Racial/Ethnic Minority Children's Use of Psychiatric Emergency Care in California's Public Mental Health System

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Although research on racial/ethnic and cultural disparities in children's mental health treatment has grown and become ever more rigorous,[1,2] little attention has been paid to services that attempt to stabilize children who are in crisis. Excess minority use of emergency care, if it occurs, is important to document and understand, because emergency services do not promote the monitoring of troubling conditions, access to all necessary treatments, or continuity of care.[3]

Racial/ethnic minority children are at increased risk for factors that lead to psychiatric emergency services use. Adversity increases children's and youths' chances of experiencing a crisis[4,5] and minority children are more likely to face certain types of adversity. For example, socioeconomic disadvantage,[3] residence in poor neighborhoods,[6] racism,[7] acculturative stress,[8] and care by family members who are themselves under pressure and distressed[9] befall minority children especially. Moreover, minority children are underrepresented in alternative sources of specialized mental health assistance that might avert a crisis, including outpatient treatment.[10,11] These factors contribute to suicidal ideation and suicide attempts, the most frequent reason children use emergency services.[12,13] Rates of suicidal behavior are higher among Latino, Asian American/Pacific Islander, and American Indian/Alaska Native children than among White children. Among African American children, suicide-related problems occur at a lower rate than among White children, but they are increasing.[14] Conversely, personal[15,16] and community strengths[17,18] protect minority children, which moderates the impact of these stressors and reduces the risk of requiring emergency services.

The limited research available to date indicates that minority children are increasingly using emergency services,[19] but the evidence is mixed as to whether they are overrepresented. We examined racial/ethnic disparities

Objectives. We examined rates and intensity of crisis services use by race/ethnicity for 351174 children younger than 18 years who received specialty mental health care from California's 57 county public mental health systems between July 1998 and June 2001.

Methods. We used fixed-effects regression for a controlled assessment of racial/ethnic disparities in children's use of hospital-based services for the most serious mental health crises (crisis stabilization services) and community-based services for other crises (crisis intervention services).

Results. African American children were more likely than were White children to use both kinds of crisis care and made more visits to hospital-based crisis stabilization services after initial use. Asian American/Pacific Islander and American Indian/Alaska Native children were more likely than were White children to use hospital-based crisis stabilization services but, along with Latino children, made fewer hospital-based crisis stabilization visits after an initial visit.

Conclusions. African American children used both kinds of crisis services more than did White children, and Asian Americans/Pacific Islander and American Indians/Alaska Native children visited only when they experienced the most disruptive and troubling kind of crises, and made nonrecurring visits. (*Am J Public Health.* 2008;98:118–124. doi:10.2105/AJPH.2006.105361)

in psychiatric emergency services use in a large, racially/ethnically diverse, multiyear sample of participants younger than 18 years in California's public mental health care services system. Services were funded by Medi-Cal, California's Medicaid program. Children qualify for Medi-Cal if their family's income falls below a legislatively mandated cutoff: $19350 for a family of 4 in 2005.[20] Under Medi-Cal, children's psychiatric emergency services are divided into 2 categories: crisis stabilization and crisis intervention. Crisis stabilization services are usually hospital based, and they are designed for the most serious crises. These services are provided in a hospital or in another kind of 24-hour health care facility, and they aim to alleviate the need for inpatient care. Compared with other crisis services, crisis stabilization is longer and more intensive.

Crisis intervention services are designed for less-urgent crises. They are provided in the community and generally include assessment, evaluation, collateral care, and therapy. Crisis intervention services are for clients who need urgent assistance but whose crisis is not severe enough to warrant confinement or removal from the community.

We considered both crisis stabilization and crisis intervention services at 2 levels of use. The first level was initial use—whether crisis intervention or crisis stabilization services were used at all during the 3-year period of observation. The second level we considered was how frequently crisis intervention or crisis stabilization services were used after initial use.

We sought to address the following 2 questions: Are minority children more likely than White children to use crisis stabilization and crisis intervention services? Are there racial disparities in the frequency of crisis service utilization?

METHODS

Sample

We obtained Medi-Cal paid claims for mental health services delivered to children younger than 18 years, between July 1,

1998, and June 30, 2001, from the California Department of Mental Health. The service record listed the child's age, gender, race/ethnicity, and primary diagnosis, as well as the date or dates, cost, and type of service. Children with marked and severe functional limitations because of mental illness or other mental or physical disabling conditions qualify for Supplemental Social Security payments. This qualification was included in the Medi-Cal claims file, and children so adjudicated were considered disabled.

The California Department of Social Services provided foster care placement records for all California children younger than 18 years for fiscal years 1999, 2000, and 2001. To obtain other child welfare participation data we merged Medi-Cal claims data with the child welfare records via probabilistic matching techniques, which provided child welfare participation data for each mental health client in our data set. Unique encrypted identifiers allowed tracking of each child throughout all 3 years.

Our final sample included 351 174 children. This represents nearly all children who received Medi-Cal specialty mental health care between July 1998 and June 2001. The majority of the children (59.7%) were male, 11.7% were disabled, 90% were aged between 6 and 17 years, and 10.6% were in foster care. When we compared the racial/ethnic composition of our sample with the proportion of racial/ethnic subgroups of children in California listed in the 2000 Census, we found that White (48.7% vs 34.8%) and African American (19.8% vs 7.4%) children were overrepresented, whereas Latinos (26.3% vs 46.0%), Asian Americans/Pacific Islanders (4.4% vs 9.9%), and American Indians/Alaska Natives (0.9% vs 1.2%) were underrepresented.[21]

Analysis

We followed a standard "2-part model" econometric approach,[22] which permitted us to address our 2 central questions—whether services were used, and if they were used, how much they were used. We first included the entire sample to estimate the probability that a child or youth in the public mental health system used any crisis stabilization or crisis intervention services within the year

(part 1). We used logistic regression to estimate part 1 equations.

We then isolated subsamples of persons who used crisis stabilization or crisis intervention services, and estimated how many times during the year the child or youth used crisis stabilization or crisis intervention services (part 2). We used ordinary least squares regressions after first transforming dependent variables into logarithmic form to adjust for skewed response variable distributions, under which very few clients made a large number of crisis visits. We used robust standard errors in making our estimates to avoid the consequences of skewed response variable distributions (heteroskedasticity).

Finally, we controlled for variables that have been shown to correlate with race/ethnicity or psychiatric emergency services use and, therefore, possibly are correlated with both. These variables were age; gender; diagnosis; whether the child was disabled; whether the child was in regular foster care, kinship care, or had no child welfare involvement; county of residence; and year of observation. We included presence of a disability and child welfare involvement in the control variables because disabled youths[23–25] and children in foster care[26] are more likely than are others to receive mental health treatment. Additionally, African American and American Indian/Alaska Native children are more likely to reside in foster care of all kinds including kinship care compared with children of other races/ethnicities.[27] We controlled for the type of foster care, because children in kinship care receive less mental health treatment than do children in other foster care.[28]

We also employed a cross-sectional fixed-effect dummy variable for each person's county of residence because, in California, mental health services are decentralized to the county level, and county systems vary greatly in how they organize mental health care, including types and availability of crisis care. Finally, we included a longitudinal fixed-effect variable that indicated year of observation, because policy-related developments and underlying state-wide trends are associated with emergency services use (L.R.S, unpublished data, 2006).

RESULTS

Descriptive Statistics

The demographics for each racial/ethnic group are shown in Table 1, and the diagnoses are shown in Table 2. In Table 3, the percentage of children in the public mental health system who received crisis intervention and stabilization services and the unadjusted mean number of visits per user are shown by the child's race/ethnicity. Overall, use of the 2 services was weighted heavily toward crisis intervention. Whereas 10.7% of all children used the less-intensive community-based crisis intervention service, only 1.6% used the more-intensive hospital-based crisis stabilization service.

Probability of Crisis Use

The results from the logistic regression that estimated likelihood of psychiatric emergency services use are presented in Table 4. Analysis of the more-intensive hospital-based crisis stabilization service showed that when covariates were controlled, African American (odds ratio [OR]=1.11; P<.01), Asian American/Pacific Islander (OR=1.20; P<.01), and American Indian/Alaska Native (OR=1.94; P<.01) children had a greater probability than did White children of using the service. Differences between Latino (OR=1.06; P<.14) and White children were not significant.

Analysis of the less-intensive community-based crisis intervention service showed that when covariates were controlled, only African American children (OR=1.09; P<.01) had a greater probability than did White children of using the service, whereas Latino (OR=0.94; P<.01) and Asian American/Pacific Islander children (OR=0.90; P<.01) had a lower probability compared with White children of using the service. Differences between American Indian/Alaska Native and White children (OR=1.08; P<.19) were not significant.

Level of Crisis Use

The results from the regression that estimated number of crisis visits per child are presented in Table 4. When we looked only at the children who received any hospital-based crisis stabilization, our analysis showed that African American (b=0.035; P<.05) children used a greater number of crisis

TABLE 1—Demographic Characteristics and Diagnosis of Children in California's Medicaid Program Who Received Specialty Mental Health Care, by Race/Ethnicity: July 1998–June 2001

Independent Variables	White, No. (%)	African American, No. (%)	Latino, No. (%)	Asian American/ Pacific Islander, No. (%)	American Indian/ Alaska Native, No. (%)	Total, No. (%)
Total	171 090 (100)	69 438 (100)	92 293 (100)	15 365 (100)	2 988 (100)	351 174 (100)
Boy	101 127 (59.1)	42 427 (61.1)	54 791 (59.4)	9 535 (62.1)	1 657 (55.5)	209 537 (59.7)
Foster care status						
Not in foster care	152 442 (89.1)	62 228 (89.6)	82 478 (89.4)	14 011 (91.1)	2 601 (87.0)	313 826 (89.4)
Kinship foster care	2 275 (3.2)	1 667 (2.4)	3 138 (3.4)	292 (1.9)	102 (3.4)	10 886 (3.1)
Non–kinship foster care	13 256 (7.7)	4 894 (7.0)	6 684 (7.2)	1 072 (7.0)	287 (9.6)	26 193 (7.5)
Disabled[a]	16 844 (9.8)	15 279 (22.0)	3 874 (4.2)	4 608 (30.0)	341 (11.4)	40 946 (11.7)
Age, y						
0–3	5 257 (3.1)	1 865 (2.7)	2 842 (3.1)	367 (2.4)	66 (2.2)	10 397 (3.0)
4–5	12 302 (7.2)	4 427 (6.4)	6 786 (7.4)	741 (4.8)	208 (7.0)	24 464 (7.0)
6–11	72 841 (42.6)	31 686 (45.6)	39 873 (43.2)	5 374 (35.0)	1 223 (40.9)	150 997 (43.0)
12–17	80 690 (47.2)	31 460 (45.3)	42 792 (46.4)	8 883 (57.8)	1 491 (49.9)	165 316 (47.1)
Diagnosis						
Mood disorder	43 709 (25.5)	15 058 (21.7)	23 270 (25.2)	3 764 (24.5)	656 (22.0)	86 457 (24.6)
Adjustment disorder	28 769 (16.8)	10 224 (14.7)	16 221 (17.6)	2 352 (15.3)	673 (22.5)	58 239 (16.6)
ADD or ADHD	26 322 (15.4)	11 877 (17.1)	11 163 (12.1)	1 996 (13.0)	339 (11.3)	51 697 (14.7)
Disruptive behavior disorder	19 963 (11.7)	11 029 (15.9)	14 196 (15.4)	2 319 (15.1)	359 (12.0)	47 866 (13.6)
Anxiety disorder	18 727 (10.9)	6 203 (8.9)	9 770 (10.6)	1 204 (7.8)	310 (10.4)	36 214 (10.3)
Developmentally disabled	5 426 (3.2)	2 407 (3.5)	2 436 (2.6)	726 (4.7)	63 (2.1)	11 058 (3.1)
Psychosis	2 350 (1.4)	1 643 (2.4)	1 225 (1.3)	568 (3.7)	34 (1.1)	5 820 (1.7)
Other	10 436 (6.1)	4 930 (7.1)	5 168 (5.6)	983 (6.4)	212 (7.1)	22 124 (6.3)
None or missing	15 170 (8.9)	5 997 (8.6)	8 866 (9.6)	1 438 (9.4)	342 (11.4)	31 813 (9.1)

Notes. ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder. Percentages add up to more than 100 because participants can be in multiple categories.
[a]Children with marked and severe functional limitations because of mental illness or other mentally or physically disabling conditions qualify for Supplemental Social Security payments and were considered disabled.

TABLE 2—Probability and Level of Psychiatric Emergency Use of Children in California's Medicaid Program Who Received Specialty Mental Health Care, by Race/Ethnicity: July 1998–June 2001

	No.	Psychiatric Emergency Intervention Use, %	No. of Visits Among Psychiatric Intervention Users, Mean (SD)	Psychiatric Emergency Stabilization Use, %	No. of Visits Among Psychiatric Emergency Stabilization Users, Mean (SD)
White	171 090	10.86	1.98 (2.45)	1.51	1.52 (1.40)
African American	69 438	11.39	2.03 (2.87)	1.84	1.50 (1.06)
Latino	92 293	9.53	1.79 (2.38)	1.51	1.40 (1.11)
Asian	15 365	10.93	1.91 (2.66)	2.58	1.37 (0.99)
American Indian	2 988	15.09	1.89 (1.92)	2.91	1.23 (0.56)
Total	351 174	10.65	1.94 (2.54)	1.64	1.47 (1.23)

stabilization visits per child compared with White children, whereas Latino (b=−0.031; $P<.05$), Asian American/Pacific Islander (b=−0.078; $P<.01$), and American Indian/Alaska Native (b=−0.093; $P<.05$) children

had fewer crisis stabilization visits compared with White children.

When we looked only at the children who received any community-based crisis intervention, our analysis showed that African American

(b=−0.051; $P<.01$), Latino (b=−0.061; $P<.01$), and Asian American/Pacific Islander (b=−0.107; $P<.01$) children had fewer crisis intervention visits per child than did White children. The differences between American Indian/Alaska Native (b=0.036; $P<.23$) and White children were not significant.

DISCUSSION

For crisis care that targets both more- and less-severe crises, African American children showed a greater likelihood of use than did White children, and for services that target the most serious crises, African American children showed more repeat use than did White children. Thus, our hypotheses were largely confirmed for African American children, who proved, like African American adults (L.R.S., unpublished data, 2006), to use emergency services disproportionately.

TABLE 3—Probability of Psychiatric Emergency Use Among Racial/Ethnic Minority Children Compared With White Children, by Type of Psychiatric Emergency: California's Medicaid Program, July 1998–June 2001

	Model A: Psychiatric Emergency Stabilization, OR (CI)	Model B: Psychiatric Emergency Intervention, OR (CI)
Total, No.	336 894	336 934
Race/ethnicity		
White (Ref)	1.00	1.00
African American	1.11** (1.03, 1.21)	1.09** (1.05, 1.13)
Latino	1.06 (0.98, 1.15)	0.94** (0.91, 0.97)
Asian American/Pacific Islander	1.20** (1.05, 1.37)	0.90** (0.85, 0.95)
American Indian/Alaska Native	1.94** (1.49, 2.53)	1.08 (0.96, 1.22)
Gender		
Girl (Ref)	1.00	1.00
Boy	0.81** (0.76, 0.86)	0.84** (0.82, 0.86)
Foster care status		
Kinship foster care (Ref)	1.00	1.00
Nonkinship foster care	2.65** (2.01, 3.50)	1.62** (1.51, 1.74)
In foster care (Ref)	1.00	1.00
Not in foster care	2.03** (1.56, 2.64)	0.70** (0.66, 0.75)
Age, y		
12–17 (Ref)	1.00	1.00
0–3	0.15** (0.10, 0.25)	0.26** (0.23, 0.29)
4–5	0.10** (0.07, 0.15)	0.41** (0.38, 0.44)
6–11	0.34** (0.31, 0.37)	0.68** (0.66, 0.69)
Disability status[a]		
Not disabled (Ref)	1.00	1.00
Disabled	1.31** (1.20, 1.42)	1.25** (1.21, 1.30)
Diagnosis		
No diagnosis (Ref)	1.00	1.00
Developmentally disabled	0.77 (0.45, 1.34)	0.90* (0.81, 0.99)
ADD or ADHD	1.24 (0.91, 1.68)	1.26** (1.19, 1.34)
Disruptive behavior disorder	1.94** (1.48, 2.57)	1.45** (1.38, 1.54)
Adjustment disorder	3.54** (2.72, 4.60)	1.47** (1.39, 1.55)
Anxiety disorder	2.16** (1.63, 2.87)	1.42** (1.34, 1.51)
Psychosis	24.61** (18.74, 32.41)	5.72** (5.31, 6.17)
Mood disorder	11.90** (9.25, 15.30)	3.38** (3.23, 3.54)
Personality disorder	8.96 (2.48, 32.36)	4.04** (2.52, 6.49)
Eating disorder	9.96** (4.99, 19.89)	3.12** (2.32, 4.20)
Substance abuse	36.12** (26.67, 48.90)	6.31** (5.60, 7.11)
Somatization disorder	4.39** (1.34, 14.34)	3.58** (2.50, 5.14)

Notes. OR = odds ratio; CI = confidence interval; ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder. Dummy variables were omitted for year and county.
[a]Children with marked and severe functional limitations because of mental illness or other mentally or physically disabling conditions qualify for Supplemental Social Security payments and were considered disabled.
*$P < .05$; **$P < .01$.

Asian Americans/Pacific Islanders and American Indians/Alaska Natives also proved more likely to require emergency intervention that targets crises of the most serious kind. This finding is consistent with findings from studies that report high rates of suicidal behavior[29] and studies that report alcohol abuse[30] among some American Indian/Alaska Native populations. It is consistent, too, with findings from studies that report high rates of suicidal ideation and suicide attempts among Asian American/Pacific Islander children,[12,13] possibly linked to troublesome caretaker–child intergenerational conflict[31] found in some Asian American/Pacific Islander populations.

Otherwise, and contrary to our hypotheses, Asian American/Pacific Islander, American Indian/Alaska Native, and Latino children did not participate more than did White children in crisis-related mental health services. They were not repeat users of crisis stabilization services, and they did not make greater use compared with White children of crisis intervention services that target less-serious crises. Such nonrecurring treatment seeking for what are probably serious and possibly unmanageable mental health problems resembles a pattern followed by Asian American/Pacific Islander adults.[3]

Limitations

One limitation of our study is that crisis stabilization users may also have used crisis intervention services and vice versa. We cannot determine this because we did not divide our sample into mutually exclusive groups based on use. Ultimately, it may be necessary to identify profiles of crisis service use to understand ethnic differences in detail. Such an analysis is beyond the scope of our study but should be conducted in future research.

A greater study limitation is that we cannot fully explain the disparities we discovered. This can be seen when our models addressed repeat use of emergency services and their coefficients of determination (R^2's) were modest, which indicates that they account for limited variation. Several areas of inquiry are promising for future researchers to consider as they attempt to explain distinctive minority patterns of crisis services use.

Conclusions

More than other racial/ethnic groups, African American children appeared to engage the mental health treatment system by using psychiatric emergency services. They may do this because they do not receive the regular outpatient care that would address their mental health problems in a timely way and that would reduce their need for emergency care.

TABLE 4—Number of Psychiatric Emergency Service Visits by Children in California's Medicaid Program Who Received Specialty Mental Health Care: July 1998–June 2001

	Model C: Log Level of Use Among Psychiatric Emergency Stabilization Users (n = 4788)		Model D: Log Level of Use Among Psychiatric Emergency Intervention Users (n = 33 304)	
	b (SE)	P	b (SE)	P
Race/ethnicity				
White	Ref		Ref	
African American	0.035 (0.017)	.038	–0.051 (0.009)	<.001
Latino	–0.031 (0.015)	.043	–0.061 (0.008)	<.001
Asian American/Pacific Islander	–0.078 (0.023)	.001	–0.107 (0.015)	<.001
American Indian/Alaska Native	–0.093 (0.038)	.015	0.036 (0.030)	.225
Gender				
Girl	Ref		Ref	
Boy	0.008 (0.012)	.520	–0.023 (0.007)	.001
Foster care status				
Kinship foster care	Ref		Ref	
Nonkinship foster care	0.145 (0.052)	.005	0.140 (0.016)	<.001
In foster care	Ref		Ref	
Not in foster care	0.049 (0.047)	.303	0.020 (0.015)	.196
Age, y				
0–3	–0.154 (0.040)	<.001	–0.150 (0.019)	<.001
4–5	–0.094 (0.057)	.100	–0.100 (0.014)	<.001
6–11	–0.006 (0.017)	.723	–0.028 (0.007)	<.001
12–17	Ref		Ref	
Disability status[a]				
Not disabled	Ref		Ref	
Disabled	0.031 (0.017)	.061	0.096 (0.010)	<.001
Diagnosis				
No diagnosis	Ref		Ref	
Developmentally disabled	0.257 (0.115)	.026	0.083 (0.026)	.001
ADD or ADHD	0.074 (0.041)	.072	0.127 (0.015)	<.001
Disruptive behavior disorder	0.040 (0.026)	.116	0.171 (0.014)	<.001
Adjustment disorder	0.067 (0.023)	.003	0.078 (0.013)	<.001
Anxiety disorder	0.169 (0.034)	<.001	0.200 (0.016)	<.001
Psychosis	0.237 (0.028)	<.001	0.367 (0.021)	<.001
Mood disorder	0.194 (0.020)	<.001	0.310 (0.013)	<.001
Personality disorder	0.058 (0.033)	.074	0.215 (0.132)	.015
Eating disorder	0.539 (0.188)	.004	0.370 (0.081)	<.001
Substance abuse	0.275 (0.043)	<.001	0.333 (0.030)	<.001
Somatization disorder	0.451 (0.171)	.008	0.135 (0.079)	.087

Notes. ADD = attention deficit disorder; ADHD = attention deficit hyperactivity disorder. Dummy variables omitted for year and county. Model D: $F_{78,33225}$ = 34.65; P < .001; R^2 = 0.069. Model C: $F_{67,4715}$ = 8.52; P < .001; R^2 = 0.12.
[a]Children with marked and severe functional limitations because of mental illness or other mentally or physically disabling conditions qualify for Supplemental Social Security payments and were considered disabled.

caretakers may be postponing treatment, perhaps until they are overwhelmed or until outside authorities, such as police or school officials, must intervene. Several barriers to seeking mental health care might prevent Asian American/Pacific Islander and American Indian/Alaska Native children from otherwise engaging the mental health treatment system. These barriers include culture-sanctioned conceptions of distress and appropriate coping,[32] stigma,[33] mistrust of the mental health system,[34] and limited proficiency in English.[35]

Cultures vary in the terms and idioms they use to describe "mental illness" and in the coping strategies they endorse; their adherence to alternative mental illness and treatment-seeking "explanatory models"[36] might lead Asian American/Pacific Islander and American Indian/Alaska Native caretakers to postpone treatment. Mental illness is particularly stigmatizing in some racial/ethnic minority communities and stigma might lead children and caretakers to postpone treatment. Mistrust and perceived racism have been studied primarily among African American populations, but they, too, might drive Asian American/Pacific Islander and American Indian/Alaska Native caretakers away from seeking needed health care services[37,38] and lead them to postpone their seeking of treatment. Future research should examine what role cultural beliefs about mental illness and explanatory models, stigma, mistrust, and perceived racism play in possibly channeling Asian American/Pacific Islander and American Indian/Alaska Native children into nonrecurring use of crisis stabilization services.

Asian American/Pacific Islander children are more likely than are others to be immigrants and refugees or children of immigrants and refugees. If their caregivers are undocumented, they may fear that bringing their children to the attention of public mental health officials will lead to detection by the Immigration and Naturalization Service and deportation. Furthermore, immigrant and refugee caretakers and children may be limited in their English proficiency, further causing them to avoid or to be pushed away from seeking mental health treatment until it can no longer be avoided.[30,39] Future research should examine what role immigrant and

Researchers should evaluate the hypothesis that better access to outpatient treatment for African Americans will reduce disparities in emergency services use.

By making nonrecurring use of crisis services that target the most serious crises, Asian American/Pacific Islander and American Indian/Alaska Native children and their

refugee status and limited English proficiency play in explaining nonrecurring use of crisis stabilization services.

Researchers also should investigate characteristics of the mental health treatment system that might affect utilization of crisis services and might help to explain distinctive patterns of minority crisis services use. Trained child and adolescent practitioners are in short supply, particularly those who are culturally and linguistically competent,[40] and too few practitioners might leave minority children with few alternatives to emergency care. Interventions that increase mental health screening and referral and provide increased mental health funding of all Medicaid recipients, such as the vigorous enforcement of Medicaid's Early and Periodic Screening, Diagnostic, and Treatment Program provisions, which reduced emergency treatment rates, might benefit minority children especially.[41] Programs that assist clients in their homes might be especially beneficial to minority children, because they often lack transportation and because long wait times at hospitals and mental health clinics are often obstacles to care for minority families.[42] Too few suitable providers, lack of aggressive mental health screening and outreach, and lack of receptive treatment programs might play some role in channeling minority children into crisis services.

Along with more-responsive mental health treatment systems, community-based interventions can be helpful in making minority persons aware of mental health treatment resources and possibly even in averting crises before they require treatment. Community outreach interventionist specialists and clinical crisis care workers[43] should reach out to minority children and their caregivers. They should assist them in recognizing signs of impending crisis and suggest de-escalation strategies that might reduce the need for emergency mental health intervention. They also should work with networks to promote crisis awareness and routine treatment among family members, close friends, and spiritual advisors whom minority caregivers often consult before seeking help for children's mental health problems.[42]

Community health workers, known as *consejeras* or *promotoras* in some Latino communities, appear to increase health care use.[44]

Building on this success, these workers might orient community members to the specialty mental health system and its array of services, including outpatient care, programs for special mental health needs, and crisis intervention services at levels lower than hospital-based crisis stabilization care. Collaboration with local school districts is indicated, because the majority of children in the United States who receive mental health care get services through their school.[45] Through improved outreach, recruitment, and collaboration, mental health providers can help caregivers and their local mental health systems both respond to minority children's mental health problems before they become crises and avoid the dire consequences that sometimes ensue from crises. ∎

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Contributors
L. R. Snowden originated the study and supervised its implementation. M. C. Masland and A. M. Libby acquired the data and assisted in the study design and implementation. N. Wallace analyzed and interpreted the data. L. R. Snowden and K. Fawley drafted and revised the article.

Human Participant Protection
Approval to use these data for research purposes was obtained from the University of California, Berkeley's institutional review board, and the California Health and Human Services Agency's Committee for the Protection of Human Subjects.

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