

Abstract

Asian/Pacific Islanders (API) are the fastest growing ethnic group in the United States, and recent reports suggest that API youth and adults are experiencing a mental health crisis. API often delay seeking help from mental health services, with the emergency system becoming the first point of contact for psychiatric care. There is a scarcity of research about psychiatric emergency service (PES) utilization patterns among API populations. This study analyzes electronic health records from an urban, multi-channel psychiatric emergency services program in Massachusetts, (1) comparing demographic and encounter characteristics between API and non-API populations and (2) exploring the extent to which API identity is associated with specific evaluation locations, diagnoses, and discharge dispositions. API youth and adults were more likely to be seen at acute evaluation locations (i.e. emergency departments), diagnosed with serious mental illness (i.e. psychosis), and were discharged to more intensive care settings (i.e. inpatient care). Our results underscore distinct patterns of PES utilization among API and highlight the urgency of developing targeted interventions tailored to the needs of this population.

Keywords: Asian/Pacific Islanders, mental health disparities, help-seeking behavior, psychiatric emergency services, inpatient admission, psychotic disorders, cultural barriers

Introduction

People of Asian and Pacific Islander (API) descent represent one of the fastest-growing ethnic groups in the United States (Budiman & Ruiz, 2021). Despite this growth, only 34.7% of adult APIs with a mental health need receive care—the lowest rate among other racial and ethnic groups—compared with 43.8% of Black adults, 47.4% of Hispanic adults, and 58.7% of non-Hispanic White adults (NSDUH, 2024). Many APIs delay professional help-seeking until mental health symptoms become severe and chronic (Abe-Kim, 2007, Snowden et al., 2008; Ihara et al., 2014, Lee et al., 2010), often due to cultural norms surrounding privacy, stigma, and preferences for handling distress within families or communities (Nguyen et al., 2024). Often APIs' first point of contact with the mental health system may occur during an acute crisis and in psychiatric emergency services (PES) settings (Mokhwelepa et al., 2025). Characterizing PES use among APIs is important because it can clarify unmet needs, and identify points where crisis driven entry may contribute to disparities in access and outcomes. Recent evidence further suggests that anti-Asian discrimination and hate crimes are directly associated with increased psychiatric emergency department utilization among APIs (Masoumirad et al., 2025), underscoring the urgency of understanding how APIs are served by PES.

Few studies have examined how APIs are evaluated, diagnosed, and dispositioned within PES pathways relative to other racial/ethnic groups. Snowden et al. (2008) found higher rates of hospital-based crisis service use among API youth compared to White youth, though it remains unclear whether similar patterns extend to adults. Among adults, Rotenberg et al. (2017) found that APIs presenting with psychosis were more likely than White adults to arrive at an ED involuntarily and via police or ambulance, and Nakamoto et al. (2024) found that methamphetamine-related psychiatric emergency encounters among APIs in Hawaii more

frequently involved police transport, emergency medication use, and longer lengths of stay.

These studies suggest that when APIs do access PES, the nature of those encounters may differ meaningfully from those of other groups — yet both are limited to specific clinical presentations and contexts, leaving open the question of whether these patterns hold more broadly.

The present study sought to address these gaps in the literature and further examine emergency psychiatric care pathways among API. Using electronic health record (EHR) data from an urban safety-net psychiatric emergency program, the study (1) compared demographic and clinical characteristics across API and non-API encounters and (2) explored to what extent API identity is associated with key outcomes, including evaluation location, repeat utilization, diagnoses, and discharge disposition.

Methodology

Setting

The [Masked Program] is a multi-channel PES program serving a large urban area and primarily intended for individuals who were publicly insured or uninsured ([Masked]).

Individuals access services through local emergency departments, psychiatric urgent care centers (UCCs), or mobile crisis units (MCUs) or by contacting a 24/7 call center. Detailed information about pathways to care can be found in [Masked].

Participants and Procedure

The research team conducted a retrospective chart review of EHRs from January 1, 2018 through December 31, 2022. Our sample included 101,093 encounters made by 38,170 individuals. All study procedures were approved by the [Masked] Institutional Review Board.

Measures

Sociodemographic Characteristics

API identities are distinct and deeply diverse, shaped by complex histories, migration patterns, and linguistic differences even within geographically adjacent regions (API GBV, 2017). For the purposes of this study, “API” follows the U.S. Census Bureau’s definition in accordance with guidelines provided by the U.S. Office of Management and Budget, encompassing individuals with origins in Asia (e.g., Central Asia, East Asia, Southeast Asia, or the Indian subcontinent) and Polynesia (e.g., Hawaiian, Pacific Islander; U.S. Census Bureau, 2024). Given the various, multifaceted factors that may contribute to one’s API identity, the research team considered race and language when identifying API encounters.

Massachusetts regulations require acute care hospitals to collect and report patients’ self-reported race, ethnicity, and preferred language using standardized methodology (Jorgensen et al., 2010). During the study period, [Masked Program] patients reported whether they identified with the racial groups: *American Indian or Alaska Native*, *Asian/Pacific Islander*, *Black or African American*, *Other*, or *White*. If *Other* was selected, a specific race could then be written into a text box. Ethnicity was also recorded in the EHR (*Hispanic or Latino*, *Not Hispanic or Latino*). This study classified individuals as API if race was recorded as *Asian/Pacific Islander* or *Other*, with a specific API race written in, regardless of ethnicity. The research team also used the primary language category of the EHR, classifying individuals who primarily spoke Asian languages as API.

The following data were also extracted from the EHR: age at first encounter during study period, gender (*Male*, *Female*, *Transgender/Non-Binary*), whether an interpreter was used for the encounter, and health insurance (*Public*, *Private*, *Uninsured*). Homelessness was also extracted for adults (this field is not consistently documented for youth). Within the [Masked Program]

system, individuals who are under the age of 21 are considered youth and eligible for specific services; we therefore categorized adults as those ages 21 and over.

Evaluation Location

[Masked Program] evaluations occurred at EDs, UCCs, or by MCUs at a range of community locations. These community locations included private homes, schools, and other settings (e.g., shelters, outpatient offices). We also identified encounters that occurred via telehealth. For each location, the study team computed a binary indicator variable representing whether an individual had any encounter at that location across the study period (cumulative evaluation location).

Primary Diagnosis

PES clinicians used International Classification of Disease 10th version (ICD-10) F codes to indicate the primary diagnosis associated for each encounter. For adults, diagnoses were classified into the following categories: substance use disorders (F10-F19); primary psychotic disorders (F20-F29); mood disorders (F30-F39); stress and adjustment disorders (F43), and other psychiatric disorders (all other F codes). For children, diagnostic categories also included childhood onset and development disorders (F80-89 and F90-95). Due to low prevalence of substance use diagnoses among youth in the sample, this category (F10-F19) was included in other psychiatric disorders. The study team created binary indicator variables representing whether an individual ever received each diagnosis category (cumulative primary diagnosis).

Discharge Disposition

After a psychiatric evaluation, patients could be discharged to inpatient care, crisis stabilization, or outpatient treatment. Inpatient settings provided 24-hour care, including inpatient medical settings and inpatient psychiatric programs (locked settings). Adult patients

could also be discharged to community crisis stabilization (up to 5 days of 24-hour care in an unlocked, voluntary setting). When patients were discharged to outpatient care, an appointment was made with either an existing provider or a new provider. Patients who did not require an inpatient level of care and did not want referral to outpatient treatment, they could also be discharged to the community. The study team created a binary variable for disposition type across the study period (cumulative discharge disposition).

Missing Data

The only field with substantial missing data was race (13.25% missing). Missing race data is a common issue in research utilizing EHRs, and the rate of missing data in our study is comparable or lower to rates in other observational studies (Polubriaginof et al., 2019, Cusick et al., 2020). Clinicians are not always be able to collect this data in the context of PES encounters. Individuals with missing data are included in Table 1. We also utilized a missing data indicator for race for the purposes of retaining the full sample in multivariate analyses.

Analysis

Chi-squared tests of independence were used to examine sociodemographic differences between API and non-API patients. Logistic regression was used to examine the association between API identity and evaluation location, primary diagnosis, and discharge disposition. All logistic regression models included age, gender, interpreter use, and insurance as covariates; models for adults additionally included homelessness status. Models estimating discharge disposition also included primary diagnosis as a covariate. All logistic regression results are presented as odds ratios (ORs) with 95% confidence intervals (CIs).

Results

Our sample included 1,260 API individuals (3.68% of full sample), comprising 513 youth and 747 adults, compared with 31,852 individuals from other racial groups (10,293 youth and 21,559 adults). Demographic characteristics are shown in Tables 1a (adults) and 1b (youth).

Demographic Characteristics

Adults

API adults were more likely to identify as female (51.14%) compared to Black (45.97%), Hispanic (45.07%), White (41.64%), and other adult groups; $\chi^2(15) = 152.15, p < .05$. API adults had higher private insurance rates (10.58%) compared to Black (5.39%), Hispanic (4.28%), White (6.05%), and other adult groups (4.15%); $\chi^2(5) = 54.02, p < .05$. However, API adults were more often uninsured (20.35%) compared to Black (16.58%), Hispanic (18.62%), and White counterparts (11.27%); $\chi^2(5) = 202.61, p < .05$. Fewer API adults were unhoused (9.91%) compared to Black (26.34%), Hispanic (20.67%), White (29.03%), and other groups (20.45%); $\chi^2(5) = 437.22, p < .05$. Sociodemographic comparisons by race/ethnicity are displayed in Figure S1.

Youth

API youth were more likely to identify as female (53.02%) compared to Black (50.81%), Hispanic (51.95%), White (49.70%), and other youth groups (51.93%); $\chi^2(5) = 173.30, p < .05$. API youth had higher private insurance rates (20.66%) compared to Black (14.57%), Hispanic (9.44%), and other youth (14.24%), but lower rates compared to White youth (29.59%); $\chi^2(5) = 484.38, p < .05$. API youth also had higher health safety net insurance rates (8.97%) compared to all other groups; $\chi^2(5) = 47.97, p < .05$. Sociodemographic comparisons by race/ethnicity are displayed in Figure S2.

Clinical Characteristics

Encounter Location

First Encounter Location. At first encounter, API adults were more likely to present in EDs compared to Black (OR=1.43, 95% CI [1.12, 1.79]) or Hispanic adults (OR=1.61, 95% CI [1.28, 2.08]), and less likely to present in UCCs compared to Black (OR=0.50, 95% CI [0.36, 0.70]) or Hispanic adults (OR=0.61, 95% CI [0.44, 0.85]). API youth were more likely to have first ED encounters compared to Black (OR=1.39, 95% CI [1.11, 1.72]) or Hispanic youth (OR=1.79, 95% CI [1.43, 2.22]), but less likely compared to White youth (OR=0.78, 95% CI [0.62, 0.97]). API youth were less likely to have first encounters at home than Hispanic youth (OR=0.61, 95% CI [0.47, 0.79]) and more likely to have school encounters compared to White youth (OR=2.33, 95% CI [1.64, 3.23]). ED first encounter odds ratios for adults and youth are presented in Figure 1a and Figure 1b, respectively.

Cumulative Encounter Location. API adults were more likely to have ED encounters compared to Hispanic adults (OR=1.33, 95% CI [1.09, 1.64]), less likely to have home encounters compared to Black adults (OR=0.65, 95% CI [0.48, 0.85]), less likely to have telehealth encounters compared to Black (OR=0.52, 95% CI [0.36, 0.75]) or Hispanic adults (OR=0.51, 95% CI [0.35, 0.75]), and less likely to have UCC encounters compared to Hispanic (OR=0.51, 95% CI [0.38, 0.68]) or White adults (OR=0.60, 95% CI [0.45, 0.79]).

API youth were more likely to have ED encounters compared to Hispanic youth (OR=1.41, 95% CI [1.15, 1.72]), less likely to have home encounters compared to Hispanic youth (OR=0.64, 95% CI [0.51, 0.80]) but more likely than White youth to have home encounters (OR=1.35, 95% CI [1.08, 1.72]), less likely to have telehealth encounters than Black (OR=0.74, 95% CI [0.54, 1.00]) or Hispanic youth (OR=0.70, 95% CI [0.52, 0.95]), and more likely to have school encounters than White youth (OR=2.63, 95% CI [1.96, 3.57]).

Diagnosis

API adults were less likely to receive mood disorder diagnoses compared to Hispanic (OR=0.68, 95% CI [0.57, 0.80]), White (OR=0.54, 95% CI [0.46, 0.63]), or other adults (OR=0.70, 95% CI [0.54, 0.92]), and less likely to receive substance use disorder diagnoses compared to Black (OR=0.50, 95% CI [0.35, 0.71]), Hispanic (OR=0.38, 95% CI [0.26, 0.54]), or White adults (OR=0.29, 95% CI [0.21, 0.42]). API adults were more likely to receive psychosis diagnoses compared to Hispanic (OR=2.04, 95% CI [1.69, 2.44]) or White adults (OR=2.63, 95% CI [2.22, 3.13]).

API youth were less likely to receive stress disorder diagnoses compared to Black (OR=0.59, 95% CI [0.49, 0.72]), Hispanic (OR=0.64, 95% CI [0.53, 0.78]), or other youth (OR=0.64, 95% CI [0.48, 0.85]), but more likely to receive mood disorder diagnoses compared to Black (OR=1.79, 95% CI [1.47, 2.17]), Hispanic (OR=1.54, 95% CI [1.25, 1.85]), White (OR=1.39, 95% CI [1.12, 1.69]), or other youth (OR=1.72, 95% CI [1.27, 2.38]). API youth were more likely to receive psychosis diagnoses compared to Hispanic (OR=1.79, 95% CI [1.22, 2.56]) or White youth (OR=2.13, 95% CI [1.43, 3.13]). Lifetime diagnosis odds ratios for adults and youth are presented in Figure 1a and Figure 1b, respectively.

Disposition

API adults were more likely to be referred for inpatient care than Black (OR=1.89, 95% CI [1.59, 2.27]), Hispanic (OR=1.79, 95% CI [1.49, 2.13]), or other adults (OR=1.96, 95% CI [1.45, 2.56]), and less likely to be referred to 24-hour voluntary care compared to Black (OR=0.31, 95% CI [0.23, 0.42]), Hispanic (OR=0.40, 95% CI [0.29, 0.54]), White (OR=0.40, 95% CI [0.29, 0.54]), or other adults (OR=0.39, 95% CI [0.26, 0.60]). API adults were less likely

to be referred to outpatient care compared to Black (OR=0.49, 95% CI [0.40, 0.58]), Hispanic (OR=0.57, 95% CI [0.47, 0.69]), or other adults (OR=0.59, 95% CI [0.44, 0.79]).

API youth were more likely to be referred for inpatient care compared to Black (OR=1.54, 95% CI [1.25, 1.88]) or Hispanic youth (OR=1.52, 95% CI [1.23, 1.85]), and less likely to be referred to outpatient care compared to Black (OR=0.59, 95% CI [0.48, 0.71]) or Hispanic youth (OR=0.64, 95% CI [0.52, 0.78]).

Discussion

This study used EHR data from a diverse urban safety-net PES program to examine differences in encounter characteristics and clinical pathways between API and non-API patients. Three main findings emerged: compared with several non-API groups, API patients were more likely to enter PES through acute settings, receive diagnoses associated with more severe presentations, and exit into more intensive levels of care.

Encounter Setting

Compared with several non-API groups, PES encounters among API adults and youth were more likely to occur in acute settings and less likely to occur in lower-intensity or community-based settings, across both first encounter and cumulative service patterns. Among adults, this was reflected in greater use of EDs and lower use of UCCs, home-based, and telehealth settings; among youth, in greater use of EDs and school-based settings and lower use of home-based and telehealth settings. This aligns with prior work suggesting that API populations may be less likely to access mental health care through routine outpatient pathways before crises escalate (Snowden et al., 2008; Ihara et al., 2014; Lee et al., 2010). API patients may therefore have fewer opportunities to be identified and engaged through lower-intensity services prior to the escalation of symptoms. Culturally rooted barriers, including stigma,

concerns about shame or family burden, and reliance on informal support networks prior to formal help-seeking, may delay connection to care until symptoms reach the point of crisis (Lin & Cheung, 1999; Lee et al., 2010; Weng & Spaulding-Givens, 2017; Yang et al., 2020). Future research should examine barriers along the pathway from emerging distress to formal psychiatric care among API patients and identify potential targets for psychoeducation and intervention.

Diagnostic Profile

API encounters showed a distinct diagnostic profile, most notably elevated odds of psychosis diagnoses across both adults and youth relative to non-API comparison groups. Also observed were lower odds of mood and substance use disorder diagnoses among API adults, and higher odds of mood disorder diagnoses alongside lower odds of stress-related diagnoses among API youth.

These patterns diverge sharply from population-based epidemiologic findings, which have consistently reported lower psychosis prevalence and lower rates of major depressive episodes among Asian Americans than among other racial and ethnic groups (NSDUH, 2024; Hong et al., 2014; Oh et al., 2023). National data show lifetime prevalence of psychosis among Asian subgroups ranging from 4.0–9.4%, well below rates among Black (10.5–12.0%) and Latino (8.0–13.0%) populations (Oh et al., 2023), and a large retrospective cohort study similarly found lower incidence of both affective and nonaffective psychosis among APIs than Black and Hispanic groups (Chung et al., 2023). That approximately one third of API adults and 8% of API youth in this sample received psychosis diagnoses runs counter to these trends.

The mechanisms are likely multifactorial, but two explanations are most consistent with the evidence. First, delayed help-seeking may mean that API individuals only present once symptoms are severe and functionally impairing, increasing the salience of psychosis at the point

of emergency contact (Lin & Cheung, 1999; Ihara et al., 2014). Second, diagnostic bias may shape how distress is categorized under the constraints of emergency evaluation: clinicians unfamiliar with cultural variations in symptom expression, communication styles, or idioms of distress may overattribute psychosis while underrecognizing mood presentations shaped by cultural norms around emotional disclosure (Whaley & Geller, 2007; Gopalkrishnan, 2018; Bauer & Alegria, 2010). Future research should disentangle whether these diagnostic patterns reflect true differences in clinical presentation, illness trajectories, or the diagnostic process itself.

Discharge Disposition

Among both adults and youth, API encounters were more likely to end in inpatient care and less likely to result in outpatient referral than several non-API comparison groups. This is broadly consistent with prior research showing that API patients in inpatient psychiatric settings are more likely than White counterparts to carry diagnoses involving psychosis (Barreto & Segal, 2005; Shin, 2009; Snowden & Cheung, 1990), and is unsurprising given the higher acuity presentations and elevated psychosis diagnoses observed in this sample.

Beyond clinical acuity, this pattern likely reflects structural factors shaping disposition. APIs who have avoided mental health services may arrive at PES without established outpatient relationships, reducing the feasibility of community-based discharge. Insurance-related factors may also play a role: private insurance, which was relatively more common among API adults in this sample, is associated with higher inpatient admission rates from emergency settings even after accounting for clinical presentation (Gao & Olfson, 2022). Discharge patterns may further reflect a mismatch between available step-down options and the preferences or circumstances of API patients — stigma and limited familiarity with lower-intensity alternatives may make these

options feel less feasible or acceptable. Future research should examine how coverage, service availability, and local crisis system organization shape discharge options for API patients.

Implications

Culturally Responsive Clinical Training

Our findings suggest a need for enhanced cultural awareness training for clinicians serving API populations in emergency settings. Training should address cultural variations in symptom expression, communication styles, and idioms of distress to reduce diagnostic bias, and should include exploration of API family values, explanatory models of illness, the model minority myth, and strategies for reducing stigma through accessible clinical language (Whaley & Geller, 2007). Clinicians should develop awareness of how values such as "saving face" and collectivistic orientations may shape help-seeking and treatment engagement (Han et al., 2022).

Community Outreach and Partnership

Our findings suggest the potential for psychoeducation, prevention, and early intervention within the API community are potentially being missed. Mental health systems should partner with API communities to co-design culturally responsive outreach and prevention strategies, including multilingual materials, community mental health literacy programs, and partnerships with trusted community leaders, faith communities, and cultural organizations who can normalize help-seeking.

Limitations

Our study has several limitations. Demographic information in EHRs varies in consistency and accuracy (Spiranovic et al., 2016; Weiskopf & Weng, 2013), and collecting self-reported race and ethnicity during psychiatric emergencies is particularly challenging. The EHR's broad racial and ethnic categories precluded identification of API subgroups, preventing

comparative analyses across the diverse ethnicities, languages, and cultural backgrounds that comprise the API population (Holland & Palaniappan, 2012). Similarly, immigration status is not collected in EHRs due to ethical, legal, and safety concerns (Kim et al., 2019), so we are unable to distinguish between U.S.-born and immigrant API participants; comparisons with studies that disaggregate these groups should therefore be made cautiously.

The absence of formal diagnostic evaluations is also a limitation; diagnoses were assigned for billing purposes and later evaluation in inpatient or outpatient settings may have resulted in additional or alternative diagnoses. We used broad diagnostic categories to minimize the risk of misclassification. Because this study reflects encounter patterns within a single urban PES system that primarily serves publicly insured and uninsured individuals, results may not be generalizable. Observed differences may reflect local variation in referral pathways, service availability, family preferences, transportation barriers, or crisis response practices. Despite these constraints, this study provides valuable insight into emergency psychiatric care for an underrepresented population.

Conclusion

Across both adults and youth, API encounters in psychiatric emergency settings were characterized by greater use of high-acuity settings, a distinct diagnostic profile marked by elevated psychosis presentations, and a higher likelihood of intensive discharge dispositions. This convergent pattern suggests that by the time API individuals reach psychiatric emergency services, their clinical needs are more severe and their pathways to care more constrained than those of many comparison groups. Addressing this requires additional research about how patterns vary across API subgroups, nativity, and language proficiency, as well as investment in clinical infrastructure and community partnerships designed to reach API populations before crises necessitate emergency care.

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Table 1

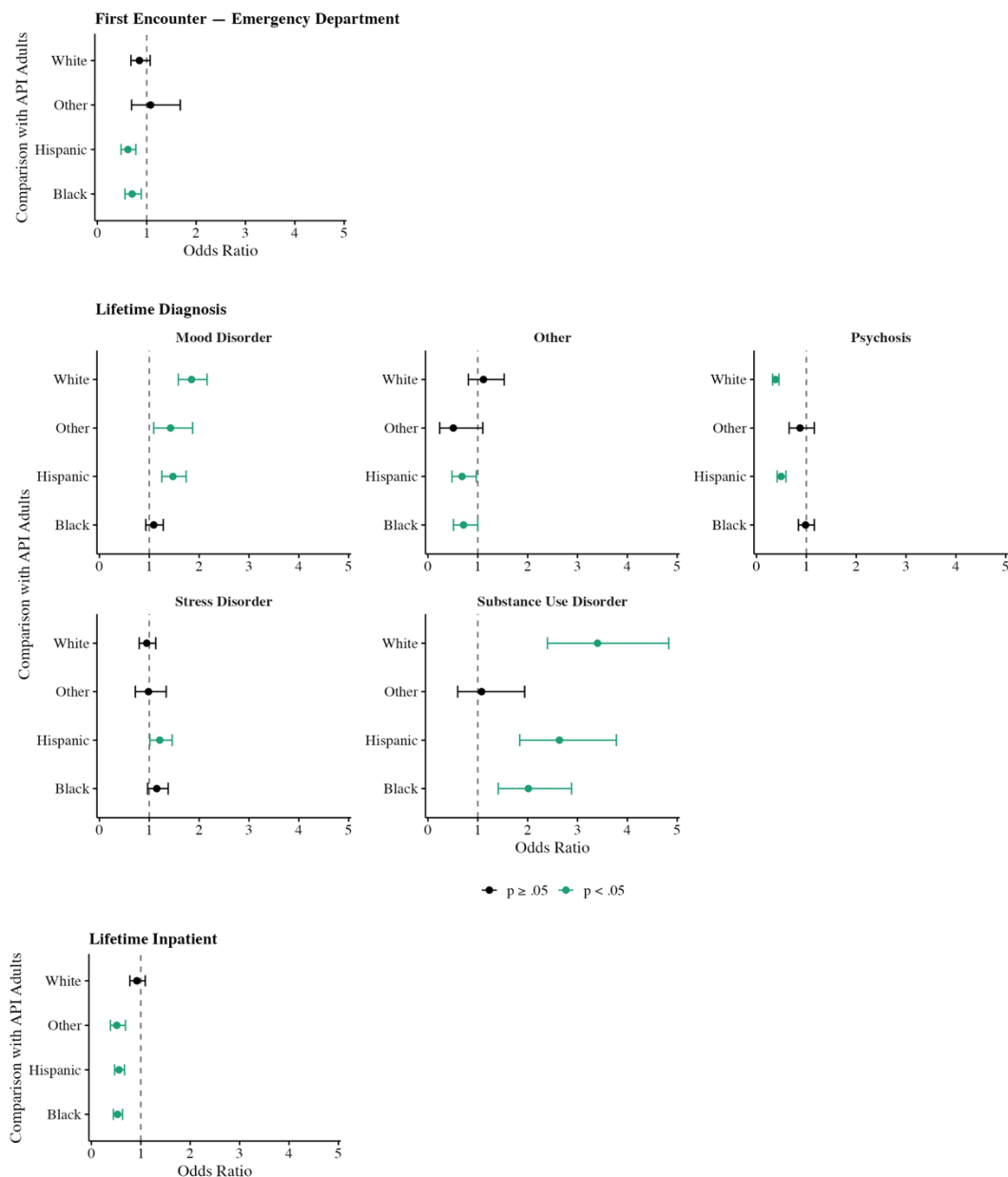
Sociodemographic Characteristics of Adults and Youth

Characteristic	Adults			Youth		
	API (N = 747)	Non-API (N = 21,559)	Missing (N = 3,182)	API (N = 513)	Non-API (N = 10,293)	Missing (N = 1,876)
Demographics						
Age, mean $\pm$ SD	41.58 $\pm$ 16.18	41.33 $\pm$ 12.68	40.13 $\pm$ 13.61	15.59 $\pm$ 3.40	14.18 $\pm$ 4.07	14.01 $\pm$ 4.10
Gender						
Female	382 (51.14)	9,380 (43.51)	1,444 (45.38)	272 (53.02)	5,249 (51.00)	1,001 (53.36)
Male	362 (48.46)	11,942 (55.39)	1,691 (53.14)	234 (45.61)	4,743 (46.08)	830 (44.24)
Trans/non-binary	1 (0.13)	225 (1.04)	29 (0.91)	7 (1.36)	283 (2.75)	31 (1.65)
Interpreter used	120 (16.10)	1,098 (5.10)	59 (1.90)	48 (9.40)	546 (5.30)	22 (1.20)
Socioeconomic context						
Insurance status						
Public	552 (73.90)	18,406 (85.38)	2,543 (79.92)	391 (76.22)	8,361 (81.23)	1,394 (74.31)
Health Safety Net	152 (20.35)	3,088 (14.32)	500 (15.71)	46 (8.97)	761 (7.39)	98 (5.22)
Private	79 (10.58)	1,186 (5.50)	197 (6.19)	106 (20.66)	1,684 (16.36)	409 (21.80)
Housing status						
Unhoused	74 (9.91)	5,731 (26.58)	450 (14.14)	—	—	—
Cumulative evaluation location						
Emergency Department	616 (82.46)	17,790 (82.52)	2,443 (76.78)	349 (68.03)	6,545 (63.59)	891 (47.49)
Home	57 (7.63)	1,738 (8.06)	150 (4.71)	112 (21.83)	2,796 (27.16)	386 (20.58)
Urgent Care Center	55 (7.36)	3,127 (14.50)	299 (9.40)	22 (4.29)	591 (5.74)	101 (5.38)

School	—	—	—	77 (15.01)	1,833 (17.81)	306 (16.31)
Telehealth	32 (4.28)	1,412 (6.55)	269 (8.45)	52 (10.14)	1,367 (13.28)	286 (15.25)
Other	103 (13.79)	3,462 (16.06)	284 (8.93)	48 (9.36)	1,373 (13.34)	194 (10.34)
Cumulative primary diagnosis						
Mood disorders	270 (36.14)	10,073 (46.72)	1,319 (41.45)	215 (41.91)	2,955 (28.71)	461 (24.57)
Primary psychotic disorders	249 (33.33)	4,828 (22.39)	594 (18.67)	43 (8.38)	493 (4.79)	50 (2.67)
Stress/adjustment disorders	184 (24.63)	5,305 (24.61)	886 (27.84)	240 (46.78)	5,963 (57.93)	1,120 (59.70)
Substance use disorders	34 (4.55)	2,733 (12.68)	319 (10.03)	—	—	—
Childhood onset/developmental disorders	—	—	—	52 (10.14)	1,497 (14.54)	243 (12.95)
Other psychiatric disorders	44 (5.89)	1,085 (5.03)	143 (4.49)	12 (2.34)	355 (3.45)	38 (2.03)
Cumulative discharge disposition						
Inpatient	487 (65.19)	12,696 (58.89)	1,605 (50.44)	277 (54.00)	4,353 (42.29)	630 (33.58)
Voluntary admission	49 (6.56)	4,257 (19.75)	256 (8.05)	—	—	—
Outpatient	167 (22.36)	6,833 (31.69)	906 (28.47)	247 (48.15)	6,129 (59.55)	975 (51.97)
Returned to community	217 (29.05)	7,610 (35.30)	780 (24.51)	147 (28.65)	3,717 (36.11)	511 (27.24)

Note. API = Asian and Pacific Islander. Values are n (%) unless otherwise noted. Percentages for cumulative categories may exceed 100% as participants could have multiple evaluation locations, diagnoses, or dispositions recorded. Dashes (—) indicate characteristic not applicable to that age group. Age (mean ± SD) not available for adults.

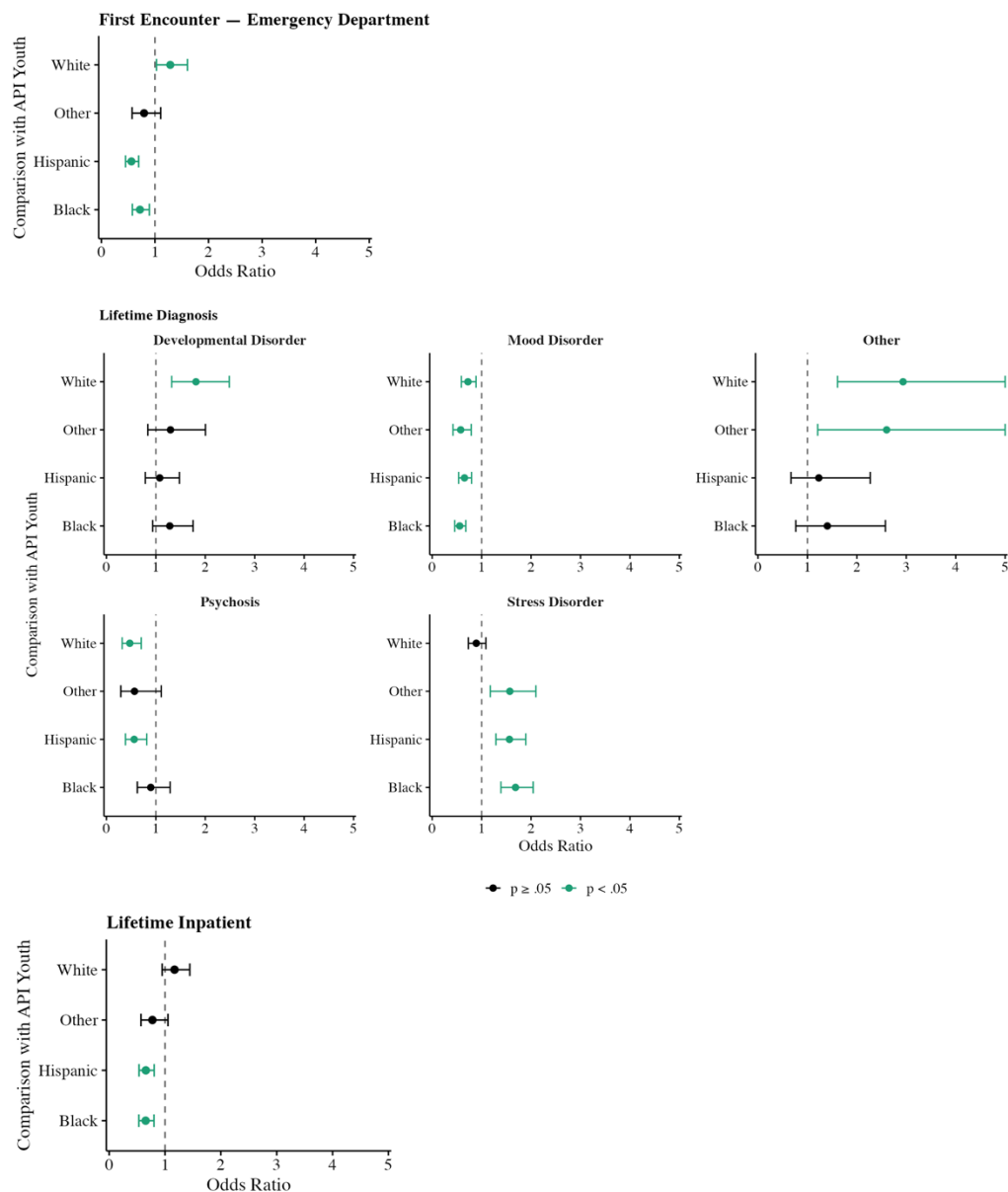
Figure 1a Odds Ratios for First Emergency Psychiatric Evaluation Location and Lifetime Psychiatric Diagnosis and Discharge Disposition Among Non-API Adult Racial/Ethnic Groups Compared to API Adults



Note. API = Asian and Pacific Islander; ED = emergency department. Error bars = 95% CI. Dashed line = OR of 1.0. Green = $p < .05$.

Note. Odds ratios are from multivariate logistic regression models with API adults as the reference group. Error bars represent 95% confidence intervals. The dashed vertical line indicates an odds ratio of 1.0. ED = emergency department. Green points indicate $p < .05$; black points indicate $p \geq .05$.

Figure 1b Odds Ratios for First Emergency Psychiatric Evaluation Location and Lifetime Psychiatric Diagnosis and Discharge Disposition Among Non-API Youth Racial/Ethnic Groups Compared to API Youth



Note. API = Asian and Pacific Islander; ED = emergency department. Error bars = 95% CI. Dashed line = OR of 1.0. Green = p < .05.

Note. Odds ratios are from multivariate logistic regression models with API youth as the reference group. Error bars represent 95% confidence intervals. The dashed vertical line indicates an odds ratio of 1.0. ED = emergency department. Green points indicate p < .05; black points indicate p ≥ .05. Lifetime refused care was excluded from youth disposition analyses due to an insufficient number of events in the API reference group (n = 1).