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RESEARCH ARTICLE

Help-Seeking in the School Context: Understanding Chinese American Adolescents' Underutilization of School Health Services

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ABSTRACT

BACKGROUND: This article examines whether school contextual factors, such as referral practices and peer dynamics, contribute to Chinese American students' underrepresentation in school health programs.

METHODS: Data from the 2007 Youth Risk Behavior Survey (N = 1,744) as well as interviews and focus groups (N = 51) with Chinese American users and nonusers of high school health programs were analyzed to identify aspects of the help-seeking process unique to Chinese American students.

RESULTS: Chinese American students primarily defined the need for school health services as having personal problems, engaging in early sexual activity, or using drugs. For the most part, they did not recognize their own health or psychosocial concerns as falling in these categories. Teacher referrals and peer dynamics were also salient factors in students' decisions to seek help from school health programs. Relationships with providers in strengths-based prevention programs improved their utilization of individual therapy and reproductive health services.

CONCLUSIONS: To increase Chinese American students' access of needed services, the organizational systems and social contexts of school health programs (in addition to the practices of individual clinicians) must be responsive to the needs and preferences of these ethnic minority youth.

Keywords: child and adolescent health; school-based clinics; school health services.

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In June 2008, a headline in the San Francisco Bay area education section of *Asian Week* newspaper announced: ''API students top suicide list: Chinese students attempted suicide multiple times.''[1] The article contrasted the high number of reported suicide attempts among Chinese American high school students in San Francisco with their relatively low use of mental health services. These local concerns parallel those voiced by a growing number of scholars and professional associations who argue that far too many Asian American adolescents do not have access to, or use, the psychosocial services they need.[2,3] The phenomenon of health service underutilization among Chinese American youth is not unique to San Francisco, and there is a pressing need across the country to understand how to serve these adolescents better, particularly given the tremendous growth in the Chinese American population in recent years.[3]

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Although the dominant stereotype of Chinese American youth is that they are the ''model minority,'' self-sufficient, and problem-free, the reality is that a significant proportion of these adolescents demonstrate substantial need for prevention and intervention services.[3,4] Ethnic-specific data are limited, but Asian American adolescents generally have higher rates of unmet mental health needs and are at greater risk for depression, anxiety, self-injury, and suicide than Whites or Black youth, even after controlling for income, insurance status, sex, age, geographic location, and a host of caregiver characteristics.[3,5-11] Such risks are elevated by stress at school and intergenerational family conflict at home.[12,13]

To explain patterns of racial and ethnic differences in service use, researchers have identified multiple cultural, social, organizational, and structural barriers that limit minority youths' access of the health care they need.[2,5-8,10,14-21] However, school health programs (SHPs) are a particularly promising strategy for reaching such underserved adolescents because they eliminate structural barriers such as cost and inconvenience. Yet, there is scant research regarding Asian American students' utilization of school-based services, and even fewer ethnic-specific studies, in part, because of small sample sizes in many national data sets.[3,16,22,23] In San Francisco, where SHPs have been established at 15 high schools through a city-county-district Wellness Initiative, Chinese American students are the largest ethnic group, making it an ideal study site for this type of inquiry. Chinese American adolescents comprise almost 45% of the high school population, but make up less than 25% of the youth served by the SHPs, although they access school services at higher rates than community-based programs.[24] Other studies of this population have demonstrated that lower reported risk-taking behaviors do not fully explain this pattern of underrepresentation; Chinese American youth in San Francisco are still significantly less likely than their peers to report using their SHP even after controlling for age, sex, language, depressive symptoms, substance use, and sexual activity.[25] In light of these trends, the Wellness Initiative has increasingly focused on the needs of Chinese American students in program evaluation and outreach efforts.

Using quantitative and qualitative data from the Wellness Initiative evaluation, this study considered whether school contextual factors contribute to Chinese American students' underutilization of SHP services. Attention to school context is needed for existing empirical research with Chinese American youth focuses almost exclusively on the constraining role of adolescents' cultural expectations, values, and norms on their pathways into services, especially in the case of mental health treatment.[26-29] Yet, a similar argument is often made with respect to Black and Latino youth—that they experience stigma and cultural norms against formal help-seeking[5]—but emerging research suggests that these students tend to be overrepresented in SHPs, including the Wellness Initiative.[21,30] Therefore, it seems unlikely that students' cultural attitudes or beliefs are the only determinants of their participation in services.

Indeed, ecological theories of help-seeking among ethnic minority youth also highlight organizational and social influences, such as referral systems and peer networks, on adolescents' pathways into services.[18] For those concerned with improving access for underserved youth, studying such contexts is critical, given the reality that most youth drop out of the help-seeking pathway before contacting a health provider.[17] Yet, the role of contexts other than culture is surprisingly understudied, despite recognition by leading scholars that, ''culturally competent services quickly become irrelevant if ethnic minority adolescents do not find their way into them.''[18]

This study uses a sequential mixed methods approach to consider the role of school organizational and social factors in help-seeking from SHPs by Chinese American students.[31] Organizational factors of interest include outreach, referral, and enrollment systems. In community-based public health centers, for example, young people most often enter care because of parental concern, whereas teachers and school staff serve to identify students in need of additional support at school.[17,18] Social factors refer to networks and relationships through which youth become aware of available services, along with their purpose, target population, quality, and perceived efficacy.[14,32] This article outlines the influence of these school contexts on three stages of the help-seeking process: (1) recognizing need, (2) deciding to seek help, and (3) selecting services.[18]

METHODS

In the first phase of the study, data from the 2007 Youth Risk Behavior Survey (YRBS) in San Francisco were analyzed to identify factors unique to Chinese American students' help-seeking process. Interviews and focus groups with Chinese American youth were conducted in the spring of 2008 to interpret the meaning of the survey findings and investigate the role of school contexts on their help-seeking pathways. Such ethnic-specific work has been identified as an important strategy to ensure the voices of Asian American youth are heard in health services research.[33]

Participants

In 2000, the city, county, and school district of San Francisco began the Wellness Initiative, whose mission

is to support adolescent health and well-being through coordinated SHPs at the high school level that offer nursing, health education, assessment, counseling, and prevention services. In the 2006-2007 school year, these SHPs served 4825 youth, representing 38% of high school enrollment district wide. The most popular services were medical care (44% of all youth served), general counseling (38%), and specialty behavioral health services (30%). Twenty-four percent of the students served were Chinese American, 27% were Latino, 20% were Black, 7% were White, 11% were from other Asian ethnic groups, and 5% were multiracial. Fifty-five percent were female and 45% were male. In contrast, 39% of all students attending high schools with SHPs were Chinese American, 20% were Latino, 11% were Black, 8% were White, 12% were from other Asian ethnic groups, 8% were multiracial or self-identified as ''other,'' and 2% declined to state their ethnicity. Forty-nine percent were female and 51% were male. Twenty percent of all high school students were classified as English language learners.

Phase 1: Survey. Overall, 1,744 high school students who attended a school with a SHP completed the YRBS. Respondents were proportionally distributed across the 9th-12th grades. Forty-two percent of the sample were Chinese American, 20% were Latino, 9% were White, 7% were Black, 15% represented other Asian ethnic groups, and 4% were multiracial. Native American, Pacific Islander, and students who declined to state their ethnicity (3% all together) were dropped from the sample because of their small numbers, resulting in a final sample of 1700. Half of the sample were female and half were male. While 60% reported at least 1 risky health behavior that indicated a need for SHP services, 40% of the sample reported accessing their SHP at least once. Five percent completed the survey in a language other than English.

Phase 2: Focus groups and interviews. Forty-four Chinese American students who had not accessed services from their SHP participated in 5 focus groups. Participants were primarily from the 9th (N = 29) and 10th grades (N = 15), reflecting the composition of the physical education (PE) classes from which they were recruited. About one third of students reported speaking primarily Cantonese at home (N = 16), speaking Cantonese and English (N = 13), or speaking primarily English (N = 15). Other studies have demonstrated that youth who do not speak English at home are less likely to use formal health and social services.[8,34,35] The majority of focus group participants (N = 39) reported that they were born in the United States, but their parents were born elsewhere. One focus group participant was born in the United States, as were his parents. The 4 remaining students and their parents were born outside of the United States. Half of the participants were female and half were male.

Seven interviews were conducted with Chinese American students who had participated in their school's health program, with participants from each high school grade level. Two students reported speaking primarily Cantonese at home, whereas 4 spoke both Cantonese and English, and one spoke primarily English. None of the interviewees were born outside of the United States, but all reported their parents were born in another country. Three of the interviewees were male and four were female.

Instruments

Phase 1: Survey. For detailed information about the YRBS items and their psychometric properties, please see the *Morbidity and Mortality Weekly Report Surveillance* summaries.[36] Forty items created by the Wellness Initiative Manager and evaluation team were added to the core YRBS survey to assess the quality, impact, and accessibility of the Wellness Initiative. A subset of 30 items from the addendum that focused on students' help-seeking was used in this study.

Phase 2: Focus group and interviews. The lead authors developed protocols based on survey items in which Chinese American youths' responses were significantly different from their peers. The aim was to elicit youths' assistance in interpreting these differences and understanding the potential influence of school context.[31] The protocol was slightly modified for individual interviews or focus groups, depending on whether the participants had used services or not.

Procedure

Phase 1: Survey. The YRBS, designed and overseen by the Centers for Disease Control and Prevention (CDC), is administered biennially in randomly selected San Francisco Unified School District classrooms to approximately 2,500 students to generate a sample that is representative at the school district level.[36] In 2007, the response rate was 77%.

Phase 2: Focus groups and interviews. Focus group participants were recruited from cooperating PE classes at 3 schools, selected purposively to be representative of the district's SHP sites on several key dimensions (particularly school size and proportion of Chinese American youth in the student population). After an in-class announcement, invitations to attend the focus group or interview were distributed to all self-identified Chinese American students. Focus groups were facilitated by the lead authors, included no more than 12 students each, and were sex-specific (eg, boys only or girls only) to encourage students' communication about potentially sensitive topics. Owing to concerns raised by program staff

about confidentiality in a group setting, individual interviews were conducted with students who had used services. Following a grounded theory approach, interviews were conducted until reaching theme ''saturation''—the point at which interviewees began repeating existing themes without providing new insights.[37]

Data Analysis

Phase 1: Survey. The CDC entered, cleaned, and calculated weights for the YRBS data set, so that the sample was representative at the school district level by student race/ethnicity, sex, and grade.[36] SPSS version 20 software (Chicago, IL) for complex samples was used to allow for the sample weight adjustments. Bivariate analyses by race/ethnicity, then stratified by sex, were conducted to identify associations between race/ethnicity and help-seeking attitudes or behaviors using Pearson chi-square tests. All analyses include students who were categorized into the 6 largest racial/ethnic groups in the sample: Chinese, Latino, Black, other Asian, White, and multiracial. Logistic regression and linear regression models (for scaled survey responses) were completed for items that were statistically significant at the bivariate level (for one or both sexes). Drawing on the extant literature regarding correlates of help-seeking in schools, regression models included the following available covariates from the YRBS: sex, language, grade level, and a summative variable for risk-taking behavior that accounted for the number of reported health problems, mental health concerns, and substances abused.[15,18,21] This variable was modeled after previous analyses of the YRBS using 3 markers of health risk behavior that are targeted by SHPs: (1) physical health (lifetime sexual activity and asthma), (2) mental health (depression and suicidality in the past year), and (3) substance use (lifetime alcohol, tobacco, and marijuana use).[38]

Phase 2: Focus groups and interviews. The focus groups and interviews were tape recorded, transcribed, and entered into NVivo software (QSR International Inc., Burlington, MA) for analysis. An inductive and deductive coding approach was employed; preliminary codes were generated from a literature review and additional codes were added as the lead authors read the transcriptions. After identifying themes from the coding of the focus groups and interviews, transcripts were reviewed again for disconfirming evidence and competing interpretations.

RESULTS

An overview of major themes from the survey, focus groups and interviews are presented below, using Cauce et al's conceptual model for ethnic minority adolescent help-seeking as the organizing framework.[18] In this study, we specifically considered how social and organizational factors in the school context influenced 3 stages of the help-seeking process for Chinese American youth: (1) recognition of service need, (2) decisions to use school-based services, and (3) service selection preferences. Results are presented using these 3 stages, first providing an overview of quantitative findings (survey results), followed by a summary of themes from the qualitative analysis (focus groups and interviews).

Recognition of Service Need

Results from the survey indicated that compared to students of other racial and ethnic backgrounds, a significantly lower proportion of Chinese American youth were aware of the services offered at their SHP (Table 1). Linear regression analyses revealed that after controlling for potential confounders, Chinese American students remained significantly less likely than all other youth, except White students, to report knowing about the full range of services available (Table 2). Among students who had never participated in their SHP, chi-square tests indicated that a significantly higher proportion of Chinese American students (compared to their Black, other Asian, Latino, and multiracial peers), reported not needing services as a reason for not accessing their SHP, a trend that was significant only for girls in the stratified analysis (Table 3). Results from the logistic regression indicated that after controlling for epidemiologically defined need in the form of risk-taking behaviors, Chinese American youth had significantly higher odds of reporting that they did not need services compared with Latino students (Table 4).

In the qualitative phase of the study, among those youth who had never accessed services, some acknowledged they had previously experienced health or psychosocial concerns at school, but did not recognize themselves as being in need of services from the SHP. Focus group participants and interviewees generally understood service need to mean having personal problems or engagement in risky behaviors. When asked: ''Who needs to go [to the SHP]?'' participants in the qualitative phase responded that it was students who do not feel well, need to talk about family, friend, or relationship issues, want to escape or ditch class, use drugs, or have sex—conduct which many youth associated with being a ''bad kid.'' They also perceived regular service users to be ''troublemakers'' who go to the SHP to ditch and hang out, not because they have a medical or personal issue that needs attention. Youth also observed teachers sending these types of students to the SHP during class.

Although these SHPs provide an array of coordinated prevention and intervention services, Chinese

Table 1. **Students' Perceptions of Their School Health Program (SHP). Chi-Square Analyses From the Wellness Initiative Supplement to the 2007 Youth Risk Behavior Survey. (All Students, N = 1,461)†**

Percent of Students Who Agreed With the Following Statements	Chinese (N = 642) %	Black (N = 76) %	Other Asian (N = 170) %	Latino (N = 278) %	White (N = 128) %	Multiracial (N = 167) %
I know about all the services offered at the SHP*	39	58	51	48	45	51
Girls (N = 769)	35	51	55	47	41	51
Boys (N = 694)*	44	66	48	48	50	51
The SHP can help any student deal with stress	57	68	65	67	56	69
Girls	57	67	70	70	60	65
Boys	57	69	62	63	50	74
I would feel comfortable going to the SHP if I was really stressed out or upset**	41	54	48	58	44	53
Girls*	39	48	45	58	42	51
Boys	43	60	50	57	45	55
I feel welcome at the SHP at my school**	53	74	65	69	64	70
Girls*	56	74	60	72	69	72
Boys*	50	74	69	66	57	69
The SHP provides confidential services	61	71	71	67	76	68
Girls	64	71	70	71	79	70
Boys	56	72	72	63	72	65
The SHP is only for students who get in trouble	12	12	10	9	4	12
Girls	9	10	10	8	1	8
Boys	15	14	10	10	8	17
The SHP is only for students with mental health problems	10	10	7	7	3	9
Girls	5	8	6	5	0	5
Boys	16	12	7	8	6	15

*p < .05; **p < .01.
†Numbers in parenthesis are unweighted and the percentages are weighted.

Table 2. **Attitudinal and Behavioral Barriers to SHP Service Use: Results From Linear Regressions. From the Wellness Initiative Supplement to the 2007 Youth Risk Behavior Survey.**

	I Know About All the Services Offered at the SHP† (N = 1,231)		I would Feel Comfortable Going to the SHP If I Was Really Stressed Out or Upset† (N = 1,224)		I Feel Welcome at the SHP at My School† (N = 1,224)		The SHP Is Only for Students Who Get in Trouble† (N = 1,233)	
	B (SE)	(95% CI)	B (SE)	(95% CI)	B (SE)	(95% CI)	B (SE)	(95% CI)
Covariates								
Sex (male)	.13 (.05)*	(.03, .24)	.07 (.02)*	(.02, .13)	.03 (.02)	(−.07, .01)	.19 (.05)**	(.08, .30)
Grade	.00 (.02)	(−.04, .04)	.02 (.03)	(−.04, .09)	−.02 (.01)	(−.05, .01)	.01 (.01)	(−.02, .03)
Language (English)	.11 (.09)	(−.09, .30)	−.56 (.11)***	(−.81, −.32)	.19 (.14)	(−.13, .51)	.16 (.13)	(−.14, .45)
Risk behavior	−.01 (.02)	(−.06, .05)	−.00 (.02)	(−.05, .04)	.03 (.02)	(−.01, .08)	−.01 (.02)	(−.05, .03)
Race/ethnicity (ref, group = Chinese)								
Black	.32 (.08)**	(.14, .49)	.24 (.11)*	(.00, .48)	.24 (.09)*	(.03, .45)	−.22 (.09)*	(−.42, −.02)
Latino	.24 (.05)***	(.13, .35)	.30 (.05)***	(.18, .42)	.19 (.05)**	(.07, .30)	−.05 (.06)	(−.19, .09)
Other Asian	.21 (.08)*	(.04, .39)	.13 (.08)	(−.05, .30)	.12 (.06)	(−.02, .26)	−.12 (.04)*	(−.21, −.02)
White	.08 (.09)	(−0.12, .29)	.05 (.08)	(−.13, .22)	.14 (.05)*	(.04, .27)	−.24 (.06)**	(−.37, −.11)
Multiracial	.19 (.08)*	(0, .37)	.21 (.06)**	(.06, .35)	.22 (.04)***	(.13, .30)	−.13 (.09)	(−.34, .08)

*p < .05; **p < .01; ***p < .001.
†Possible responses were on a 5-point Likert scale of agreement (1 = strongly disagree, 2 = disagree, 3 = do not know, 4 = agree, 5 = strongly agree).

American students clearly associated service need with having a particular set of concerns, or being a particular type of kid, with whom many did not identify. Service users suggested these perceptions might exist because individual counseling and therapy is ''such a big part'' of these particular SHPs. In response to the strength of this theme in the qualitative stage of the study, we conducted further linear regression analyses on the survey item regarding perceptions of the SHP as being only for students who get in trouble. These analyses revealed that, after controlling for language, sex, grade, and risk behaviors, Chinese American youth were significantly more likely than Black, White, and other Asian peers to perceive that their SHP is only for troublemakers (Table 2).

Table 3. **Reasons for Not Seeking Help From the School Health Program (SHP). Results of Chi-Square Analyses of the Wellness Initiative Supplement to the 2007 Youth Risk Behavior Survey. (Nonusers, N = 923)†**

If You Have Not Visited Your SHP, Why Not?	Chinese (N = 492) %	Black (N = 32) %	Other Asian (N = 99) %	Latino (N = 131) %	White (N = 80) %	Multiracial (N = 89) %
I did not know there was a SHP at my school	9	13	4	15	4	14
Girls (N = 446)	8	12	2	17	3	9
Boys (N = 475)	9	14	5	13	6	20
I did not know what information or services were offered at the SHP	12	13	9	15	12	12
Girls	13	13	7	12	10	6
Boys	11	13	11	16	13	15
I did not need any information or services**	77	68	72	57	83	75
Girls***	79	68	82	57	92	85
Boys	75	68	66	57	75	66
I was afraid my parent/guardian(s) would find out	2	0	2	6	4	6
Girls	4	0	2	6	3	4
Boys	0	0	2	6	6	7
I was afraid someone at my school would find out	4	3	4	5	4	7
Girls	4	6	10	4	2	7
Boys	4	0	0	6	6	7
I did not think they would be able to help me with my problems	14	26	13	16	18	16
Girls	16	25	14	20	20	19
Boys	11	27	12	12	15	11
I do not want anyone to know about my problems	11	17	14	15	8	11
Girls	12	20	23	18	10	15
Boys	10	13	8	12	5	7
I think students should be able to deal with problems on their own	14	19	16	9	5	17
Girls	13	19	13	7	0	8
Boys	13	19	17	10	10	25

*$p < .05$; **$p < .01$; ***$p < .001$.
†Numbers in parenthesis are unweighted and the percentages are weighted.

The Decision to Seek Help

In stratified bivariate analyses of the survey data, a significantly lower proportion of Chinese American students reported feeling welcome at the SHP relative to students of all other racial/ethnic backgrounds (Table 1). A significantly lower proportion of Chinese American girls also reported they would feel comfortable accessing their SHP if they were stressed out or upset (Table 1). After controlling for sex, grade level, language, and risk behavior, Chinese American youth were significantly less likely than their Black, Latino, and multiracial peers to report feeling welcome or comfortable accessing services (Table 2).

Chinese American students in the focus groups explained that their decisions not to seek help, and discomfort with service use in times of distress, were partly in response to social relationships in their school context. They associated regular service users with being ''different,'' or having ''problems,'' which made them ''feel awkward'' about using services because they did not view themselves, or their friends, that way. At times these dynamics were recognized by students as explicitly being racialized. A 10th-grade boy noted:

> There's a bunch of other Mexicans or whoever that go [to the SHP] and... for Asians, especially, I find most people probably think it's really awkward... there's this awkward Asian just walking in while everyone's been there like 20 times before.

Given the trend of Black and Latino youths' overrepresentation in SHPs, such experiences of difference may be common and could contribute to Chinese American students' feelings of not being welcome at their schools' health program.

For those students who did access services, referral practices emerged in the interviews as a salient factor in their decision to seek help. Teachers' referrals were helpful to Chinese American students in overcoming their discomfort with seeking help from their SHP, particularly with respect to behavioral health treatment. For all interviewees seeing a therapist on an ongoing basis, a formal referral from a school staff person served as the point at which they realized they could benefit from behavioral health services and decided to enroll. The experience of being referred was generally positive for students, especially when services were framed as ''help dealing with stress.'' As one freshman girl reported:

> I was surprised that somebody actually noticed [me]... because teachers don't really pay attention most of the time.

Table 4. **Attitudinal and Behavioral Barriers to SHP Service Use: Results From Logistic Regressions**

	Did Not Access SHP Because Did Not Need Services† (N = 786)		Did Not Access SHP Because Did Not Feel Welcome† (N = 786)		Used SHP to Talk to Someone Individually About My Personal Problems† (N = 419)		Used SHP to Participate in Empowerment Group† (N = 419)		Used SHP to Take a Break/Hang Out† (N = 419)		Used SHP to Get Condoms† (N = 419)	
	Adj. OR	(95% CI)	Adj. OR	(95% CI)	Adj. OR	(95% CI)	Adj. OR	(95% CI)	Adj. OR	(95% CI)	Adj. OR	(95% CI)
Covariates												
Gender (male)	0.68*	(.46, .99)	1.17	(.42, 3.3)	0.99	(.58, 1.73)	0.57	(.28, 1.17)	0.89	(.50, 1.58)	2.67***	(1.69, 4.22)
Language (English)	7.34***	(3.36, 16.0)	1.4	(.09, 22.1)	0.31	(.03, 3.31)	10.78***	(8.47, 35.28)	1.29	(.12, 14.13)	1.2	(.11, 13.76)
Grade	0.96	(.79, 1.2)	1.05	(.79, 1.40)	1.19	(.91, 1.56)	1.34	(.79, 2.26)	0.96	(.81, 1.15)	1.12	(.88, 1.44)
Risk behavior	0.57***	(.47, .68)	2.14***	(1.51, 3.04)	1.40**	(1.13, 1.73)	0.726	(.46, 1.15)	1.19	(.97, 1.47)	1.73**	(1.31, 2.29)
Race/ethnicity (ref. group = Chinese)												
Black	1.35	(.19, 7.92)	2.42*	(1.03, 5.67)	0.81	(.36, 1.83)	5.8**	(1.58, 21.31)	2.86	(.71, 11.49)	2.27	(.47, 10.92)
Latino	0.48**	(.29, .79)	1.04	(.23, 4.71)	1.41	(.64, 3.07)	0.77	(.31, 1.89)	2.15**	(1.43, 3.23)	2.43*	(1.17, 5.02)
Other Asian	0.92	(.53, 1.61)	0.37	(.04, 3.25)	1.65	(.97, 2.80)	0.89	(.41, 1.93)	1.39	(.87, 2.22)	1.82	(.82, 4.02)
White	2.44	(.78, 7.5)	0.69	(.10, 4.58)	0.87	(.27, 2.86)	1.39	(.78, 2.47)	1.05	(.49, 2.25)	1.68	(.75, 3.78)
Multiracial	1.73*	(1.10, 2.69)	1.75	(.41, 7.58)	1.37	(.68, 2.77)	0.97	(.21, 4.59)	2.44*	(1.12, 5.29)	1.5	(.63, 3.57)

*p < .05; **p < .01; ***p < .001.
CI, confidence interval; OR, odds ratio; SHP, School Health Program.
From the Wellness Initiative Supplement to the 2007 Youth Risk Behavior Survey.
†Possible responses were binary (0 = no, 1 = yes).

Another sophomore student noted:

> It was nice because it seemed like somebody was looking after me.

Service Selection

In stratified bivariate analyses of the survey data from students who had accessed services, a significantly lower proportion of Chinese American youth reported visiting their SHP to hang out or take a break (Table 5). In contrast, a significantly higher proportion of Chinese American youth participated in a support or empowerment group compared with all other students, except Black girls (Table 5). Among boys, there were also significant subgroup differences by race/ethnicity in use of their SHP for individual counseling and condom distribution (Table 5). After controlling for potential confounders, racial/ethnic group differences lost significance for use of individual counseling services or support/empowerment groups, except for Black students, who were significantly more likely than Chinese American youth to report accessing support groups (Table 4). Logistic regressions revealed that Chinese American youth had significantly lower odds than Latino or multiracial students of visiting their SHP to take a break or hang out (Table 4). Chinese American students also had lower odds of accessing their SHP for condoms in comparison to Latinos, after controlling for sex, language, grade, and risk behavior (Table 4).

Interviewees explained that they accessed particular services largely based on others' evaluation of their service needs, in the form of a referral, as discussed previously. Their relationships with SHP staff also emerged as an important influence on youths' willingness to participate in more stigmatized services, such as contraception distribution or individual therapy. For example, all of our interviewees who used behavioral health services reported they had previously participated in a prevention-oriented support or empowerment group facilitated by staff person who was not a mental health clinician. According to our interviewees, participation in these groups enabled subsequent service use because they became familiar with a SHP staff person, which made them feel more comfortable seeking help for more stigmatized services. A 12th-grade boy observed:

> It's like meeting new people . . . you don't know who [SHP staff] are so you don't feel exactly complete open up to them. But the thing was, I knew [SHP staff] from Asian Club. . . . Maybe [other students] didn't have that type of interaction with a person that works in the [SHP], so they don't have that same thing that I had. . . . If you go there by yourself, you're going to be like, what am I

Table 5. **Reasons for Seeking Help From the School Health Program (SHP). Chi-Square Analyses From the Wellness Initiative Supplement to the 2007 Youth Risk Behavior Survey. (Users, N = 521)†**

If You Have Visited Your SHP, Why Did You Go?	Chinese (N = 143) %	Black (N = 44) %	Other Asian (N = 58) %	Latino (N = 153) %	White (N = 45) %	Multiracial (N = 78) %
To get first aid/medical help	38	28	22	29	42	34
Girls (N = 291)	52	26	32	31	41	45
Boys (N = 230)	16	30	14	27	43	12
To talk to someone individually About My personal problems	25	25	38	30	27	41
Girls	19	25	33	40	32	31
Boys*	33	24	41	19	21	61
To participate in a support/empowerment group**	16	34	10	9	16	10
Girls*	20	41	13	11	16	15
Boys	10	26	9	8	16	4
To get information about counseling and/or support group services at my school	13	17	7	16	11	11
Girls	12	24	0	13	15	15
Boys	15	9	12	19	6	4
To get information on health services outside of school (doctors, clinics, and hospitals)	13	18	14	17	14	16
Girls	13	21	21	22	19	21
Boys	13	16	9	12	6	4
To set up an appointment for medical testing (eg, asthma, diabetes, pregnancy, etc)	3	5	9	8	5	5
Girls	1	4	17	12	4	4
Boys	5	6	3	4	6	8
To get information on general adolescent health issues	7	14	7	9	14	8
Girls	5	8	4	8	25	9
Boys	10	20	8	10	0	5
To get condoms	13	27	27	29	27	20
Girls	9	16	12	25	13	16
Boys*	17	41	38	33	46	29
To take a break/hang out*	20	42	28	41	24	46
Girls	19	49	30	44	33	42
Boys*	21	35	27	37	11	53
To get help for a family member or friend	10	9	3	8	7	16
Girls	7	17	4	11	12	17
Boys	15	0	3	6	0	13
To go to a safe and comfortable place	9	12	14	17	9	19
Girls	7	13	12	25	11	24
Boys	11	11	15	10	6	8
To go to a place where I feel physically safe	5	8	9	11	6	12
Girls	2	9	0	14	7	15
Boys	9	6	16	7	5	5

*$p < .05$; **$p < .01$.
†Numbers in parenthesis are unweighted and the percentages are weighted.

> doing here? You don't know anything involving the place . . . and of course you're gonna be nervous.

In other words, these universal programs strengthened social contexts that enable formal help-seeking from SHPs.

In the focus groups, Chinese American students who had not used their SHP, but recognized a health or psychosocial concern and decided to seek help for it at school, reported turning to teachers and friends. This pattern may reflect larger dynamics between teachers and students in the school. An 11th-grade girl observed:

> Some students just go [to the SHP] because they don't want to go to class . . . [and] they have nowhere else to go.

DISCUSSION

Despite the differences identified in our results, it is important to keep in mind that Chinese American students' survey responses were more similar to other youth than they were different (less than one third of the items were significantly different by race/ethnicity). This suggests that contextual influences other than culturally informed attitudinal and behavioral barriers are shaping students' help-seeking trajectories in schools. Chinese American students' views of service need and users appear to constrain Chinese American students' self-identification, and possibly, others' evaluation of their need for SHP services. Chinese American adolescents are less likely to engage in the very risk behaviors that they associated

with SHP users, such as school disengagement, drug use, and early sexual activity.[38,39] Emerging evidence also suggests that teachers often expect Asian youth to be perfectionist, anxious, and shy, while also perceiving they are less hostile, disruptive, and aggressive than Blacks or Latinos.[40,41] These stereotypes, consonant with the ''model minority'' myth, may lead educators to overlook Chinese American students' distress, leaving their needs more likely to go unmet.[4,28] Other studies have confirmed that teachers tend to refer disruptive youth who make it difficult for them to manage their classrooms, and less often identify students who are experiencing internalized distress.[15,42]

If need for SHP services is associated with having externalized ''problems,'' both teachers and Chinese American youth alike may be less likely to see themselves as experiencing service need. Moreover, if in their outreach to students and school staff, providers emphasize that SHPs target risk behaviors like early sexual activity and substance abuse, they may unintentionally discourage teacher referrals of Chinese American youth and promote ideas about service need that are not aligned with the type of challenges these students experience most often, such as somatic symptoms, stress, anxiety, and depression.[5,6] As students of other backgrounds, or with more externalized needs, use services in greater proportions, Chinese American youth may become less comfortable accessing these spaces. Other studies have confirmed that the relationships between Chinese American students and other youth of color are often strained in public schools.[43,44]

Support and empowerment groups that allow for relationship building between Chinese American youth and SHP staff appear to help students overcome these barriers. This finding is supported by research regarding the important role of ''gateway'' providers in behavioral health service utilization.[45,46] It may also be that Chinese American students, who tend to experience higher academic achievement than their peers of other racial and ethnic backgrounds in San Francisco, have other spaces in their school—such as the classroom—where they can take a break, ''hang out,'' or ask a caring adult for advice about health and personal matters. In contrast, youth of other backgrounds, particularly those perceived as ''problem'' students, may feel less connected to their teachers and therefore more often need to rely on their SHP staff for support.[47-49]

Limitations

The sample of Chinese American youth in the survey was representative of high school students in San Francisco, but the findings may not be generalizable beyond the study site. Although the high proportion of Chinese American youth in San Francisco Unified School District was the strength in this study, it is relatively unique. Moreover, participants in the focus groups and interviews were not representative of the population of Chinese American students at their school or in the school district, as the phase 2 samples also included only fluent and English proficient youth (recruitment efforts, focus groups, and interviews were conducted in English). The small number of high schools also precluded the quantitative examination of school contextual features on service use using multilevel modeling methods.

Conclusion

Despite these limitations, the perspectives of students who participated in the focus groups and interviews are nevertheless helpful in interpreting the phase 1 findings and for developing a richer, contexualized understanding of Chinese American students' help-seeking from SHPs. This study suggests that when Chinese American youth, who tend to report somatic and internalizing symptoms, observe their SHPs serving primarily ''problem'' students who engage in risky externalizing behaviors, they are less likely to recognize their own service need.[5,6,25] Stereotypes about Chinese American students may limit teacher referrals on behalf of these youth, although when referrals are made, they positively facilitate youths' help-seeking from SHPs. Finally, participation in strengths-based prevention programs appears to serve as ''gateway'' into more formal services, improving Chinese American students' utilization of individual therapy and reproductive health services.

IMPLICATIONS FOR SCHOOL HEALTH

These findings support the call for more expansive notions of culturally responsive services that look beyond the skills and interventions employed by individual clinicians to the larger systems and contexts within which health providers operate.[50] Although moving health and psychosocial programs into schools removes structural barriers for underserved youth, this study indicates that improving Chinese American adolescents' access to care requires more than eliminating barriers of cost, transportation, or inconvenience. School-based providers also need to tailor their services and outreach messages to these youths' service preferences and needs. For example, in marketing materials and presentations to the school community, providers may want to highlight any universal services offered (primary care, support/empowerment groups, health education, recreational, or leadership activities) and programs that support stress management, such as yoga and meditation. This may change students' perceptions of what it means to need SHP services. Increasing the provision of universal or

strengths-based programs and colocating them with more indicated and stigmatized services may also lead to increased service use on the part of Chinese American students. The relationships students build through these gateway programs increase their familiarity with and trust of providers and help youth overcome the discomfort often experienced when seeking support for behavioral or reproductive health concerns. Finally, to facilitate increased referrals of Chinese American youth, school staff members may need training to identify and refer students experiencing somatic or internalizing symptoms.

Additional research is needed regarding the organizational and social contexts of students' pathways into services. In particular, insufficient attention has been paid to the ways in which institutional actors shape students' help-seeking trajectories. Studies of teacher referral practices, particularly in schools with large numbers of Chinese American youth, could generate useful information about the training teachers need to be more aware of diverse forms of illness and symptom expression. Quantitative studies with a larger sample of schools and measures of multiple contextual influences would also further knowledge development in this area. Evaluations of effective strategies for improving Chinese American youths' service use are almost nonexistent. Both types of inquiry—of the problem and potential interventions—are necessary to understand the causes of, and solutions to, Chinese American adolescents' underutilization of SHP services.

Human Subjects Approval Statement

This study was approved by the Office for the Protection of Human Subjects at the University of California at Berkeley and the San Francisco Wellness Initiative.

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