Soleimanpour, & Brindis, 2012). The population of students at the school in which this study took place is predominantly ethnic minorities. Only a small amount of students are enrolled in the SBHC, however, and an even smaller amount in mental health treatment or awaiting treatment. It is undeniable that SBHCs have the potential to address many barriers to mental and physical health services, including raising awareness about mental health. It is likely that these services are an ethnic minority student's first encounter with treatment, so it is important that the counselors and the SBHC staff make their presence known amongst school teachers, staff, parents and students to increase enrollment and therefore awareness of services. Lastly, cultural competency is very important for SBHC therapists, given the population that is predominately served.

Though the results of this study refuted negative perceptions, awareness, and stigmas as barriers to mental health services, we still know that these are in fact barriers to the ethnic

minority population. These can be addressed in the school and the School based health center using the recommendations above.

Conclusion

Data from this study did not yield the results that were expected in regards to barriers to seeking and utilizing treatment. The results did show, however, some strength in the SBHC's mental health services. It indicated that treatment has been successful in improving perceptions of mental health and services, and that treatment has been favorable for the majority of the sample, lending them to be open to seeking and utilizing treatment in their community once they no longer have access to the SBHC.

Appendix

Table 1

Perception/views of mental health

	N	M	1		2		3		4		5	
			n	%	n	%	n	%	n	%	n	%
Item 2: “Heard negative views”	3	1.0	1	33	2	67	0	0	0	0	0	0
Item 3: “Have negative views”	3	1.0	1	33	2	67	0	0	0	0	0	0
Item 6: “SBHC improved views”	3	1.0	0	0	0	0	0	0	1	33	2	66

Note: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree.

Table 2

Awareness of mental health and services

	N	M	1		2		3		4		5	
			n	%	n	%	n	%	n	%	n	%
Item 1: Pre-SBHC awareness	3	1.0	1	0	0	0	0	0	2	67	1	33
Item 4: Post-SBHC awareness	3	1.0	1	0	1	33	1	33	1	33	0	0

Note: 1 = Very Little, 2 = Little, 3 = Neutral, 4 = Some, 5 = Very Much.

Table 3

Likeliness to further utilize mental health treatment

	N	M	1		2		3		4		5	
			n	%	n	%	n	%	n	%	n	%
Item 5: Further utilization	3	1.0	0	0	0	0	1	33	1	33	1	33

Note: 1 = Very Unlikely, 2 = Likely, 3 = Unsure, 4 = Likely, 5 = Very Likely.

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