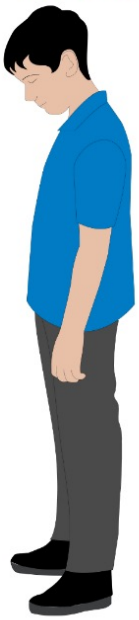
Research Brief | November 2022

UCLA Asian American Studies Center
ASIAN AMERICAN & PACIFIC ISLANDER POLICY INITIATIVE

CLOSING THE CARE GAP

Understanding Asian American and Native Hawaiian/Pacific Islander Youth At Risk for Suicide in Los Angeles

Youth suicide is a critical public health concern. Suicide is the second leading cause of death among youth ages 10-24 in the U.S., and rates of youth hospitalization due to suicide risk have more than doubled over the past decade. Despite skyrocketing rates of youth suicidality, less than 1 in 5 youth who have suicidal thoughts and behaviors receive mental health care. Timely linkage to follow up mental health care after a suicidal episode is critical to decreasing future attempts and hospitalizations, yet fewer than half of youth who attempt suicide receive mental health care within one year after their hospital discharge.



Among youth at risk for suicide, Asian American and Native Hawaiian/Pacific Islander (AANHPI) youth are an underserved yet high-risk group. AANHPI youth receive less mental healthcare for mood and anxiety disorders in general, and after identification of suicide risk in schools, AANHPI students are less likely to receive follow-up care and caregiver consent to services compared to youth from other racial/ethnic groups. Factors driving the care gap for AANHPI youth at-risk for suicide are not well understood. We present key findings on disparities in care continuity for AANHPI youth who received psychiatric emergency care from the Los Angeles County Department of Mental Health (LACDMH) Mobile Crisis Response (MCR) Team from October 2016- 2019.

Key Findings

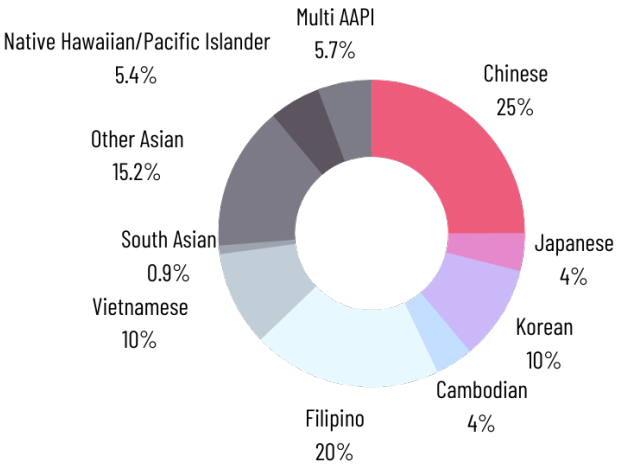
AANHPI youth are underrepresented in public mental health services, but this belies their actual mental health need. AANHPI youth are more likely to be served during psychiatric crisis encounters than in routine mental health services, suggesting that AANHPI youth don't receive care until mental health acuity and severity are high. After an emergency encounter, AANHPI youth served within LACDMH are the least likely to receive follow-up mental healthcare in general and receive fewer therapy sessions compared to youth of all other races/ethnicities.

Additional Takeaways

AANHPI youth who received LA County MCR services were, on average, 14 years old, slightly more likely to be female than male, more likely to be deemed a danger to themselves, and more likely to be placed on legal hold for hospitalization.

Most MCR calls for AANHPI youth originate from schools, suggesting that acute mental health needs and potential suicide risk are most often identified in school contexts.

AANHPI youth live in neighborhoods with high overall opportunity but also high overall and education opportunity inequality – the latter is linked to higher rates of youth psychiatric emergency encounters.



AANHPI youth who received MCR services encompassed 18 different ethnicities: East Asian, Southeast Asian, South Asian, Other Asian, Native Hawaiian/Pacific Islander, and multiple AANHPI identities.

Recommendations

1. **Map areas of high need where AANHPI youth reside**, particularly neighborhoods with high AANHPI youth density and neighborhoods with high overall and educational opportunity inequality
2. **Identify needed supports for schools** as a common point of entry into emergency care.
3. **Prepare educators to meet the needs of AANHPI youth** experiencing psychiatric emergencies.
4. Build upon community mental health awareness promotion and stigma reduction campaigns to **increase culturally appropriate outreach to AANHPI 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 AANHPI youth and families with lived experience with MCR services.
6. **Deploy culturally responsive, in-language care navigators** trained to facilitate access and engagement in follow-up mental health services after a MCR encounter that are aligned with the needs of AANHPI families.
7. **Implement statewide benefit mandates** for private/commercial insurance to cover both preventive and post-crisis stabilization mental health services across all plan types.
8. **Identify and streamline pathways into outpatient community-based care** for AANHPI youth identified as at-risk for suicide who have Medi-Cal, private insurance, or no/limited insurance coverage.

Figure 1: AANHPI youth in LA County live in neighborhoods with high education opportunity inequality. On the left, darker red indicates higher education opportunity inequality. On the right, larger circles indicate denser AANHPI populations.

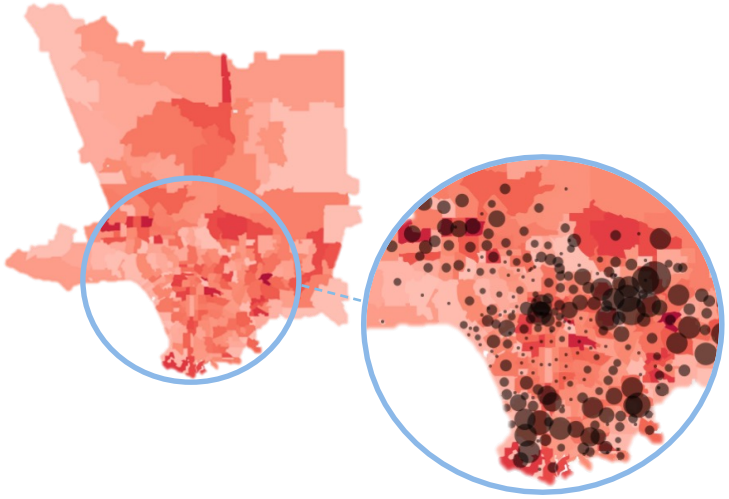
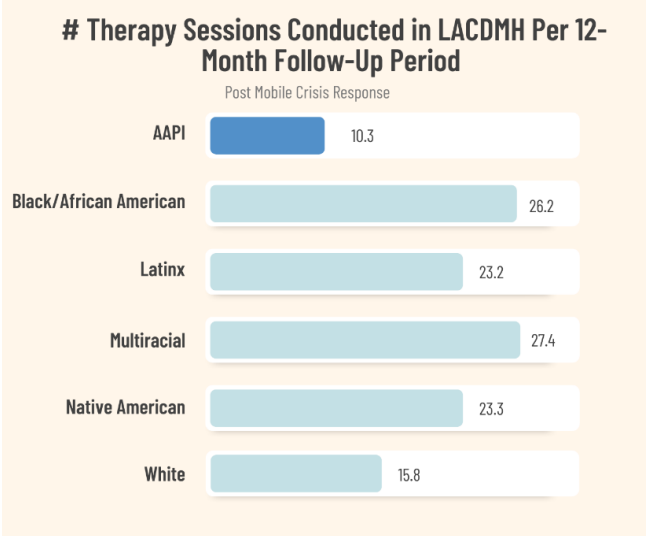


Figure 2: On average, AANHPI youth served within LACDMH received fewer therapy sessions following an MCR encounter than youth from all other racial/ethnic groups.



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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.

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