

**PROVIDER PERSPECTIVES ON SCHOOL-BASED MENTAL HEALTH FOR URBAN  
MINORITY YOUTH: ACCESS AND SERVICES**

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**ABSTRACT**

This article provides results from a qualitative study on the efforts of school-based mental health providers (SBMHPs) who serve students in urban, suburban, and ethnically diverse settings to help families access quality mental health services. School-based mental health plays a key role in the provision of direct and indirect intervention services to support life skills and social-emotional development. A cohort of school psychology graduate trainees enrolled in a counseling course conducted 39 semi-structured interviews with school based mental-health providers (i.e., 36 schools psychologists, two therapists, and one school counselor). Findings indicate SBMHP's efforts to promote minority access are often hindered by culturally-related factors, and that more careful data-based tracking and decision making is necessary to improve mental health services, especially for minority youth. Additionally, increased designated mental health staff as well as more professional development and training are needed to improve service delivery.

**Introduction**

In the United States, nearly one fifth of children and adolescents experience signs and symptoms of mental health problems during a school year. Historically, minority groups have faced higher levels of unmet needs, limited access to services, and poorer quality of mental health care. For minority youth, access to quality mental health treatment is especially important as schools are becoming increasingly diverse (Cook, McGuire & Miranda, 2008; Ho, McCabe, Yeah, & Lau, 2010). For minority youth living in urban communities, these disparities are magnified and mental health needs become particularly complex due to fewer available health-related resources, frequent exposure to violence and crime in surrounding neighborhoods, and poorer quality school-based services (Farahmand, Grant, Polo, Duffy & DuBois, 2011; U.S. Department of Health and Human Services, 2001). As schools are called upon to address *both* academic and mental health needs affecting educational performance, especially in urban settings, it is important to carefully examine SBMHPs' perspectives on mental health services for minority youth and related issues of access and cultural responsiveness.

**Mental Health and Minority Youth: A Social Justice Issue**

For well over a decade, researchers have found minority groups' limited use of quality mental health services a concern (Snowden, Masland, Ma, & Ciemens, 2006; U.S. DHHS, 1999). Significant evidence indicates that minority youth have higher levels of unmet mental health need as compared to non-Hispanic Whites (Ho et al, 2009; Kataoka, Zhang, & Wells, 2002; U.S. DHHS 1999). Additionally, minority populations (Ghafoori, Barraga, Tohidian, & Palinkas,

2012), and particularly youth (Huey & Polo, 2008), underutilize services as well as prematurely terminate from treatment. These statistics are troubling as trauma, depression, suicidality, and anxiety are increasing for youth from diverse linguistic and racial/ethnic backgrounds (Huey & Polo, 2008). Minority youth are particularly likely to be impacted by poverty as well as live in segregated urban communities with fewer available resources (Mather, Pollard, & Jacobsen, 2010; U.S. Bureau of the Census, 2011). Studies have shown that youth living in urban environments are significantly more likely than their peers in non-urban settings to report vandalism, theft, violence, witness the sale of illegal drugs, and partake in alcohol use prior to the age of thirteen. These risk factors, in combination with fewer supports from surrounding communities and schools, and less frequent monitoring by parents can certainly exacerbate mental health challenges for urban youth of color (Farahmand et al. 2011; Shwah & Bossarte, 2009). The disproportionate sentencing of minorities to the juvenile corrections systems adds yet another contextual nuance to the challenges facing urban minority youth (Skiba et al., 2011). Skiba et al. and others (e.g. Nebbitt, 2009; Oravec, Koblinsky, & Randolph, 2008) have pointed out the impact of violence, incarceration, and other challenges in low-income urban areas, which leave minority youth particularly vulnerable to the impact of trauma and the need for high quality mental health support (Atkins, Graczyk, Frazier, & Abdul-Adil, 2003).

### **School Psychologists' Service of Minority Youth**

The National Association of School Psychologists (NASP, 2010) has identified the provision of preventive and ongoing mental health services as part of a comprehensive school psychology practice model. School psychologists have the research, clinical training, and expertise to increase access to mental health services as well as evaluate and improve the quality of services. While school psychologists are well poised to address these issues in our schools, far too little focus on increasing minority access to quality mental health services, with special consideration given to the impact of living in urban areas, has taken place within the field. Other professions such as school counseling (Tucker, 2009), social work (Gilbert, Harvey, & Belgrave, 2009), and medicine (American Academy of Pediatrics, 2004) have been discussing this more proactively for some time. Compounding this issue, literature in psychology and school psychology underreport or fail to disaggregate findings for minority groups in many of the published articles regarding mental health access and outcomes, which make it difficult to develop evidence-based mental health interventions that may be generalizable to minority groups (Graham, 1992; Graves & Mitchell, 2011; Stevenson, 2003; Swesey, 2008). Data provided by the US Census also underreports the population and needs of minority families and youth, especially those in urban contexts (Mather et al., 2010).

In an innovative series featured in *School Psychology Review*, Atkins, Graczyk, Frazier, and Abdul-Adil (2003) offered a new model for school-based mental health. They suggested that accessibility, effectiveness, and sustainability become more salient features of mental health models, yet they do so without clearly identifying the populations that need access the most (Matsen, 2003; Sugai, 2003; Weist, 2003). According to Stevenson (2003), there is a conspicuous absence of qualitative or quantitative data to help with the generalizability of findings and program application to populations such as African Americans or other minorities who are largely underserved by mental health providers. Stevenson's critique highlights the need to gain a greater understanding regarding efforts to provide mental health services to minorities.

## **Research Questions**

Four research questions were investigated in the current study: (a) What do SBMHPs report are barriers to delivering mental health services for minority students and families in urban settings? (b) What types of services do SBMHPs most frequently deliver? (c) Who most often receives SBMHS? and (d) What do SBMHPs report is needed to do their job more successfully?

## **Methods**

### **Interview Participants**

Thirty-nine school-based mental health providers (SBMHPs) were interviewed in the current study. Of the 33 SBMHPs who responded to the question on gender, 64% were female. The racial/ethnic breakdown of the SBMHPs was 33% Latino, 35% Caucasian, 1% Asian Pacific Islander, and 31% did not disclose their race/ethnicity. The SBMHPs consisted of school psychologists (n=36), school counselors (n=1), and clinical therapists (n=2).

### **Schools Served**

The SBMHPs served twelve public school districts in Los Angeles and Orange Counties in California. More specifically, these SBMHPs served children across 39 schools with some of these providers working at multiple sites (sixteen high, seven middle, twelve elementary, two K-8, and two not indicated). A majority of the school populations consisted of students of color (25 schools with a population of 45% or more Latino, four schools with 45% or more Asian/Asian Pacific Islander, three schools with 45% or more Caucasian and seven schools multicultural – no racial/ethnic group over 45% and more than four groups represented). Across all schools, the Academic Performance Index (California Department of Education, 1999) scores ranged from 619 to 926, with 800 as the average. A school's API score was not indicative of the amount of services offered or provided by SBMHPs.

### **SBMHP Qualitative Interview**

The interview protocol used with SBMHPs was developed from previous pilot studies (Gamble, 2007; Gamble, Huff, & McQueen, 2010) surveying program leaders about services used with school youth. The Best Practices in mental health services from NASP (NASP, 2010) and the California Association of School Psychologists (Beam, Brady, & Sopp, 2011) were also used to help develop this qualitative interview protocol.

Four open-ended questions were asked that included information about (a) barriers to mental health services for minority students, (b) types of mental health services most frequently provided to students, (c) who most frequently receives mental health services, (d) resources needed (e.g., type of support, programs) to enhance the provision of mental health services at the school.

### **Pilot Study**

In 2008 and 2009, a pilot study using a preliminary version of this qualitative interview

protocol was conducted with graduate students in school psychology enrolled in a counseling course. The survey results were presented at the California Association of School Psychologists' annual convention (Gamble et al., 2010). Interview questions were analyzed via item response design, and the protocol was updated with more explicit directions for the graduate student interviewers as well as the development of follow-up probes if needed.

### **Interview Administration and Inclusion Criteria**

Graduate students interviewed their school psychology supervisors or someone recommended by supervisors such as a school counselor or therapist (e.g., Marriage and Family Therapist or Licensed Clinical Social Worker) who worked at the school site (and self-identified as a SBMHP). Interviews were conducted at school sites, and interview inclusion criteria in the final analysis required the following: a) administration of all interview questions and b) collection of school indicators (Academic Performance Index, school demographics). Thirty-nine out of 60 interviews met criteria and were included.

### **Research Design**

In this study, interviewers used a qualitative interview protocol (Gall, Gall, & Borg, 2003), which involved asking participants identical questions that were intentionally open-ended. This format allowed participants to contribute detailed information in their own words and from their perspective and also allowed the researcher to ask follow-up questions as needed. Qualitative interviews are often used to uncover the subjective interpretations of social phenomena, including opinions, experiences, and shared understandings (Mertens, 2010).

### **Data Analyses**

Survey responses were reviewed and coded by a team of graduate students based on the most frequently occurring responses, and their instructor reviewed the data for consistency. For example, when reviewing codes for what SBMHPs needed to do their jobs (Table 3) the graduate students copied verbatim what was said in the interview and used a codebook with larger categories to code each response. Coded responses were re-examined by the lead author to identify patterns, themes, distinct differences between subgroups, and common sequences relating to the provision of mental health services in schools. These data were confirmed with the co-author. The same was done for the data in Tables 1 and 2. Authors worked together to choose the response selections to share as examples of each code. As often occurs in qualitative interviewing, responses were not limited to one per each respondent, and some providers gave more than one response per question. The majority of the respondents, however, gave one short answer per question.

## **Results**

### **SBMHPs' Views of Access Barriers for Minorities**

The most frequently occurring responses regarding limited access to mental health services for minority populations were associated with culturally related factors (n = 24). As an

example, several responses (see Table 1) involved a perceived stigma regarding help seeking, especially for mental health problems.

Table 1

*SBMHP's view of barriers to access for minorities*

<b>Response Category</b>	<b>Response Frequency</b>	<b>Examples of Qualitative Responses</b>
Culturally-related factors (Stigma; Culture-specific training and professional development; language translation services; ethnic specific clubs)	24	<p>“Machismo in the Latino community, I mean how do you tell people to be less macho, you can’t really change their culture”...</p> <p>“An issue that has often come up is talking to Latino fathers about seeking mental health. As a young Latina women, sometimes parents might seem reluctant to follow through with my advice and I find myself talking to them about the importance of seeking help and the importance of women in the household.”</p> <p>“The reason for not contacting one of his bilingual associates is because of the associate’s level of understanding, communicating, and translating in Spanish... The SBMHP thinks that more students and parents can be informed of the services through flyers translated in different languages...</p>
Insurance Qualification	8	<p>“... The (SBMHP) also doesn’t refer students to some of the people he knows because they don’t take Medi-Cal or (Medicaid), and nearly all of the students seek services that accept these forms of payment”.</p> <p>“There are no preventative services offered at this school. SBMHP stated that she knows that Medi-Cal offers a lot of services, often more than private insurance in a lot of cases, so she will refer those kids out (rather than find ways to provide the service on the site)”.</p>
Agency collaboration & parent follow-up	6	
Consistency (services, policy, & screening)	6	
“All students are minorities”	3	
LGBT support	3	
Mentoring	1	
Does not take the time	1	

Embedded within many of the comments was the idea that “machismo” from the fathers of Latino and African American heritage was, at times, a barrier to families accessing services. The lack of information/services translated into primary languages is a second example of a culturally related factor (n = 8). Five responses indicated that culturally specific training to increase cross-cultural competence was a barrier in the referral process for minority students. Two mentioned the lack of ethnic specific clubs as places for outreach and referrals located at the school or available in the surrounding urban community, while there was only one professional who mentioned the lack of mentoring available for African American and Latino males within schools situated in urban contexts.

The second level of access barriers was related to parental access to services. For example, there were some reports of parents not being able to access services due to limited or poor insurance (n = 8). In six responses, non-collaboration among service agencies in addition to lack of parent support was seen as a systemic challenge. Due to the lack of inter-agency collaboration and an identified case manager, parents are often left to navigate a complex system of services, which can hinder access. Three respondents mentioned the lack of Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) support as a barrier to services. Only three of the 39 respondents indicated that access is not a problem, as indicated by the statement, “All of our students are minorities.”

### **SBMHPs’ Report of Services Delivered**

Each respondent was asked to provide at least three types of SBMH services they have offered. No one respondent gave more than three responses for this question; however, the majority (> 15) gave fewer than three. Responses were coded by frequency. The most commonly reported service was individual student counseling (n = 28), followed by outside agency referral (n=20). Group counseling services were also frequently reported (n = 17). The remainder of service types (i.e., DIS/Related Services, Collaboration with MH agencies) were reported at a far lower frequency. Three SBMHPs reported providing family consultation services and fewer reported utilizing multi-tiered school services including conflict-resolution, crisis response, and school-wide positive-behavioral support (PBIS) systems.

### **SBMHPs’ Estimation of Who Receives School-Based Services**

When asked who most frequently receives MH services in their respective schools (e.g., which grade, gender, ethnic group, behavior type, teacher referred, parent referred), the majority of SBMHPs responded that those most often receiving services mirror the “school demographic.” It must be noted that only one of the SBMHPs surveyed actually provided caseload data to support services received. The second most frequently occurring response (n=7) indicated a specific ethnicity that often received services. With similar frequency (n = 7), several SBMHPs reported that students under the Emotionally Disturbed (ED) special education category received most of the mental health services. Females were seen utilizing services (n = 7) more frequently than males (n = 5). Students with Autism Spectrum Disorders (ASD) were also mentioned as those who received services (n = 4). A final group (n = 4) did not answer this question because, as one person stated, “there is no time to aggregate data.”

Table 2

*SBMHP's estimation of those who receive services*

Response Code	Responses
School Demographics are consistent with the CP	18
Ethnicity indicated*	7
Special Day Class for ED	7
Female	7
Males	5
Autism	4
Not Indicated	4
Crisis response	1
Foster Care specific services	1
Small Learning Communities	1
Speech/Language Pragmatics	1
School Wide Positive Behavioral Intervention and Support	1

\*Although requested, respondents provided no clear data only a memory of what they thought the population reflected by ethnicity.

### **SBMHPs: What We Need to Do Our Job**

When SBMHPs were asked to list their top three needs to more effectively deliver mental health services (see Table 3), the most frequent responses were (a) to have designated staff (school psychologist, counselor or therapist) as mental health providers (n = 22) and (b) more time to provide these types of services (n = 15). The respondents also wanted an increase in family participation in therapy (n = 9), as well as an increase in staff development, specifically for SBMHPs within the context of minority access and stigma (n = 7). The remainder of responses were mentioned with far less frequency, but included student access to insurance, academic tutoring for students, social skills classes and school-wide PBIS.

Table 3

*SBMHP's indication of what they need to do their job*


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Response Code	Responses
Agency or specific SBMHP staff	22
Time to the do job	15
Parent participation/family connections	9
Insurance support for families	8
Staff Development for SBMHP	7
Academic Tutoring	6
Social skills classes or use of School Wide Discipline	6
“Funding or Money”	5
Test kits	5
Administrative Support	4
Translation services	3
Teacher/staff collaboration	3
Drug/Alcohol counseling	2
Library or Online Information	2
Ideas to motivate students “passion”	2

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### Discussion

In the current study, SBMHPs were interviewed about several aspects of their mental health service provision, especially for urban minority youth. When asked about barriers to providing services to minority youth in urban settings, the responding school psychologists, school counselors, and therapists in these semi-structured qualitative interviews reported concerns about culturally related factors such as stigma about mental health problems and resistance to help-seeking efforts. More specifically, “machismo” was mentioned as impactful to treatment, which according to some scholars is defined by perceptions of male dominance and



power (Rivas Quiñones, 2009). Of course, the concept of machismo embodies interwoven and highly complex ideas about masculinity, gender roles, and family caretaking. In many families, traditional notions of machismo may be in direct conflict with how a father perceives help seeking and psychological intervention for mental health problems, especially fathers of Black (Connor & White, 2011) and Latino youth (Rivas Quiñones, 2009). Machismo should be understood as part of a group's cultural heritage; however, it needs to be analyzed more carefully and on an individual basis with regard to its impact on the lives of the families needing ongoing treatment. Additionally, while the vast majority of psychologists, counselors, and therapists are female, machismo may also interfere with the therapeutic relationship and follow-through on treatment recommendations.

In an ongoing effort to become more culturally responsive, cultural factors like the aforementioned need to be considered, especially for minority students and their families in urban settings. The lack of translation resources, both for meetings and in printed material, was also indicated as a significant barrier to accessing services for some minority families, which has been an ongoing concern for urban schools (Ortiz, Flanagan, Dynda, 2008). Other frequently mentioned barriers included inability to refer to outside providers due to insurance restrictions. Without adequate insurance, many families are simply unable to address the mental health needs of their children. As poverty and urbanicity are associated with a multitude of stressors, ranging from systemic community challenges (underemployment, crime, violence) to smaller everyday hassles (lack of transportation, translation services), students from these environments face a continuum of challenges in accessing services. As one example, a recent study conducted in Los Angeles County—where many of the current study's interviews were conducted—underscores a significant gap in the understanding of challenges within an urban area. More specifically, as many of the SBMHPs are middle to high income earners, their well-meaning suggestions to seek treatment at mental health agencies fails to take into account that urban, low income, and minority families are more likely to rely on public transportation, which may greatly increase family burden (Amissah, 2010). While SBMH has evolved as a solution to address access barriers, not all schools can provide comprehensive onsite services and need improved coordination with community resources (Hunter et al., 2005), especially for students needing intensive services.

Three SBMHPs mentioned the lack of support for working with LGBTQ minority youth. More attention should be devoted to sexual minorities who are also ethnic or racial minorities as it may be less likely that SBMHPs focus on the mental health support of LGBTQ youth other than in regards to bully prevention (Gamble, 2009). While this question certainly elicited several important barriers to MH services for minority groups, these authors were reminded of the importance of awareness and advocacy for MH services for “hidden” minorities and those represented by small numbers. As one Latino male honestly stated, “Our school does not reach out to African American males because they are such a small part of the population.” Such a comment is consistent with Stevenson's (2003) critique of school psychology related services.

It is important to note that while SBMHPs identified several barriers, not one mentioned the lack of access to interventions that address mental health conditions in culturally and linguistically diverse groups. Historically, research on mental health interventions with diverse populations has been limited (US DHHS, 2001); however, more recently, established evidence-based interventions that address mental health with minority youth have been examined (Ho et al., 2009; Huey & Polo, 2008; Miranda et al., 2005). Schools must carefully consider whether a treatment approach is culturally appropriate for a given schools' needs by evaluating

responsiveness on a range of cultural concerns (i.e., languages, traditions, values) as well as concerns particular to the urban context (e.g., transportation, jurisdiction of county vs. city, etc.).

When asked about the types of services delivered, the SBMHPs most frequently conducted individual and group counseling. Secondly, they reported making referrals to outside agencies. This is consistent with prior studies (Foster et al., 2005); however, it was surprising that only three SBMHPs involved family members in the therapy sessions. This seemed to highlight a missed opportunity, as many respondents listed parents as their most frequent referral sources.

As parents are notifying schools about mental health problems affecting their children, many of which overlap with problems in home dynamics, it is unfortunate that services are not more inclusive and engaging of parents. As research has revealed that mental health conditions are often intergenerational, how can school services be optimally effective if they are not engaged in home school collaboration (Hunter, et al., 2005)? This points to stronger links with the mental health sector in the provision of family services. It is also noteworthy that few providers reported implementing school wide Positive Behavior Intervention Supports (PBIS), which stands in contrast to the growing research supporting PBIS as part of Response to Intervention (RtI) service delivery to address mental health.

Another surprising finding was the lack of consistent data collection by the SBMHPs regarding caseload characteristics and/or demographics. When asked who most frequently received their services, the majority of SBMHPs reported that students receiving services matched the demographics of the student body; however, only one provider had readily available data to support this. All others recalled details about their caseload demographics from memory. Only one out of the 39 respondents was able to access demographic data that had been recorded (e.g., referral reason, disability status, race/ethnicity) on their current caseload.

This insufficient level of data collection and tracking has been identified as a practice that can potentially lead to discriminatory services. One particularly troubling comment occurred when one respondent retrieved their “Designated Instructional Services” or related counseling services caseload from the district database and exclaimed in the interview, “They are all Black males”—at a school with less than 20% African Americans in the student body. Skiba et al. (2011), in addition to other researchers, recommend that practitioners frequently disaggregate site-based data across various student groups to evaluate school-based MH services and their associated outcomes in an effort to be more culturally responsive (Gamble, 2011; Rueda, 2004; Skiba et al., 2011).

### **Limitations**

Although measures were taken in a preliminary pilot study to ensure that graduate students were able to conduct the semi-structured interviews, there are inherent challenges with having qualitative interviews conducted by novice researchers. Also, self-reports of school psychologists are limited by the fact that the results are based only on their perceptions. Conclusions drawn must be tentative as this represents a preliminary, exploratory study of provider perspectives.

### Implications for Educators to Address School-Based Mental Health

School administrators, school psychologists, and other mental health providers in schools and communities are faced with increasing demands due to complex student needs in addition to cultural factors and systemic challenges (Beam et al. 2011). To address access barriers, Gutkin (2012) suggests school psychologists develop approaches based on a public health model. This model, which includes (a) tracking the incidence/prevalence of problems, (b) identifying risk and protective factors that are impactful to intervention design and (c) appropriate dissemination to stakeholders can address the complexity of student needs in urban schools. These stakeholders are often a part of the surrounding community and can provide more authentic cultural context and support for mental providers working in diverse settings as well as give them formative and summative feedback to improve their service delivery (DeAngelis, 2001; Stevenson, 2003). For educators, a multi-tiered model is well aligned with this charge proposed by Gutkin (2010), and should ideally include evidence-based prevention and screening that increases in specificity and intensity based on individual school needs. Additionally, a suggested shift from assessment and diagnosis to advocacy, consultation, education and training should be the future direction of school services, which may increase awareness, lessen stigma, and ultimately address the crisis in the area of mental health in today's schools. When the school and community are empowered and knowledgeable about advances in applied psychology and mental health, they can address needs and mitigate associated challenges. Moreover, if SBMHPs can adopt a public health perspective and ecological approaches to understanding, rather than individual-pathological ways of knowing, improved outcomes for students may be realized.

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