

Understanding Chinese American Students' Underutilization of Wellness Program Services: A Review of the Research Literature

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Executive Summary

The Mental Health Needs of Chinese American Youth

- *Overall Rates of Mental Health Disorders*
 - Although very little representative research involving API youth exists, it appears that overall prevalence rates of psychopathology do not differ by race and ethnicity.
 - The implication of this finding is that lack of mental health need cannot explain the underutilization of Wellness services by Chinese American youth.
- *Types of Mental Health Problems*
 - API youth are at higher risk for depressive disorders and suicide than White or African American youth.
- *Other Mental Health Needs*
 - API youth are much less likely than students of other backgrounds to engage in risk behaviors, though they experience more stress at home, school, and in their personal relationships.
 - Given the broad, preventative mission of the Wellness Initiative, the lower rates of reported risk behaviors on the part of API youth may help to explain why they are underrepresented in Wellness services.
- *Risk Factors*
 - API youth who experience intergenerational conflict at home, or have controlling or authoritarian parents, are at greater risk for mental health problems.

API Youth's Underutilization of Mental Health Services

- *Evidence of Underutilization*
 - A strong body of literature documents that API adolescents are significantly less likely than youth of all other racial or ethnic backgrounds to access outpatient treatment for social and emotional problems, even after controlling for need, age, gender, income, urbanicity, insurance status, and a host of other caregiver characteristics.

Explaining Underutilization: Cultural Influences

- *Norms and Stigma*
 - Although mental health treatment is stigmatized across all racial and ethnic minority groups, it is possible that norms mitigating service use are more closely intertwined with Chinese American youths' cultural values and offer more explanatory power in their case. More research in this area is needed.
- *Symptom Manifestation*
 - A growing number of studies suggest that API youth tend to focus on the physical symptoms of psychological disorders. As a result, Chinese American students may seek medical or nursing assistance instead of mental health counseling.
 - To understand the significance of this issue, information is needed regarding Chinese American students' utilization of medical services offered by the Wellness Programs, compared to students from other racial or ethnic groups.
- *Explanatory Models for Psychological Problems*
 - Explanatory models of mental illness are a person's, beliefs about what symptoms constitute mental health disorders, their origins, and how they can be resolved.
 - The concept of alternative explanatory models could help to explain disproportionalities if the parents of Chinese American youth are significantly less acculturated or have different beliefs regarding etiologies for mental health problems than their Latino and African American counterparts. More research in this area is needed.

Explaining Underutilization: Contextual Influences

- *The Unique Context of the Wellness Initiative*
 - Studies of API youth's underutilization of mental health services have almost exclusively focused on community based, public mental health services where youth and their families experience practical barriers (e.g. cost, transportation) to service use. The Wellness Initiative has eliminated these access issues.
 - In community-based settings, young people most often enter mental healthcare because of parental concern, whereas teachers and staff serve as the main referral source in schools. Parents of color and teachers often have different views of student behavior and likely have different motivations for enrolling youth in services.
 - The utilization patterns observed in Wellness Programs are different from those noted in community mental healthcare. In the population served by community systems, all youth of color are generally underrepresented and White adolescents are overrepresented. However, in the Wellness Programs, API and White youth underutilize behavioral health and general counseling programs, whereas African American and Latino youth appear to over-utilize these services.
- *Bias in Mental Health Referrals*
 - Teachers are less likely to notice internalizing behaviors and are more likely to respond to student conduct perceived to be disruptive. Since API youth appear to be at greater risk for internalizing disorders (depression and suicidality), teachers

may be more likely to overlook API students' mental health needs. More research in this area is needed.

- A small number of studies indicate that teachers expect API youth to be introverted and over-controlled. If they consider these internalizing behaviors to be normal for API students, they may be less likely to refer students exhibiting symptoms for mental health services. More research in this area is needed.
- *Coercive Referrals Stemming from School Discipline*
 - API youth are less likely than Latino and African American youth to be disciplined in school, perhaps because school staff view API and White youth as less threatening than peers of other racial backgrounds or because they are more academically engaged. Therefore, API youth may be less likely to enter school-based services because of disciplinary sanctions that involve mandates for youth participation. More research in this area is needed.
- *Organizational Dynamics*
 - Research from special education suggests that, higher referrals of Latino and African American youth, coupled with lower rates of White and API referrals to school-based mental health services may reflect schools' maladaptive attempts to cope with growing demands to raise standardized achievement amongst an increasingly diverse student body. More research in this area is needed.

Practices That May Increase Chinese American Students' Service Use

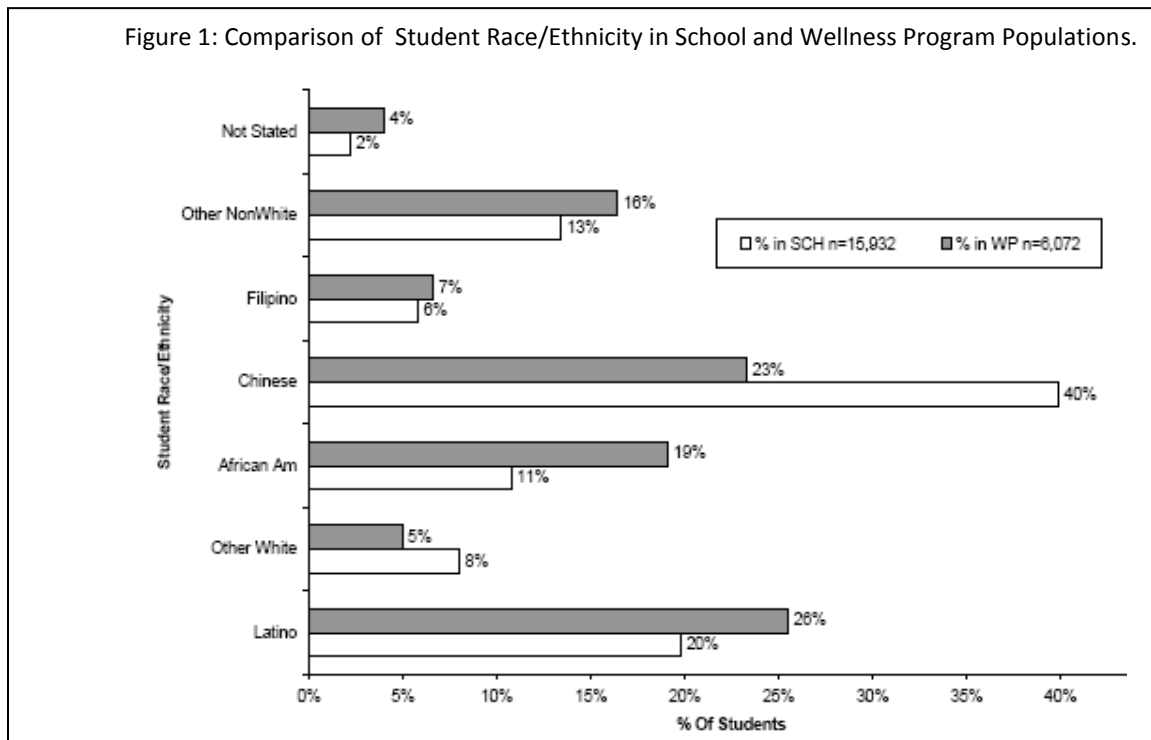
More research is needed in these areas, as very few studies have considered the efficacy of these interventions on increasing API youth's utilization of mental health services. These suggestions are based on the literature review.

- *Teacher Training*
 - Train teachers to identify and refer Chinese American youth who may be experiencing internalizing or psychosomatic symptoms.
- *Increase Staff Diversity*
 - Hire additional staff who share underrepresented students' ethnic background and match Chinese American students to these staff members if they are referred.
- *Tailor Outreach Efforts*
 - Tailor health education and outreach efforts to reflect the psychological challenges, symptom manifestation and risk factors most often experienced by Chinese American youth.
- *Integrate Mental Health Clinicians into Non-Stigmatized Services*
 - Incorporate mental health clinicians into non-stigmatized services where students can build relationships with staff and receive support without officially accessing mental health treatment.

Introduction

Rates of Wellness Program service utilization in San Francisco schools differ significantly by race and ethnicity (see Figure 1). Specifically, African American and Latino students are overrepresented in the population served by the Wellness Centers, while White and Chinese American youth are underrepresented (Shields & Ong, 2006). Chinese American students' underutilization of services is most dramatic and of great concern to practitioners in the Wellness Initiative. For example, Chinese American students comprise 40% of San Francisco's high school population, but they make up only 23% of the youth served by the Wellness Program. If these statistics reflect significant unmet need for services amongst Chinese American youth, then the disparities are certainly troubling. Research that indicates unmet mental health need is a potential contributor to youth violence, delinquency, school dropout, suicide and debilitating psychological disorders in adulthood (Cocozza & Skowrya, 2000; W. E. Copeland, Miller-Johnson, Keeler, Angold, & Costello, 2007)

This paper reviews literature regarding the mental health needs of API youth, their underutilization of therapeutic services, and possible explanations for this behavior. Potential strategies for increasing the representation of Chinese American students in Wellness services will also be discussed. Whenever possible, information that is specific to Chinese American youth will be outlined. However, such ethnic group-specific research is rare and aggregated analyses, where all Asian subgroups are combined into one, are much more common. In these cases, the term Asian Pacific Islander (API) will be used.



The Mental Health Needs of Chinese American Youth

Overall Rates of Psychopathology

In order to understand the service utilization patterns of Chinese American youth, one must first consider whether their levels of need are different from young people of other backgrounds. Estimates for American youth with mental health need varies from 14% to 37%, depending on the level of impairment, degree of symptom, and the period assessed (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Kataoka, Zhang, & Wells, 2002; R.E. Roberts, Attkisson, & Rosenblatt, 1998; R.E. Roberts, Roberts, & Xing, 2007; Wu et al., 1999). Epidemiological research indicates that general prevalence rates of psychological disorders are similar across racial and ethnic groups, once income, gender, age and urbanicity are taken into account (Burns et al., 1995; Edman et al., 1998; Kodjo & Auinger, 2003; Makini et al., 1996; R.E. Roberts, Roberts, & Xing, 2006; Siegel, Aneshensel, Taub, Cantwell, & Driscoll, 1998). Although nationally representative studies may have included Chinese American youth in their “other” category, we are not aware of any publications that provide an overall prevalence rate of psychopathology amongst a representative group of Chinese American youth, or even API adolescents. However, non-representative studies using small community samples, ethnic-specific populations, and youth in public sectors of care also suggest that API youth experience mental health problems at overall rates that are comparable to their White, Latino, and African American counterparts (Edman et al., 1998; Garland et al., 2005; Gudino, Lau, Yeh, McCabe, & Hough, 2009; E. Kim & Cain, 2008).

Types of Mental Health Problems

It appears that overall prevalence rates of psychopathology do not differ by race and ethnicity, but there is growing evidence that API youth are at higher risk for depressive disorders and suicidality than White or African American youth (Goldston et al., 2008; The Services and Advocacy for Asian Youth Consortium, 2004). Sen’s secondary analysis of the 1996 Health Behavior in School Aged Children survey, which includes 6-10th graders revealed that API youth have significantly higher odds of suffering from depressed mood and self-injury risk when compared to White youth, after controlling for basic demographics, number of siblings in household, family structure, days spent unsupervised and number of times bullied. (Sen, 2004). Similarly, amongst a representative community sample from Los Angeles County, Siegel (1998) found that Asian youth experienced more symptoms of depression than their White counterparts. However, their scores on the Child Depression Inventory were lower than those of Latino and, in the case of API girls, African American youth (Siegel et al., 1998). In San Francisco, Chinese American high school students report serious suicidal thoughts more often than African American youth, but less often than White and Latino students (The Services and Advocacy for Asian Youth Consortium, 2004).

Other Mental Health Needs

The research literature documents a clear and compelling psychological need amongst API youth for mental health interventions, but it is important to note that the aforementioned studies focus on psychopathology exclusively, whereas the Wellness model of mental health services is also preventative and intended to address a broader range of psychosocial challenges faced by youth in adolescence, such as substance use, sexual decision-making, school failure, stress, and delinquency (Shields & Ong, 2006). Using a nationally representative sample of high school students who completed the Youth Risk Behavior Survey, Grunbaum and her colleagues (2000) found that API youth were far less likely than students of other backgrounds to engage in risk behaviors (56% reported no risk behaviors, versus 25% of African American, 30% of Hispanic and 34% of White students). Specifically, these API youth were less likely than students of other racial or ethnic backgrounds to ever have had sexual intercourse, be sexually active or have had four or more partners, but once sexually active, were just as likely to use alcohol or drugs at last intercourse (Grunbaum, 2000). They are also less likely than many of their peers to have been in a physical altercation or put themselves at risk for unintentional injury (e.g. riding in a car with a driver who had been drinking) (Grunbaum, 2000). In terms of substance use, API youth in California report the lowest prevalence rates across ten categories of drugs, but their usage is higher than African Americans with respect to cigarettes, amphetamines, and LSD (Harachi, Catalano, Kim, & Choi, 2001). When comparing subgroups in California, it appears that Pacific Islanders have the highest rates of drug use and sexual activity, whereas Southeast Asians and Chinese American youth reported the lowest levels (Harachi et al., 2001; Horan, 1993). In San Francisco, API youth also have the lowest arrest rates of all racial or ethnic groups, though their arrests are increasing (The Services and Advocacy for Asian Youth Consortium, 2004). Locally and at the state-level, API youth have the lowest rates of high school dropout (California Department of Education, 2009). At the national level, Chinese students have among the highest rates of graduation and outperform their peers on a number of educational achievement measures (Kao & Thompson, 2003). There is, however, limited evidence that API youth experience more stress at school, home and in their personal relationships than other students. For example, in a non-representative sample, API youth report higher levels of various forms of stress than their White, and African American peers (Choi, Meininger, & Roberts, 2006).

Risk Factors for Mental Health Problems

While a range of variables, such as collectivist orientation and acculturative stress, have been hypothesized to be related to psychopathology and risky behaviors amongst API youth (see Goldston et al., 2008 for a review), a growing number of empirical publications have examined the relationship between particular risk factors and symptoms of psychological disorders for these adolescents. In particular, intergenerational conflict and parenting style may be particularly salient contributors to the emotional distress these young people experience. Multiple studies have confirmed that intergenerational conflict is positively correlated with elevated depressive symptoms, substance use, and risk for suicidality amongst this population

(Choi et al., 2006; Harachi et al., 2001; E. Kim & Cain, 2008; Anna S. Lau, Jernewall, Zane, & Myers, 2002; Ying & Han, 2007). This research suggests that a young person's level of acculturation is not a risk factor in and of itself; instead, acculturation only indirectly affects depressive symptomatology as it contributes to family conflict, which has a direct effect. For example, low acculturated youth may find intergenerational arguments more upsetting because of closely held traditional values or limited access to other forms of social support, whereas youth who are more acculturated may experience greater conflict with their less acculturated parents (Anna S. Lau et al., 2002; Ying & Han, 2007). In general, API youth appear to experience greater social and familial stress than their White peers, but have fewer internal and familial resources (e.g. self-esteem, family cohesion, and coping strategies) to draw from in order to deal with these challenges (Choi et al., 2006). Such findings are supported by additional studies which indicate that controlling or authoritarian parenting styles that involve high expectations, low parental warmth, and/or low responsiveness to a child's individuality are correlated with higher depression scores amongst Vietnamese and Korean youth, even after controlling for a range of demographic variables (E. Kim & Cain, 2008; P. V. Nguyen, 2008).

Understanding Underutilization

Evidence of Underutilization

Over fifteen years of research have documented the underutilization of mental health services by API adolescents; they are less likely than youth of all other racial or ethnic backgrounds to access treatment for social and emotional problems (U.S. Department of Health and Human Services, 2001). Differences in service use have been consistently documented in nationally representative samples (Huang, Yu, & Ledskey, 2006) and across multiple public service systems (Bui & Takeuchi, 1992; Garland et al., 2005; Ho, Yeh, McCabe, & Hough, 2007; McCabe et al., 1999; May Yeh, McCabe, Hough, Dupuis, & Hazen, 2003; May Yeh et al., 2005); they remain statistically significant even after controlling for need, age, gender, income, urbanicity, insurance status, and a host of other caregiver characteristics. In one large study of high-risk adolescents involved in public sector services (e.g. child welfare and juvenile justice), almost 72% of API youth in need of mental health services had not received treatment, compared to 48% of African Americans, 47% of Latinos and 30% of White teens (May Yeh et al., 2003). Using the same sample, another group of researchers also found that API adolescents experiencing symptoms of a psychological disorder were actually less likely to use services than White youth who were not experiencing any clinically significant distress (Gudino et al., 2009). The only type of mental health service that API youth may be more likely to use than their peers is emergency psychiatric intervention, which may reflect a tendency to postpone treatment until a serious crisis that prompts authorities to intervene (Snowden, Masland, Libby, Wallace, & Fawley, 2008).

It is worth noting that the utilization patterns observed in Wellness Programs are different from those noted in most studies of racial or ethnic disproportionality, which have almost

exclusively focused on community based, public mental health services. In the population served by those systems, all youth of color are generally underrepresented and White adolescents are overrepresented. However, in the Wellness Programs, API and White youth underutilize behavioral health and general counseling programs, whereas African American and Latino youth appear to over-utilize these services.

Explaining Underutilization

Given growing evidence that overall rates of psychopathology do not differ significantly by race or ethnicity, lack of mental health need cannot explain the underutilization of Wellness services by Chinese American youth. However, the mission of the Wellness Initiative goes beyond providing treatment to students with diagnosable psychological disorders and encompasses the goal of increasing students' access to prevention services (Shields & Ong, 2006). As such, the lower rates of reported risk behaviors on the part of API youth may help to explain why they are underrepresented in Wellness services. However, it is unlikely that differential risk-taking behaviors fully explain racial and ethnic disproportionalities, for research has established that need is only one of many factors that determines whether a young person enters treatment (Rickwood, Deane, & Wilson, 2007; Rothi & Leavey, 2006; Srebnik, Cauce, & Baydar, 1996). Other influences on Chinese American students' help-seeking behavior and must also be considered.

In the early literature discussing racial and ethnic disproportionalities in mental health service use, much theoretical attention was given to the potential influence of practical barriers, such as accessibility and affordability, on decisions by individuals of color to forgo participation in treatment (Cauce et al., 2002). More recent research found unexpected relationships between race and ethnicity, unmet need, reported barriers, and service; parents of children of color actually reported fewer service barriers than White parents and those who accessed services tended to report more barriers than those who do not (May Yeh et al., 2003). For example, although API youth have the highest unmet need and lowest rate of service use, their parents report the fewest barriers of all racial and ethnic groups (though they were more likely to report language barriers), suggesting that other factors influence their decisions not to pursue treatment and reported barriers do not provide the most useful way of understanding patterns of utilization (May Yeh et al., 2003). Moreover, the phenomenon of mental health service underutilization in educational settings, where practical barriers like transportation, insurance coverage and cost are essentially eliminated, indicates that attention to cultural and contextual influences on service use is required in order to understand the causes of this problem (Cauce et al., 2002; Srebnik et al., 1996). In the section that follows, research and theory regarding cultural and contextual factors in help seeking will be reviewed.

Cultural influences.

To explain adolescents' underutilization of mental healthcare, a growing body of theory and empirical research explores the influence of culture on adolescents' help seeking. Three general

areas of interest have emerged from the literature: norms and stigma, symptom manifestation, and explanatory models for psychological problems (Cauce et al., 2002; Srebnik et al., 1996). In the following section, each factor will be explored in further detail, as will their potential ability to explain the lower rates of participation on the part of Chinese American youth in San Francisco. It is important to note that the majority of this research and theorizing has taken place in the context of community-based services.

Norms and stigma.

Norms and stigma refer to attitudes about mental illness and sanctioned coping or help-seeking practices that are culturally mediated (E. P. Copeland & Hess, 1995). Research indicates that youth of color associate greater stigma with mental health services than their White peers, but these attitudes have not been directly linked to service use (Chandra & Minkovitz, 2007; Watson, 2005). Still, it follows that if young people perceive formal help-seeking to be contradictory to cultural expectations, they may be less likely to use mental health services (Corrigan, 2004). Many authors have suggested that API individuals find extra-familial interventions, such as seeking professional psychological help, to be shameful and a violation of the family hierarchy, as it could indicate inadequacy on the part of family members (Shea & Yeh, 2008; D. W. Sue, 1994; Zane, Mak, Chun, Balls Organista, & Maran, 2003). Therefore, cultural values including collectivism, familial piety and avoiding loss of face may help to explain why Chinese American students are underrepresented in the population served by Wellness Centers (Shea & Yeh, 2008; D. W. Sue, 1994). In fact, amongst college-age students, adherence to Asian values was significantly, and negatively related to attitudes towards seeking professional help (Shea & Yeh, 2008). However, this same argument has been made with respect to the African American and Latino community, but these students are overrepresented in Wellness services (Goldston et al., 2008). Thus, although mental health treatment is stigmatized across all racial and ethnic minority groups, it is possible that norms mitigating service use are more closely intertwined with Chinese American youths' cultural values and offer more explanatory power in their case. For example, in a small study of a multi-racial group of students attending one East Coast high school, API youth were significantly more likely than their White, Latino and African American peers to report barriers to help-seeking such as self-, family- or peer-sufficiency (Kuhl, Jarkon-Horlick, & Morrissey, 1997).

Symptom manifestation.

Researchers have theorized that API youth are less emotionally communicative and tend to focus on the physical symptoms of psychological disorders because of cultural norms that emphasize conformity and group interests over individual expression (L. Chang, Morrissey, & Koplewicz, 1995; Choi, 2002; Goldston et al., 2008). One nationally representative study of Chinese American youth validated this hypothesis, finding that the underlying structure of depression was different for these adolescents in contrast to white and Filipino students, after controlling for gender, generational status, home language and mother's education (Russell, 2008). This study found that Chinese American teens did not differentiate between bodily and

psychological symptoms of depression (Russell, 2008). Several studies of API youth receiving mental health treatment have found that they are more likely to receive nonpsychiatric diagnoses, which may indicate that these youth express their symptoms in a unique manner (Bui & Takeuchi, 1992; L. S. Kim & Chun, 1993). As a result, Chinese American students may seek medical or nursing assistance instead of mental health counseling, which may help explain their underrepresentation in these services. However, Chinese American students also underutilize medical services offered by the Wellness Programs (*CMS data needed).

Explanatory models for psychological problems.

Explanatory models of mental illness are a person's beliefs about what symptoms constitute mental health disorders, their origins, and how they can be resolved (Cauce et al., 2002). A young person's cultural background may influence how they identify problem behaviors and feelings, and what types of providers they turn to for assistance. It is unlikely that youth and their parents will seek psychological services for a concern they do not conceive of as a mental health problem; instead, they may turn to medical doctors, indigenous healers or religious leaders (Leong & Lau, 2001; R.E. Roberts, Alegria, Roberts, & Chen, 2005; May Yeh et al., 2005). Scholars have suggested that alternative explanatory models may explain the underrepresentation of immigrant youth in psychological services, as they likely have closer ties to non-Western belief systems and less exposure to the medical model of understanding mental health disorders (Garland et al., 2005; Snowden et al., 2008).

However, evidence in support of this theory has focused almost exclusively on parents, whose belief systems may be less relevant in the context of school based services where youth themselves or teachers often initiate referrals (Shields & Ong, 2006; Srebnik et al., 1996). One study found that parental affinity to an alternative culture was a partial mediator in the negative relationship between ethnicity and service use for Asian and Latino youth, even when a variety of other relevant variables were taken into consideration (Ho et al., 2007). After controlling for age, gender, income, parent education, and need, other investigators found that Latino and Asian parents' belief that their child's symptoms were caused by a physical health problem or trauma were more likely to seek services but there was not a statistically significant relationship between sociological, spiritual or natural disharmony beliefs and utilization (May Yeh et al., 2005). In the case of the Wellness Initiative, the concept of alternative explanatory models of mental illness could help to explain disproportionalities if the parents of Chinese American youth are significantly less acculturated or have different beliefs regarding etiologies for mental health problems than their Latino and African American counterparts.

Contextual influences.

A limitation of the cultural explanation for underutilization is that it fails to attend to the ways social institutions and their agents (e.g. schools and teachers), directly shape adolescents' patterns of service use. Most of the aforementioned research on the influence of culture on help-seeking was conducted in community mental health systems, or with them in mind. In

community-based settings, young people most often enter mental healthcare because of parental concern, whereas teachers and staff serve as the main referral source in schools (Cauce et al., 2002; Srebnik et al., 1996). Parents of color and teachers often have different views of student behavior and likely have different motivations for enrolling youth in services (A. S. Lau et al., 2004). Therefore, the dynamics of service use in schools may be unique from those in community settings. In order to understand disproportionalities in school-based mental health services, these contexts should be explored. However, such research is virtually nonexistent and the following section will be supplemented with studies of racial disproportionalities in special education and school discipline, which highlight the roles of organizational needs, coercion and bias in referrals.

Bias in mental health referrals.

Teachers and other school staff are often the first to identify a student in need of mental health services and serve as a major source of Wellness referrals (Shields & Ong, 2006). However, school professionals often view API youth in substantively different ways than students of other racial or ethnic backgrounds, which may influence their decisions regarding whether or not to refer an API student for mental health services. One study found that teachers expect Asian youth to exhibit internalizing symptoms and behave in an over controlled manner, defined as being anxious to please, afraid of making mistakes, concerned with perfection, and shy or timid (D. F. Chang & Sue, 2003). Teachers' expectations that Asian students will be over controlled may reflect dominant stereotypes of the "model minority" and could help explain why less attention is paid to Asian students' psychological distress, leaving their mental health need more likely to go unmet (Leong & Lau, 2001; S. Sue, Sue, Sue, & Takeuchi, 1995). In fact, in one study, internalizing symptom severity was negative related to school-based mental health service use for API youth (Gudino et al., 2009). Similar indications of bias have been found in clinician's assessments of API youth (L. Nguyen, Huang, Arganza, & Liao, 2007).

Regardless of race or ethnicity, it appears that teachers are less likely to notice internalizing behaviors and are more likely to respond to conduct perceived to be disruptive. In general, racial disparities in service use appear to be greater for internalizing problems and only externalizing, or acting out, behaviors predict the use of mental health services for API youth in school settings (Gudino et al., 2009). Researchers found that differences between teachers and youths' scores on the Child Behavior Checklist, which is used to assess for psychopathology, were largest for Asian students, even after controlling for gender, age and income (A. S. Lau et al., 2004). In other words, teachers generally rated Asian youth lower on externalizing and internalizing scores than the youth rated themselves. Such discrepancies in teacher/student perception may help explain API underutilization, for if teachers do not perceive API youth to be acting out it is unlikely that they will refer them for mental health services.

Coercive referrals stemming from school discipline.

Since the school-based mental health center models only eliminate practical barriers, and

they are just one among many others that hinder youth of color's help seeking, it is possible that some adolescents involved in school-based mental health services did not arrive there under purely voluntary conditions (Barker & Adelman, 1994; Cauce et al., 2002). Such an analysis is supported by evidence that Latino and African American youth are overrepresented in coercive mental health services offered in community settings (Takeuchi, Bui, & Kim, 1993; May Yeh et al., 2002). Other research has demonstrated that African American and Latino youth, regardless of socioeconomic status, are disproportionately disciplined in schools because of differential teacher treatment of behavioral infractions in the classroom (Gordon, Della Piana, & Keleher, 2000; Skiba, Michael, Nardo, & Peterson, 2002). There is emerging evidence that school staff view API and White youth as less threatening than peers of other racial backgrounds (Morris, 2005). Therefore, Latino and African American students may be more likely to enter school-based services because of disciplinary sanctions that involve mandates for youth participation, whereas White and API youth may be less likely to enter for such reasons. Instead of objectively identified need, it is possible that these decisions and referrals stem from subjective responses to unfamiliar, feared or forbidden student behaviors and uses of language that school professionals perceive to be abnormal or unreasonable.

This perspective is bolstered by research in special education that suggests such programs serve a social control function in schools as they legitimize the removal of "deviant" students from regular classrooms in order to minimize behaviors teachers find challenging (Barton & Tomlinson, 1981). It may be that the same student behaviors teachers interpret as problematic, or indicative of mental health need, actually represent disengagement from culturally unresponsive teaching (Downey & Pribesh, 2004). In fact, the quality of teaching does matter in the identification of children for special education; when instruction is poor, more students are identified as learning disabled, but if those same students are placed in classrooms with better teachers who focus their instruction on problem areas, these same students are able to succeed (Dudley-Marling & Dippo, 1995; Ysseldyke, 2001).

Organizational dynamics.

Referral, assessment and intervention decisions made by school professionals are influenced by the organizations within which they work and the larger social, political and historical contexts that shape these educational institutions (Dudley-Marling, 2004). Here, attention is shifted to the pressures and policies that inform the behaviors of institutional agents. Although research regarding the role of organizational dynamics in perpetuating racial and ethnic disparities is limited, some studies have considered how disproportionalities in special education may reflect broader challenges faced by schools in meeting the needs of an increasingly diverse student body. For example, research has demonstrated that the presence of a court order for integration in mixed race districts (less than 57% minority) is positively correlated with the overrepresentation of students of color in special education (Eitle, 2002). Furthermore, as individual schools become more integrated, they also are more likely to reflect racial disproportionality in their special education programs (Eitle, 2002). Finally when schools are

accountable to high stakes tests, referral and enrollment rates for special education increases (Ysseldyke, 2001).

In light of these findings, theorists have argued that exclusionary practices, such as special education assignment or enrollment in mental health treatment, masks the inability of public schools to serve students of color equitably and instead locates the problem in the behaviors and minds of individual children (Dudley-Marling & Dippo, 1995). As the consequences of student failure increase for schools, the identification of students with learning disabilities and, potentially, mental health problems, serves to transfer “the blame [from schools] to students through medicalizing and objectifying discourses” (Skirtic, 2005, p. 149). This approach affectively absolves schools from acknowledging their failure to teach all students effectively (Dudley-Marling, 2004). As such, higher referrals of Latino and African American youth, coupled with lower rates of White and API referrals to school-based mental health services may reflect schools’ maladaptive attempts to cope with growing demands to raise standardized achievement amongst an increasingly diverse student body. Attention to these organizational dynamics illustrates that school-based mental health services may serve interests other than those of young people.

Conclusion

As this review illustrates, the problem of racial and ethnic disproportionalities in school based mental healthcare is complicated and multi-faceted. Lower risk taking behaviors amongst API youth, cultural constraints, and the nature of the school context all contribute to underrepresentation of Chinese American youth in Wellness services. Existing research suggests that the following practices may increase Chinese American students service use: 1) training teachers to identify and refer Chinese American youth who may be experiencing internalizing or psychosomatic symptoms, 2) hiring additional staff who share these adolescents’ ethnic background (May Yeh, Eastman, & Cheung, 1994; M. Yeh, Takeuchi, & Sue, 1994), 3) tailoring health education and outreach efforts to reflect the psychological challenges, symptom manifestation and risk factors most often experienced by Chinese American youth, and 4) incorporating mental health clinicians into non-stigmatized services where students can build relationships with staff and receive support without officially accessing mental health treatment.

However, additional research is sorely needed to discern which factors play a larger role in these youths’ underutilization of mental health treatment. Moreover, evaluations on effective interventions to improve Chinese American youths’ service use are almost nonexistent. Both types of inquiry are necessary in order to understand the causes of, and solutions to, racial and ethnic disproportionalities.

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