

CLOSING THE CARE GAP

UNDERSTANDING ASIAN
AMERICAN YOUTH AT-RISK
FOR SUICIDE IN
LOS ANGELES COUNTY

BELINDA C. CHEN, JOYCE H.L. LUI,
LISA A. BENSON, YEN-JUI R. LIN,
NINEZ A. PONCE, AND ANNA S. LAU



ACKNOWLEDGEMENTS

This research is a collaborative effort of the UCLA Asian American Studies Center, the UCLA Department of Psychology, and the Los Angeles County Department of Mental Health. It was made possible with the generous support of the UCLA Asian American Studies Center under the Ogata Fund and the Asian American Pacific Islander Policy Initiative.

DISCLAIMER

The views expressed herein are those of the authors and not necessarily those of the University of California, Los Angeles. The authors alone are responsible for the content of this report.

CONTACT

Belinda C. Chen, belindachen2@ucla.edu



TABLE OF CONTENTS

EXECUTIVE SUMMARY4

INTRODUCTION5

DATA & FINDINGS6

CONCLUSIONS & RECOMMENDATIONS13

ABOUT THE AUTHORS16

REFERENCES.....17



EXECUTIVE SUMMARY

AAPI youth remain underrepresented in public mental health services, but this belies their actual levels of mental health need. AAPI youth are more likely to be served during emergency psychiatric crisis encounters than in routine mental health services in general. After a psychiatric emergency encounter, AAPI youth are less likely to receive follow-up mental healthcare compared to other racial/ethnic groups. Our analyses produced six key findings:

KEY FINDINGS

1. AAPI youth who received LA County MCR services were **fourteen years old on average and female (53.1%), deemed a danger to themselves (69.2%), and placed on legal hold for hospitalization (59.6%).**
2. AAPI youth who received MCR services represent a **highly diverse group**, encompassing **eighteen different ethnicities** falling into East Asian (39.1%), Southeast Asian (33.8%), South Asian (0.9%), Native Hawaiian/Pacific Islander (5.4%), multiple AAPI ethnic identifications (5.7%), and identities described as “Other Asian” (15.2%).
3. The **majority of MCR calls for AAPI youth originated from schools (57.8%)**, suggesting that schools are where AAPI youth acute mental health need and potential suicidality are commonly identified.
4. Within Los Angeles County Department of Mental Health (LACDMH), **AAPI youth are represented in MCR services at higher rates than they are in routine outpatient mental health services**, suggesting that AAPI youth may not receive care until mental health acuity and severity are high.
5. At the community level, AAPI youth tend to live in neighborhoods with **high levels of overall opportunity but also high levels of overall and educational opportunity inequality** – the latter condition is linked to higher local rates of youth MCR encounters.
6. Among youth of all racial/ethnic groups, **AAPI youth are the least likely to receive follow-up therapy** in general and receive fewer therapy sessions following an MCR encounter.

The following is a summary of recommendations, detailed in the report:

Mobile crisis response (MCR) programs provide rapid stabilization services for individuals who may be at-risk of harming themselves or others, or who are unable to access food, shelter, or clothing due to a mental disorder. In LA County, MCR teams consist of licensed clinicians and law enforcement officers who are dispatched to assess individuals after receiving calls from community sources (e.g. schools, residences, police departments, mental health clinics). Upon dispatch, the team evaluates and triages individuals to care for their assessed risk level, which may include transportation to a 72-hour involuntary hospitalization.

RECOMMENDATIONS

1. **Map areas of high need where AAPI youth reside**, particularly neighborhoods with higher AAPI youth density and high levels of overall opportunity and educational inequality, and identify schools where AAPI emergency encounters may be concentrated.
2. **Identify needed supports for schools** as a common point of entry into emergency care.
3. **Prepare educators** to meet the needs of AAPI youth experiencing psychiatric emergencies.
4. Build upon **community mental health awareness promotion and stigma reduction campaigns** to increase culturally appropriate outreach to AAPI caregivers around youth suicide prevention as well as early identification and intervention.
5. Co-design **outreach efforts** with trusted community mental health professionals, educators, and AAPI youth and families with lived MCR service experiences.
6. Deploy **culturally responsive, bilingual care navigators** trained to facilitate access and engagement in follow-up mental health services after an MCR encounter that are aligned with the needs of AAPI families.
7. Identify and streamline pathways into **outpatient community-based care** for AAPI youth identified as at-risk for suicide who have Medi-Cal, private insurance, or no/limited insurance coverage.

8. Implement statewide benefit mandates for private/commercial insurance to cover both preventive and post-crisis stabilization mental health services across all plan types.

INTRODUCTION

Youth suicide is a critical and costly public health concern. Suicide is the second leading cause of death among youth ages ten to twenty-four in the U.S. (Lowry et al., 2014) and rates of child and adolescent hospitalization due to suicide risk have more than doubled over the past decade (Plemmons et al., 2018).

Despite skyrocketing rates of youth suicidality, less than one in five youth who have suicidal thoughts and behaviors receive mental health care in the community (Cummings & Druss, 2010). Timely linkage to follow-up mental health care after a suicidal episode is critical to decreasing future suicide attempts and hospitalizations, yet fewer than half of youth who attempt suicide receive mental health care within one year after their hospital discharge (Fontanella et al., 2020). Public mental health systems have not been resourced to address the rise in youth suicide, with the costliest consequences incurred by youth from racial/ethnic minoritized groups.

Among youth at-risk for suicide, Asian American and Pacific Islander (AAPI) youth are an underserved yet high-risk group (Hwang et al., 2008; LaSalle et al., 2017). AAPI youth receive less mental health care for mood and anxiety disorders in general (Martinez, Gudiño, & Lau, 2013; Gudiño

et al., 2009). Furthermore, recent data indicate that following identification of suicide-related risk in schools, AAPI students are less likely to receive follow-up care than their White and Latine peers and their caregivers are less likely to consent to mental health services (Kim et al., 2018).

Factors driving the mental health care gap for AAPI youth at-risk for suicide are not well understood. This report presents key findings on disparities in mental health care continuity for at-risk AAPI youth who received psychiatric emergency care from the Los Angeles County Department of Mental Health (LACDMH) Mobile Crisis Response (MCR) Team between October 2016 to October 2019 (Acevedo-Garcia et al., 2020). This report is motivated by the need for timely information about barriers to care continuity for vulnerable AAPI youth populations that have largely been overlooked in research and policy.

DATA & FINDINGS

IDENTIFYING THE AAPI YOUTH WHO RECEIVE MOBILE CRISIS RESPONSE SERVICES

To date, research on MCR response across the country has been limited, and little is known about the AAPI youth who receive care through these services. Because Los Angeles County and LACDMH serve diverse youth and are the most populous county and largest county public mental health system in the U.S., respectively, LACDMH MCR services offer a unique opportunity to understand the AAPI youth who receive community-based mobile crisis response services

for psychiatric emergencies. This is a particularly timely investigation given the July 2022 implementation of the 988 National Suicide Prevention Lifeline to provide emergency mental health support services nationwide (SAMHSA, 2022).

As shown in **Figure 1**, AAPI youth (n = 778) comprised 3.7% of the 20,782 youth who received a LACDMH MCR response between October 2016 and October 2019.

Additionally, **Figure 2** shows the most common (i.e. average) demographic and service characteristics for AAPI youth served by MCR. Mood disorders include anxiety and depression disorders.

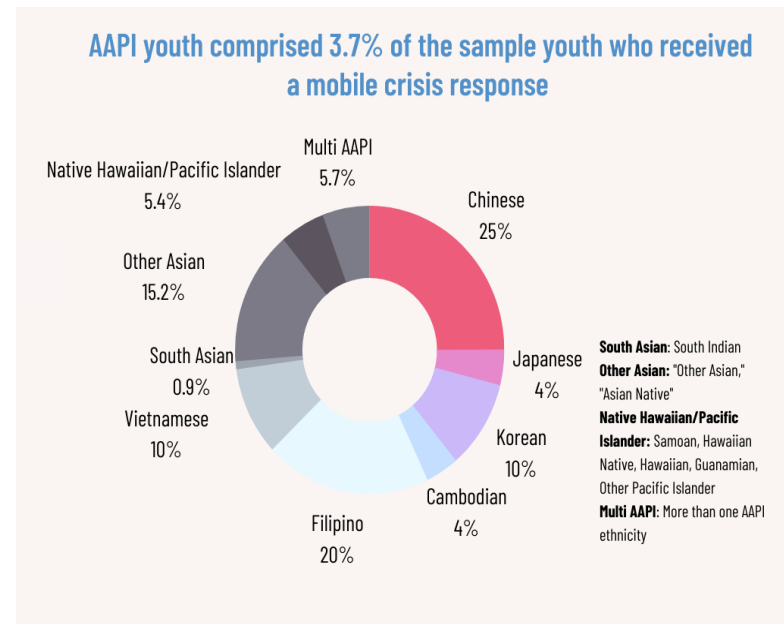


Figure 1: Breakdown of AAPI youth who received a LACDMH MCR response by ethnicity.

On average, AAPI youth who received MCR services were / had:

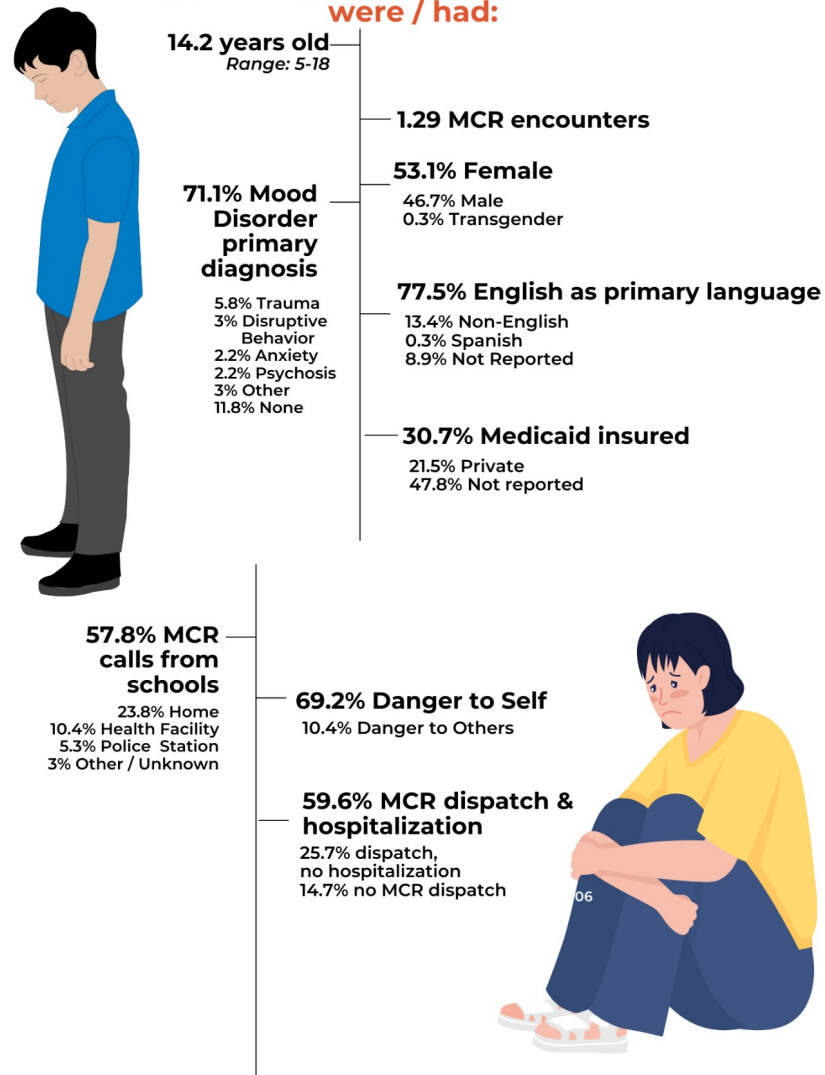


Figure 2: Demographic and service characteristics of AAPI youth who received a LACDMH MCR response.

AAPI youth are underrepresented in mental health services overall, but present for care more often in emergency MCR encounters

Overall, AAPI youth are underrepresented in mental health services relative to their population representation. AAPI youth represent 12.5% (1 in 8) of the LA County youth population, but AAPI youth were only 1.9% (1 in 50) of the youth served by LACDMH across all mental health services.

The underrepresentation of AAPI youth in routine LACDMH service utilization relative to their county representation should not be interpreted as evidence of low rates of mental health need. **AAPI youth disproportionately are served in MCR services compared to services in general.** AAPI youth represented 3.7% (1 in 30) of total youth who received MCR.

This pattern suggests that AAPI youth with mental health needs may not receive treatment until they are in a crisis state. AAPI youth mental health need is under-identified and underserved. The model minority stereotype may lead community gatekeepers (e.g., educators, health professionals) to systematically underdetect AAPI youth mental health needs, and low mental health literacy as well as stigma interfere with self and caregiver identification of need (Guo et al., 2014; Fung & Lau, 2010).

1 in 8

Youth in LA County are AAPI



1 in 50

youth served by LACDMH between 2016-2019 were AAPI



1 in 30

youth who received an MCR encounter were AAPI



Conditions of opportunity inequality in neighborhoods where AAPI youth live are linked to occurrence of psychiatric emergency encounters

AAPI youth in LA County tend to live in neighborhoods with higher overall levels of opportunity compared to other youth of color (but not compared to White youth). **Yet, AAPI youth also live in neighborhoods with higher levels of overall, education, social and economic, and health and environment opportunity inequality, all of which are linked to higher local frequency of youth MCR encounters.**

After controlling for other neighborhood conditions (e.g., racial composition, neighborhood opportunity, and opportunity inequality levels), neighborhood educational opportunity inequality independently predicted MCR encounter frequency.

Figure 3 shows that AAPI youth in LA County tend to live in neighborhoods with higher levels of education opportunity inequality.

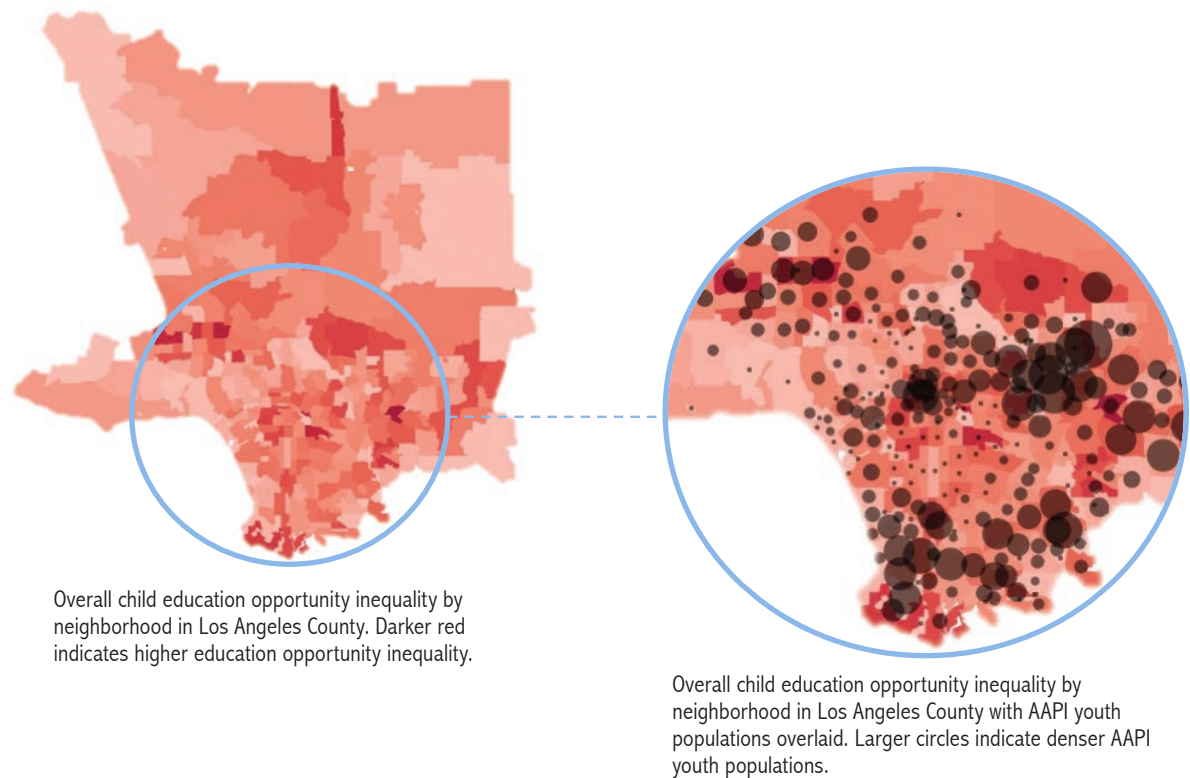


Figure 3: Education opportunity inequality by neighborhood in LA County overlaid with AAPI youth population density.

Furthermore, **Figure 4** shows that AAPI youth in LA County tend to live in neighborhoods with higher levels of overall opportunity inequality.

Neighborhood-level opportunity was measured using publicly available data from the Child Opportunity Index, which measures the quality of overall, education, social and economic, and health and environment resources and conditions necessary for healthy child development in every large metropolitan area in the United States.

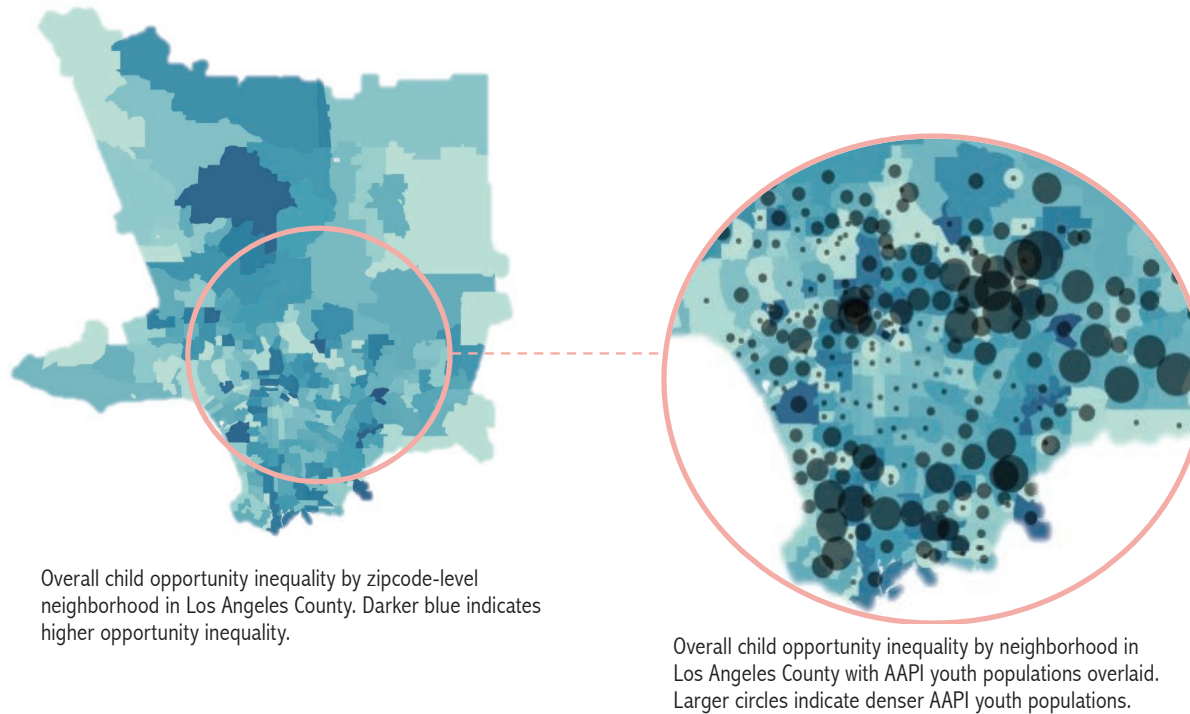


Figure 4: Overall opportunity inequality by neighborhood in LA County overlaid with AAPI youth population density.

AAPI YOUTH RECEIVE LESS FOLLOW-UP CARE AFTER A PSYCHIATRIC EMERGENCY

Receiving timely follow-up therapy after a psychiatric emergency encounter is critical to decreasing future suicidal thoughts, behaviors, and hospital readmissions. Of concern, AAPI youth have lower odds of receiving follow-up care after an emergency MCR encounter than youth of all other racial/ethnic groups:

AAPI youth have lower odds (.75 x) of receiving **any** outpatient therapy after an MCR encounter than youth of all other races/ethnicities.*

and

AAPI youth have lower odds (.77 x) of receiving **8+** sessions of therapy after an MCR encounter than youth of all other races/ethnicities.*

* indicates results after controlling for youth age, sex, clinical diagnoses, MCR call location, classification of youth as danger to self or others, MCR follow-up period, history of outpatient care receipt, and socioeconomic index of MCR call location.

8+ sessions was used as a measure of a “reliable dose” of therapy after an MCR encounter because multiple research studies suggest that on average, patients in community settings begin to experience clinical improvement after a minimum of eight therapy sessions.

We also identified notable disparities between the average number of therapy sessions AAPI youth received after an emergency MCR encounter compared to youth of all other racial/ethnic groups.

As shown in **Figure 5**, AAPI youth received the least number of follow-up therapy sessions after an MCR compared to youth of all other races/ethnicities.

On Average, AAPI Youth Received Fewer Therapy Sessions Than Youth from Other Racial/Ethnic Groups Following an MCR

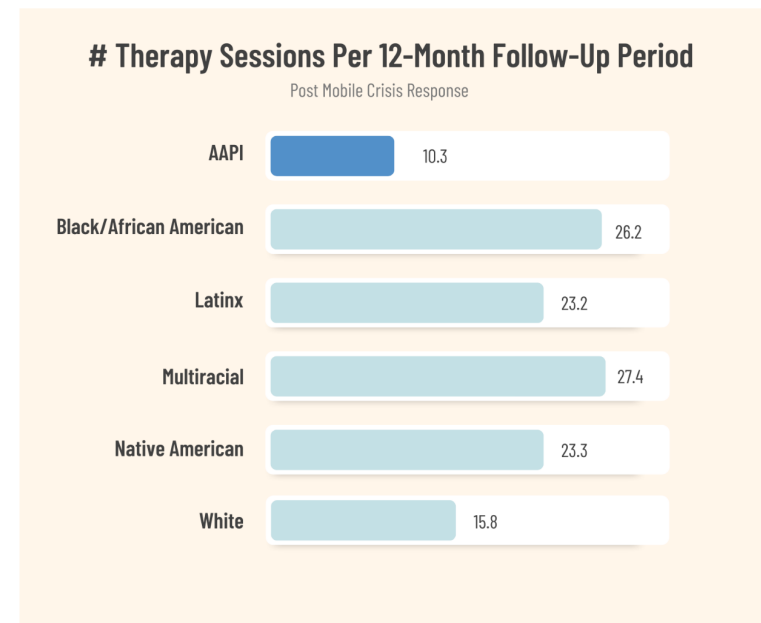


Figure 5.

Furthermore, as shown in **Figure 6**, AAPI youth were the least likely to receive eight or more therapy sessions following an MCR compared to youth of all other races/ethnicities.

Finally, to identify barriers and facilitators of care continuity, we investigated predictors of receiving eight or more sessions of therapy following an MCR encounter for

Only 34.2% of AAPI Youth Received 8+ Therapy Sessions Following a Mobile Crisis Response

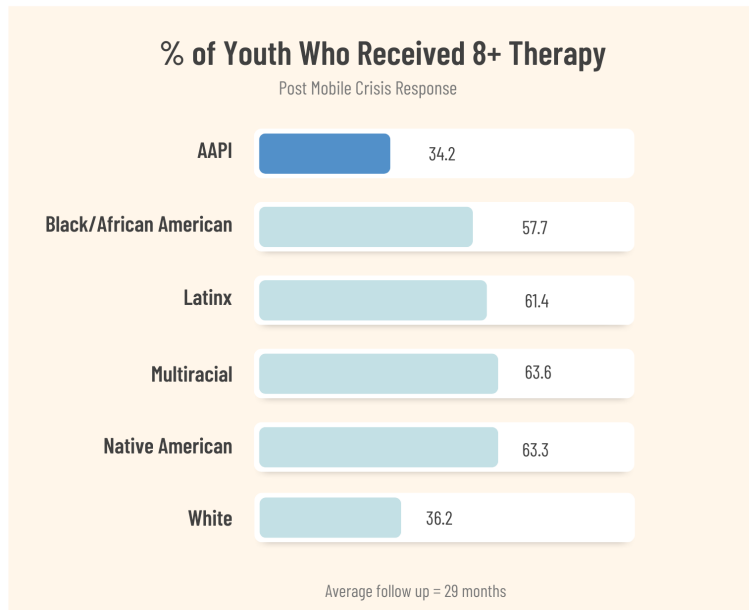


Figure 6: Percentage of youth who received eight or more therapy sessions following an MCR response by racial/ethnic group.

AAPI youth. Among AAPI youth, speaking a non-English primary language and having more MCR encounters were associated with higher odds of receiving eight or more therapy sessions (**Figure 7**). In comparison, having private insurance or no reported insurance was associated with lower odds of receiving eight or more therapy sessions.

Odds of Receiving 8+ Therapy Sessions

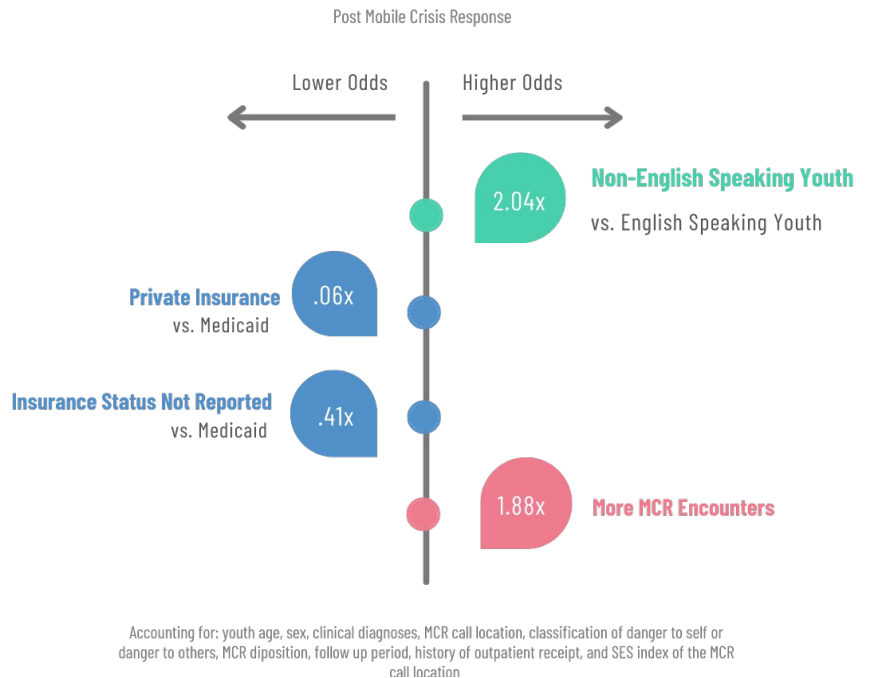


Figure 7: Spectrum of AAPI youths' odds of receiving eight or more therapy sessions by various characteristics.

AAPI with private insurance and insurance status not reported had lower odds of receiving follow-up therapy from LACDMH than AAPI youth with Medicaid. Though we cannot determine if AAPI youth without insurance or without Medicaid received care elsewhere, there is nonetheless cause for concern that these AAPI youth fall through the cracks of a fragmented service system. Harmonized data from public *and* private health systems are needed to draw conclusions about care continuity following psychiatric emergency encounters for AAPI youth. Additionally, AAPI youth who had more MCR encounters had higher odds of receiving eight or more sessions of therapy. Numerous MCR encounters may signal more chronic and severe mental illness and multiple opportunities to link to care. Finally, non-English speaking AAPI youth were more likely to receive eight or more sessions of therapy. Additional data on where and by whom non-English speaking and English-speaking AAPI youth are served (e.g., ethnic specific services) may shed light on explanations for this difference in engagement.

CONCLUSIONS & RECOMMENDATIONS

This report is the latest to document a concerning mental health care gap for AAPI youth at-risk for suicidal thoughts and behaviors. One of the key care indicators for decreased risk of repeated suicide attempts and hospital readmissions is timely connection to follow-up therapy after psychiatric hospitalization. On this measure, AAPI youth fared the worst

compared to all other racial/ethnic groups. Our findings indicate that AAPI youth not only receive the lowest average number of therapy sessions in the year following a psychiatric emergency encounter, but they also have lower odds of receiving any therapy at all, as well as receiving a dose of therapy (eight or more sessions) associated with meaningful clinical change.

Coordinated, stakeholder-engaged partnerships are necessary to serve AAPI youth mental health needs more appropriately and adequately. At the neighborhood level, areas of high overall opportunity and education inequality must be identified. Within neighborhood schools, culturally responsive approaches to suicide risk identification and care linkage are necessary. Workforce training and community outreach efforts are sorely needed to reduce the systematic under-detection of earlier signs of psychological distress among AAPI youth. At the health-system level, care navigation services are indicated to increase receipt of follow-up care and culturally responsive care coordination that can attend to caregiver mental health literacy and medical trust concerns. Finally, the structural challenges associated with low continuity of care in a fragmented service system will remain significant barriers to care continuity for AAPI youth as well as all other youth served in the County. MCR encounters may represent an unrealized venue for engaging AAPI youth with significant need in the care system. Novel partnered approaches are needed to ensure that AAPI youth whose acute needs have at last been recognized are served well.

Informed by the findings described in parts one through four of this report, we recommend that the following actions are taken to address observed inequities for AAPI youth:

1. **Map areas of high need and identify schools where AAPI youth emergency encounters may be concentrated.**

- This can include neighborhoods with higher AAPI youth density and high levels of overall opportunity inequality and educational inequality, as well as high-need schools that frequently deploy MCR services for students.
- The Child Opportunity Index (Acevedo-Garcia et al., 2020; Noelke et al., 2020) is publicly available at the zip code and census tract levels and can be used to identify neighborhoods in LA County with high levels of opportunity inequality.
- Mapping geolocations of potential areas and schools of highest need can inform LACDMH service planning efforts. The Los Angeles County Office of Education Community Schools Initiative could also be a natural partner in this work.

2. **Identify needed supports for schools as a common point of entry into emergency care.**

- Conduct stakeholder-engaged local needs assessments at high-need schools and in schools located in identified “high-risk” neighborhoods for AAPI youth.
- Partner with community-based organizations, key opinion leaders, families, and youth representing the diverse range of AAPI groups served in Los Angeles.

3. **Prepare educators to meet the needs of AAPI youth experiencing psychiatric emergencies.**

- Develop and disseminate culturally responsive training specific to needs of AAPI youth and families for educators in high AAPI enrollment schools that aligns with the requirements of AB 2246 & AB 1767.
- Community-engaged research with the local AAPI community and trusted mental health providers can guide the augmentation and tailoring of suicide prevention training and policies that is already required in California local educational authorities.
- Center the experiences of AAPI youth and families with lived experiences in this work

4. **Build upon community mental health awareness promotion and stigma reduction campaigns to increase culturally appropriate outreach to AAPI caregivers around youth suicide prevention and early identification and intervention.**

- Research suggests that some reasons AAPI youth do not receive routine mental health services intended to prevent psychiatric emergency include low acceptance of services by AAPI youth and caregivers (Kim et al., 2018), limited mental health literacy and understanding of treatment among caregivers (Wang et al., 2019), and caregiver language barriers (Guo et al., 2014).
- Increasing and funding culturally appropriate outreach to reduce barriers to connecting with AAPI in all threshold AAPI languages and disseminating outreach

materials in traditional and social media outlets with known penetration across diverse AAPI communities are promising potential approaches.

5. **Co-design outreach efforts with trusted community mental health professionals, educators, and AAPI youth and families with lived experience with MCR services.**

- Engaging stakeholders who are involved at every point of the AAPI youth care process—from need recognition, to initiation of mental health services, to connection to ongoing follow-up therapy—is critical to providing AAPI youth and families with access to services that appropriately serve their needs without stigmatizing their concerns.
- Partnering with leaders and community members representing the diversity of the AAPI community is essential to inform development of culturally appropriate outreach content and dissemination strategies.

6. **Deploy culturally responsive, bilingual care navigators trained to facilitate access and engagement in follow-up mental health services after an MCR encounter that are aligned with the needs of AAPI families.**

- Research suggests that lower levels of AAPI caregiver consent for follow-up mental health services among youth who experience psychiatric emergencies in schools may be because students and parents feel excluded from decision-making processes and report having traumatic experiences with crisis intervention (Kodish et al., 2020).

- Culturally responsive, bilingual care navigators can help families transcend access barriers and can support care coordination that prioritizes youth and caregiver involvement. Family-centered discharge planning has been associated with increases in entry into follow-up care by one week and one-month post-discharge (Haselden et al., 2019). Care navigators can help to demystify services, identify and link families to services for which youth are eligible and covered, and mitigate mistrust in the mental healthcare system in service of increasing engagement with follow-up specialty care.

7. **Identify and streamline pathways into outpatient community- and school-based care for AAPI youth following MCR encounters whether they have Medi-Cal, private insurance, or no/limited insurance coverage.**

- LACDMH outpatient care is available to youth who are Medi-Cal eligible, yet youth with and without Medi-Cal are served in MCR services.
- For AAPI youth who are significantly underrepresented in LACDMH services, initial recognition of need through mobile response crisis services represents a potentially crucial pathway into care.
- Public-private partnerships and more inclusive third-party payor options should be explored for AAPI youth identified with suicidal risk post-MCR stabilization.

8. **Implement statewide benefit mandates for private/commercial insurance to cover both preventive and**

post-crisis stabilization mental health services across all plan types.

- 73% of Asian American and 84% of Native Hawaiian/Pacific Islander youth ages 0-17 receive health insurance through employment-based or privately purchased insurance programs in California¹⁹. Our analyses indicate that privately-insured AAPI youth have lower odds of receiving LACDMH follow-up services after a psychiatric emergency. Due to fragmented and poorly coordinated systems of care, a large portion of AAPI youth in California are at-risk for poor care continuity after a mental health crisis is detected in public safety net services.
- Although the 2020 amendment to the California Mental Health Parity Act required all insurance plans (individual, small group, large group/managed care) to provide behavioral health benefits, not all insurance plan types are required provide coverage for preventive and post-crisis stabilization mental health services.
- Preventive mental health services (i.e. screening, outpatient care for early illness phase) should be covered to reduce the number of AAPI youth who require acute crisis services when mental health conditions become more intractable).
- Health system and provider performance metrics should include wait times for linkage to ongoing outpatient care following crisis intervention and hospitalization for suicidal thoughts and behaviors.

ABOUT THE AUTHORS

Belinda C. Chen, M.A. is a clinical psychology doctoral student at the University of California, Los Angeles.

Joyce H.L. Lui, Ph.D., is a project scientist at the University of California, Los Angeles, and an Assistant Professor in the Department of Psychology at Concordia University.

Lisa A. Benson, Ph.D. is a supervising psychologist in the Office of Clinical Informatics at the Los Angeles County Department of Mental Health.

Yen-Jui R. Lin, Ph.D. is a clinical psychologist in the Office of Clinical Informatics at the Los Angeles County Department of Mental Health.

Ninez A. Ponce, MPP, Ph.D. is a professor in the Fielding School of Public Health Department of Health Policy and Management at the University of California, Los Angeles.

Anna S. Lau, Ph.D. is a professor in the department of Psychology at the University of California, Los Angeles.

REFERENCES

- Acevedo-Garcia, D., Noelke, C., McArdle, N., Sofer, N., Hardy, E. F., Weiner, M., Baek, M., Huntington, N., Huber, R., & Reece, J. (2020). Racial And Ethnic Inequities In Children's Neighborhoods: Evidence From The New Child Opportunity Index 2.0. *Health affairs (Project Hope)*, *39*(10), 1693–1701. <https://doi.org/10.1377/hlthaff.2020.00735>
- Cummings, J. R., & Druss, B. G. (2011). Racial/ethnic differences in mental health service use among adolescents with major depression. *Journal of the American Academy of Child and Adolescent Psychiatry*, *50*(2), 160–170. <https://doi.org/10.1016/j.jaac.2010.11.004>
- Fontanella, C. A., Warner, L. A., Steelesmith, D. L., Brock, G., Bridge, J. A., & Campo, J. V. (2020). Association of Timely Outpatient Mental Health Services for Youths After Psychiatric Hospitalization With Risk of Death by Suicide. *JAMA Network Open*, *3*(8), e2012887. <https://doi.org/10.1001/jamanetworkopen.2020.12887>
- Fung, J. J., & Lau, A. S. (2010). Factors associated with parent-child (dis)agreement on child behavior and parenting problems in Chinese immigrant families. *Journal of clinical child and adolescent psychology : the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, *39*(3), 314–327. <https://doi.org/10.1080/15374411003691693>
- Gudiño, O. G., Lau, A. S., Yeh, M., McCabe, K. M., & Hough, R. L. (2009). Understanding racial/ethnic disparities in youth mental health services: Do disparities vary by problem type? *Journal of Emotional and Behavioral Disorders*, *17*(1), 3–16. <https://doi.org/10.1177/1063426608317710>
- Guo, S., Kataoka, S.H., Bear, L., & Lau, A.L. (2014). Differences in School-Based Referrals for Mental Health Care: Understanding Racial/Ethnic Disparities Between Asian American and Latino Youth. *School Mental Health* **6**(1), 27–39. <https://doi.org/10.1007/s12310-013-9108-2>
- Haselden, M., Corbeil, T., Tang, F., Olfson, M., Dixon, L. B., Essock, S. M., Wall, M. M., Radigan, M., Frimpong, E., Wang, R., Lambert, S., Schneider, M., & Smith, T. E. (2019). Family Involvement in Psychiatric Hospitalizations: Associations With Discharge Planning and Prompt Follow-Up Care. *Psychiatric services (Washington, D.C.)*, *70*(10), 860–866. <https://doi.org/10.1176/appi.ps.201900028>
- Hwang, W.C., & Ting, J. Y. (2008). Disaggregating the effects of acculturation and acculturative stress on the mental health of Asian Americans. *Cultural Diversity and Ethnic Minority Psychology*, *14*(2), 147–154. <https://doi.org/10.1037/1099->
- Kim, J. J., Kodish, T., Bear, L., El-Hendi, T., Duong, J., & Lau, A. S. (2018). Disparities in follow-up care for Asian American youth assessed for suicide risk in schools. *Asian American Journal of Psychology*, *9*(4), 308–317. <https://doi.org/10.1037/aap0000136>
- Kodish, T., Kim, J. J., Le, K., Yu, S. H., Bear, L., & Lau, A. S. (2020). Multiple stakeholder perspectives on school-based responses to student suicide risk in a diverse public school district. *School Mental Health: A Multidisciplinary Research and Practice Journal*, *12*(2), 336–352. <https://doi.org/10.1007/s12310-019-09354-w>
- LaSalle, T. P., Wang, C., Brown, J., & Parris, L. (2017). Associations between school climate, suicidal thoughts and behaviors and demographics among middle school students. *Psychology in the Schools*, *54* (10), 1294–1301. doi.10.1002/pits.22078
- Lau, A. S. (2006). Making the Case for Selective and Directed Cultural Adaptations of Evidence-Based Treatments: Examples From Parent Training. *Clinical Psychology: Science and Practice*, *13*(4), 295–310. <https://doi.org/10.1111/j.1468-2850.2006.00042.x>

- Lowry, R., Crosby, A. E., Brener, N. D., & Kann, L. (2014). Suicidal thoughts and attempts among U.S. High school students: trends and associated health-risk behaviors, 1991-2011. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*, 54(1), 100–108. <https://doi.org/10.1016/j.jadohealth.2013.07.024>
- Martinez, J. I., Gudiño, O. G., & Lau, A. S. (2013). Problem-specific racial/ethnic disparities in pathways from maltreatment exposure to specialty mental health service use for youth in child welfare. *Child maltreatment*, 18(2), 98–107. <https://doi.org/10.1177/1077559513483549>
- Noelke, C., McArdle, N., Baek, M., Huntington, N., Huber, R., Hardy, E., & Acevedo-Garcia, D. (2020). Child Opportunity Index 2.0 Technical Documentation. Retrieved from

diversitydatakids.org/researchlibrary/research-brief/how-we-built-it.

- Plemmons, G., Hall, M., Douppnik, S., Gay, J., Brown, C., Browning, W., Casey, R., Freundlich, K., Johnson, D. P., Lind, C., Rehm, K., Thomas, S., & Williams, D. (2018). Hospitalization for Suicide Ideation or Attempt: 2008-2015. *Pediatrics*, 141(6), e20172426. <https://doi.org/10.1542/peds.2017-2426>
- SAMHSA (2022). <https://www.samhsa.gov/find-help/988/key-messages>.
- Wang, C., Do, K. A., Frese, K., & Zheng, L. (2019). Asian immigrant parents' perception of barriers preventing adolescents from seeking schoolbased mental health services. *School Mental Health: A Multidisciplinary Research and Practice Journal*, 11(2), 364–377. <https://doi.org/10.1007/s12310-018-9285-0>





LOS ANGELES COUNTY
**DEPARTMENT OF
MENTAL HEALTH**
hope. recovery. wellbeing.

UCLA

**Asian American
Studies Center**

<https://aasc.ucla.edu>