Racial/Ethnic Disparities in Mental Health Service Use among Children in Foster Care

Ann F. Garland
University of California, San Diego
Child and Adolescent Services Research Center

John A. Landsverk
San Diego State University
Child and Adolescent Services Research Center

Anna S. Lau
University of California, San Diego
Child and Adolescent Services Research Center

Children in foster care show elevated need for mental health services, and there is some evidence of greater unmet need among racial/ethnic minority youth compared to Caucasian youth. This paper reviews the evidence for racial/ethnic disparities in mental health service use among children in foster care, including previously published data, as well as new, unpublished data, and examines the extent to which the disparities persist when the effects of other service use predictors are accounted for. Potential explanations for racial/ethnic disparities in service use are also explored, including cultural differences in help seeking and factors associated with decision-making processes in child protective service systems.

Children placed in foster care have significantly elevated need for mental health services due to many factors including exposure to multiple risk factors pre-placement and the potentially disruptive experience of placement itself (Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998; Garland, Landsverk, Hough, Ellis-MacLeod, 1996; Pilowsky, 1995; Trupin, Tarico, Low, Jemelka, & McClellan, 1993). Estimates of the prevalence of development and mental health problems for children in foster care vary from approximately 50 percent to over 80 percent, and these rates are significantly higher than the prevalence of such problems in socio-economically comparable samples (Landsverk & Garland, 1999; Pilowsky, 1995). Thus, the elevated need

Request for reprints should be sent to Ann Garland, Child and Adolescent Services Research Center, 3020 Childrens Way (MC 5033), San Diego, CA 92123 [agarland@casrc.org]
for mental health services is well established for children in foster care; however, the extent to which this need is met through use of mental health services, and the identification of factors that facilitate or inhibit the use of such services, is relatively unexplored.

Rates of mental health service use among children in foster care are higher than community averages, and higher than rates for children from comparable socio-economic backgrounds (Halfon, Berkowitz, & Klee, 1992a, 1992b; Landsverk & Garland, 1999; Takayama, Bergman, & Connell, 1994). However, racial and ethnic disparities in service utilization have been identified, suggesting that unmet need may be greater for some racial/ethnic minority groups (Courtney et al., 1996; Garland et al., 2000; Leslie et al., 2000). These racial/ethnic disparities are particularly concerning given that entry into foster care may represent an important "gateway" into rehabilitative and supportive services (Landsverk & Garland, 1999). Given the overrepresentation of racial/ethnic minority children in protective services generally and foster care specifically as described earlier in this volume by Needell, Brookhart, & Lee, the high risk of serious mental health, educational, and social problems for those children (Pilowsky, 1995), and the limited resources available to provide mental health services, it is essential to gain greater understanding of factors contributing to underutilization of mental health services by racial/ethnic minority youth. Furthermore, it is important to identify the extent to which system-level factors may evidence bias in the delivery of mental health services for the foster care population.

Interpretation of group differences in mental health service utilization rates is difficult because service use is multi-determined and thus, there could be many confounding factors responsible for these differences. Factors that have been shown to increase likelihood of mental health services for children in foster care include such socio-demographic factors as age and gender; specifically, older children and males may be more likely to receive services (Garland et al., 1996; Leslie et al., 2000). Children living in kinship care appear to be less likely to use mental health services (Leslie et al., 2000). In addition, children entering foster care reportedly due to sexual and physical abuse are more likely to receive services than those entering for neglect (Garland et al., 1996). Finally, as would be expected, children with greater severity of emotional or behavioral problems are more likely to utilize mental health services (Garland et al., 1996; Leslie et al., 2000). Given these potential confounding factors, it is important that any investigation of racial/ethnic disparities in service utilization take into account additional explanatory factors.
The purpose of this paper is to, a) review the evidence of racial/ethnic disparities in mental health service use among children in foster care, including previously published, as well as new, unpublished data; b) examine the extent to which these disparities persist even when accounting for potentially confounding factors, such as socio-demographics, types of maltreatment, and severity of mental health problems, and, c) to illuminate potential explanations for observed racial/ethnic disparities in mental health service utilization, including decisionmaking in child protective service systems, and cultural differences in help seeking.

Evidence Of Racial/Ethnic Disparities In Mental Health Service Utilization

Several studies have demonstrated racial/ethnic disparities in utilization of mental health and other supportive services for children in foster care. Close (1983) originally reported that race/ethnic minority children received fewer “preferred” services and fewer contacts with child welfare staff relative to Caucasian American youth. Benedict and colleagues (1989) also reported that Caucasian American children in foster care in Baltimore, Maryland received more frequent visits for psychological services than did African American youth. In a review of the literature, Courtney and colleagues (1996) reported that Caucasian American children in foster care were more likely to receive counseling and “family services” than were racial/ethnic minority youth in care. These early studies were critical in documenting the existence of racial/ethnic disparities, but they did not include analyses of potentially confounding factors that could account for the disparities. More recent studies reported below have replicated the findings of disparities and advanced the research by including assessment of many additional factors known to influence mental health service utilization.

Much of the most recent research in this area has been conducted in San Diego county, California, using data obtained in a federally funded cohort study of children entering foster care in 1990-91 (Garland et al., 1996, 2000; Leslie et al., 2000). Extensive data on need for and use of mental health services was obtained for over 600 children ages 2-17 entering a new foster care placement. This was a diverse sample of children that was composed of 45 percent Caucasian American, 32 percent African American, 19 percent Latino American, and 4 percent Asian American, and Other racial/ethnic minorities.
Two-thirds of the children were placed in non-kinship foster care and the majority were placed with caregivers of the same race/ethnicity.

Caregivers were interviewed approximately 6 months after the children had been placed in foster care. A well-established measure of childhood emotional/behavioral problems was used to assess need for mental health services (i.e., Child Behavior Checklist [CBCL], Achenbach, 1991). Service utilization was assessed through structured interview questions asking the caregiver if he/she had ever taken the child "to anyone for help with any emotional, behavioral, social, school, or other adjustment problems." Thus, the assessment of mental health services was broad and defined by the caregiver informant. A structured follow-up question regarding the frequency of visits during the past 6 months was administered if any service use was reported. Child protective service case files were abstracted to yield data regarding the type of maltreatment triggering the removal of the child from his/her home.

Results of this study indicated that 57 percent of the children received some kind of mental health services within the first 6 months of their foster care placement, according to the foster parent informant. There were, however, significant differences in service use rates across the three major racial/ethnic groups. Caucasian American subjects had a higher rate of service utilization (65%), compared to both African American (50%) and Latino American (47%) youth. In addition, among those who received services, there was a trend for the Caucasian American children to receive more visits compared to the African American and Latino American children (Garland et al., 2000).

Studying the same cohort of children, Leslie and colleagues (2000) examined service use using Medicaid billing claim data, as opposed to caregiver report of service use. They found that 42 percent of the children used mental health services billed to Medicaid within the first 18 months of foster care placement and that there were significant racial/ethnic disparities in the amount of services received. Specifically, Caucasian Americans received significantly more visits than Latino American children; the number of visits for African Americans was not significantly different than that for Caucasian Americans.

The two studies reported above examined service use for the same general cohort of children entering foster care in the early 1990s in San Diego County, California. These original patterns identified in San Diego County have also been replicated with a new sample of youth under court jurisdiction in the child welfare system, using improved, established measures of service utilization. The Patterns of Care (POC) study enumerated all youth aged 6-17 years
who were served by one or more public sectors of care in San Diego County (alcohol/drug treatment, child welfare, juvenile justice, mental health, and public school services for youth with Serious Emotional Disturbance [SED]). From this complete enumeration, a sample of 1,715 youth was selected by simple random sampling techniques and was stratified by race/ethnicity and level of restrictiveness of placement. A poststratification weighting procedure was used to account for the original sampling design, which was comprised of simple random sampling stratified by race/ethnicity and level of restrictiveness of placement. Sampling weights are applied to the data in order to generate results that would reflect the distribution of variables in the full population of youth in these five service sectors.

Previously unpublished data for a subsample of 200 POC youth, ages 12 to 17 years who had a history of foster care placement, including 59 Caucasian Americans, 70 African Americans, 60 Latino Americans, and 11 Asian Pacific Islanders was analyzed to examine service use patterns. Biracial youth and youth who identified themselves in other racial/ethnic groups were excluded from the current study. This study represented a methodological advance over previous studies of racial disparities in receipt of mental health services by using validated measures of service utilization (Services Assessment for Children & Adolescents, or SACA, Horwitz et al., 2001), and maltreatment victimization (Childhood Trauma Questionnaire, or CTQ, Bernstein et al., 1994) in addition to a well-established measure of mental health need (CBCL). Logistic regression analyses were conducted to identify predictors of a lifetime history of specialty outpatient mental health services among this sample of children with a lifetime history of placement in foster care (youths were not necessarily in foster care at the time of data collection). History of service use was regressed on gender, age, family income, race/ethnicity, youth-reported maltreatment (emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect), and parent-reported behavior problems. Results of this study provided more evidence of racial/ethnic disparities. Caucasian American youth were over 14 times as likely to have received mental health services as African American youth, and were over 25 times as likely to have received services as Latino American youth.

Although the relatively consistent results obtained using different methods supported the validity of the findings in San Diego, the generalizability of these findings to other geographic locations and more recent cohorts is not known. Indirect but corroborating support for the existence of racial/ethnic disparities in mental health service use among children in foster care is found in research documenting service use patterns among sexually and/or physically
abused children. Each of these studies indicates that ethnic minority youth who have been identified by child protective services as maltreated are less likely to receive mental health services than are their Caucasian counterparts (Kolko, Selelyo, & Brown, 1999 in Pittsburgh, PA; Tingus, Heger, Foy, & Leskin, 1996 in Los Angeles, CA).

Controlling For Alternative Interpretations of Racial/Ethnic Disparities

With racial/ethnic disparities relatively well established (in at least some geographic areas), it is important to test whether or not the disparities can be explained by potentially confounding factors, (i.e., the extent to which the disparities persist when the effects of other explanatory variables are taken into account). Predictors of mental health service use for children include such clinical factors as severity of problems, and such socio-demographic factors as age and gender (Cohen & Hesselbart, 1993; Costello & Janiszewski, 1990; Zahner et al., 1992), SES, and insurance coverage. The fiscal factors are likely less relevant for children in foster care because, in most states, services for these children are covered through publicly funded sources and there is less variability in SES for children in foster care than there is in community samples.

The type of maltreatment experienced (or reported) for children in foster care has been shown to predict likelihood of mental health service use. Garland and colleagues (1996) reported that children placed in foster care due to sexual abuse were the most likely to receive mental health services, even when the effects of other potential explanatory variables, such as severity of problems, was controlled. Children placed due to physical abuse were also more likely to receive services than those not placed for physical abuse. Children placed due to neglect were significantly less likely than others to receive mental health services. Type of maltreatment interacts with race/ethnicity in such a way that minority individuals are more likely to be reported to Child Protective Services (CPS) for physical abuse and neglect than Caucasian Americans, but equally likely to be reported for sexual abuse (AAPC, 1986; Cappelleri, Eckenrode, & Powers, 1993). Reports of neglect and physical abuse (but not sexual abuse) are also more likely to be substantiated for ethnic minority children (Eckenrode et al., 1988). Given the complex interactions between race/ethnicity, age, gender, and type of maltreatment in the child welfare system, it is important to test whether these other factors account for the racial/ethnic disparities in mental health service use.
Several studies have, in fact, tested the effects of the potentially confounding factors cited above and have found that the racial/ethnic disparities are robust, and cannot be explained by these potential confounds. For example, in the San Diego County studies using the caregiver’s self-report assessment of service use (Garland et al., 2000) and the Medicaid billing data assessment of service use (Leslie et al., 2000), all of the above factors (age, gender, type of maltreatment, and severity of emotional/behavioral problems) were entered into regression analyses and the effects of race/ethnicity on likelihood of service use remained significant. For example, in the Garland (2000) study, even when the effects of other factors were controlled, African American and Latino youth were still significantly less likely to receive mental health services than Caucasians.

Likewise, new data from the San Diego Patterns of Care study indicate that racial/ethnic disparities are found even after controlling for a variety of other predictor variables. African American and Latino American youth were less likely to receive mental health services even after accounting for gender, age, family income, youth-reported maltreatment victimization, and severity of emotional/behavioral problems. As discussed previously, this study utilized established and validated self-report measures of maltreatment victimization (and child mental health problems) rather than relying on official child protective service records. Table 1 displays the results of multiple logistic regression analyses predicting lifetime use of specialty mental health outpatient services among youth with a history of foster care placement. The odds ratios (O.R.) indicate the odds of lifetime service use compared to the identified comparison group, or, for continuous measures such as age, income, and CBCL score the incremental odds of service use for each increase in the measure (i.e., females were 4 times more likely to receive services than males; African Americans were .07 times less likely to receive services than Caucasian Americans). The p value column indicates the statistical significance of the odds ratio.

Relationship Between Need And Use Of Mental Health Services, By Race/Ethnicity

There has been minimal research linking need for and use of mental health services for children in foster care. Data from the studies reviewed above report the expected link between need for and use of mental health services for children in foster care, demonstrating that the severity of emotional/behavioral problems is a significant predictor of service use (Garland et al., 1996, 2000; Leslie et al., 2000). However, a study by Glisson (1994, 1996) in Tennessee
report relatively low rates of referral to mental health services overall (14% of 600 children ages 5 –18 entering placement) and no relationship between severity of problems and likelihood of referral to services.

Table 1
Logistic regression predicting lifetime use of specialty mental health outpatient services among youth with a history of foster care in the Patterns of Care study. (N=200)

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>S.E.B</th>
<th>t</th>
<th>p</th>
<th>O.R.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (^a)</td>
<td>1.40</td>
<td>.71</td>
<td>1.99</td>
<td>.047</td>
<td>4.07</td>
</tr>
<tr>
<td>Age (by year)</td>
<td>-.29</td>
<td>.16</td>
<td>-1.78</td>
<td>.07</td>
<td>.75</td>
</tr>
<tr>
<td>Family Income</td>
<td>.02</td>
<td>.06</td>
<td>.28</td>
<td>.78</td>
<td>1.01</td>
</tr>
<tr>
<td>African-American (^b)</td>
<td>-2.67</td>
<td>1.32</td>
<td>-2.01</td>
<td>.044</td>
<td>.07</td>
</tr>
<tr>
<td>Hispanic-American (^b)</td>
<td>-3.23</td>
<td>1.37</td>
<td>-2.37</td>
<td>.018</td>
<td>.04</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>-1.47</td>
<td>1.40</td>
<td>-1.05</td>
<td>.29</td>
<td>.23</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>-.301.78</td>
<td>1.14</td>
<td>1.55</td>
<td>.12</td>
<td>5.95</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>1.81</td>
<td>1.62</td>
<td>1.12</td>
<td>.26</td>
<td>6.11</td>
</tr>
<tr>
<td>Emotional Neglect</td>
<td>-1.83</td>
<td>.85</td>
<td>-2.14</td>
<td>.032</td>
<td>.16</td>
</tr>
<tr>
<td>Physical Neglect</td>
<td>-.33</td>
<td>.86</td>
<td>-3.9</td>
<td>.70</td>
<td>.71</td>
</tr>
<tr>
<td>CBCL Total Problems</td>
<td>.03</td>
<td>.01</td>
<td>2.23</td>
<td>.026</td>
<td>.36</td>
</tr>
</tbody>
</table>

\(^a\) Male=1, Female=2
\(^b\) Reference Group= Caucasian American

One study (Garland et al., 2000) specifically addressed the issue of the extent of unmet need by race/ethnicity by examining the rates of service use by severity of emotional/behavioral problems for each of the three major race/ethnic groups. Severity of emotional/behavioral problems was assessed using caregiver reports on the CBCL (Achenbach, 1991). The sample distribution of \(t\) scores on the Total Behavior Problem scale of the CBCL was divided into tertiles. The lowest problem score group had \(t\) scores less than 53; the middle-range group had scores between 53 and 65, and the highest range group had scores above 65. Given that a \(t\) score of 50 is the mean for non-clinical populations, the lowest group could be considered to exhibit low “need” for mental health services according to this measure of emotional/behavioral problems. Alternatively, a \(t\) score higher than 63 is considered clinically significant, so the highest-tertile group could definitely be con-
sidered to evidence need for mental health services according to this measure of emotional/behavioral problems. Figure 1 shows that patterns of service use were related to severity of total behavior problem score by race/ethnicity. Caucasian Americans were much more likely to get services even when the total problem score was relatively low. African Americans demonstrated the strongest relationship between problem severity and use of services, with Latino American subjects showing a main effect of relatively low service use across problem severity categories.

**Figure 1**

Mental health service use by race/ethnicity and CBCL Scores

The graph in Figure 1 displaying the service utilization rates by race and emotional/behavioral problem status may be particularly informative in examining the complex relationships between race/ethnicity, need, and use of mental health services for these children. A linear relationship between this particular measure of need for services and self-reported use of services is most
apparent for African American subjects. Caucasian Americans evidence relatively high levels of service use across need categories, and Latinos evidence relatively low levels of service use across need categories. In fact, the rate of service utilization for Caucasian Americans in the lowest-need group is approximately the same as the rate of service utilization for Latinos in the highest-need group. One possible interpretation of these findings may be that some Caucasian American children are receiving services when clinical necessity is not apparent. It may be that the threshold for perceived need for mental health services (perceived by parents’ or other referral sources) is higher for ethnic minority youth compared to Caucasian American youth. Weisz and Weiss (1991) have demonstrated that perceptions of the “referability” of different types of behavior problems of a child to mental health services do differ by culture. If so, it may be important to develop more structured screening and triage for mental health services that includes perceived need and more objective measures of problems and functional impairment. Some localities do routinely conduct standardized developmental and/or mental health evaluations of all children entering the foster care system, but it is not known whether this results in more equitable service use patterns.

It is certainly possible that there are aspects of need for mental health services that are not detected using the CBCL Total Problem Score and that the service use patterns reflect this unmeasured need. It could be argued that most youth who have experienced maltreatment and removal from their homes are at extraordinarily high risk for mental health problems and the majority should receive mental health services regardless of current observable, or reported, behavior problems. If this is true, then these results suggest that African American and Latino youth are being underserved, relative to Caucasian American youth, given that they are utilizing services at lower rates.

**Possible Reasons For Racial/Ethnic Disparities In Mental Health Service Use**

Racial/ethnic disparities in reported service utilization may be due to many different and potentially interacting factors, ranging from culturally driven differences in help-seeking patterns, to differential receptivity and accessibility of providers, to systematic bias in referral and service delivery patterns. Research and policy attention to these factors is growing, as reflected in the recent *Supplement to Mental Health: A Report to the Surgeon General*, devoted to issues of culture, race, and ethnicity (USHHS, 2001). One aim of research
in this area is to identify the obstacles to access to care for ethnic minority youth. Suggested barriers include lack of minority mental health providers, cultural and language barriers, biased assessment techniques resulting in triage to alternative services, and lack of knowledge about available services (Cross et al., 1989; Hoberman, 1992). In addition, there may be biased referral patterns from “gateway” providers, such as teachers, health care professionals, juvenile probation workers, and caseworkers or judges in the child welfare system. Recent research has highlighted the important role these gatekeepers play in getting children into mental health services (Stiffman et al., 2000).

One study with children in foster care addresses a possible cause for ethnic disparities in service use. Garland & Besinger (1997) examined whether there were systematic biases by race/ethnicity of children in patterns of court referral to services for children in foster care, thereby testing the extent to which disparities in service use may be attributable to systematic referral biases, as opposed to racial/ethnic variance in help-seeking behavior. In California, all children placed in foster care and their families proceed through several court hearings until the final disposition hearing is held to make a legal determination on the care of the child and plans to reunify the family. A minimum of three hearings within the first 60 days after the child’s removal from home is required, although many families appear in many more hearings. Mental health services may be recommended and/or mandated at any of these hearings. Caseworkers usually make recommendations to the court and these are usually approved with little review (Lindsey, 1994).

Comprehensive court records for 142 children ages 2-16, randomly selected from the larger San Diego foster care study cohort described above (Garland et al., 1996; Leslie et al., 2000), were reviewed extensively. There was roughly equal representation of all three major racial/ethnic groups (34% Caucasian American, 35% African American, and 31% Latino American). The results of this study indicated that the court process did play a significant role in referring children to mental health services. Overall, 59 percent of the children were referred to mental health services during the court process. Caucasian American youth were significantly more likely to receive referrals for counseling/psychotherapy services compared to African American and Latino American youth (rates of 71%, 46%, and 61% respectively). There was evidence in the case records that the majority of those referred to services did, in fact, utilize services and there was no significant difference by race/ethnicity in rates of following through with the referrals.

These data provide some support for systematic bias at key “decision points” in referral patterns. However, the possibility that cultural factors in
help-seeking preferences may play a role in driving the referral patterns must also be considered. Zima et al. (2000) conducted interviews with a random sample of 302 children and caregivers in foster care in Los Angeles County. Caregivers and teachers were interviewed about several steps in the help-seeking process including problem detection, perceived need for specialty mental health services, contact with potential service providers, referral to specialty mental health services, and eventual service utilization. Within the subsample of children meeting criteria for attention deficit hyperactivity disorder (ADHD), race/ethnicity was predictive of eventual service use — that is, Caucasians were more likely to receive services than ethnic minority children. Yet, there were no racial/ethnic differences in problem detection, caregiver perceived need, contact with service providers and referrals. In this study, ethnic minority youth appeared to be no less likely to be identified as having mental health needs and to be given access to treatment by system gatekeepers, but they were still less likely to receive mental health services. Although ethnic minority caregivers were as likely as Caucasian caregivers to identify child problems in need of treatment, it appeared that cultural beliefs and preferences about formal mental health treatment for ADHD might have deterred minority caregivers from following through with treatment referrals (Bussing et al., 1998; Stevenson & Renard, 1993). It is also possible that pragmatic barriers (e.g., access to childcare for other youth in the home, problems with transportation) may have contributed to the lower rate of receipt of services among minority youth after referrals were provided. This study provided preliminary evidence that racial/ethnic differences in eventual service utilization may stem from socio-cultural influences that impact help-seeking later in the process — after problem identification and receiving referrals to care.

These two sets of findings regarding racial/ethnic differences in system referrals and in foster family help-seeking patterns may be related. Differences in referral patterns may be based on accurate or inaccurate perceptions of a family’s interest in mental health services. Latino families, for example, have been found to be less likely to use mental health services than Caucasian American families across a number of studies (Bui & Takeuchi, 1992; McCabe et al., 1999), even when controlling for need (Pumariega, Holzer, & Nguyen, 1993) and insurance status (Padgett, Patrick, Burns, & Schlesinger, 1994). Caseworkers responsible for making recommendations for referrals may be influenced by the family’s or child’s preferences, and/or perceptions of the availability of culturally responsive (or linguistically appropriate) services. They may also be making assumptions about the relative benefits of psychotherapy for youth of different cultural or racial/ethnic backgrounds. Such as-
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assumptions could not be based on fact as there are no strong data available to suggest that psychotherapy is more or less effective for certain racial/ethnic groups. Thus forces contributing to racial/ethnic disparities in mental health service utilization may stem from multiple sources.

Implications and Future Research Directions

More research is needed to identify the reasons for racial/ethnic disparities in mental health service utilization for this high-risk group of children. In the meantime, data reported here should be shared with child welfare professionals to raise awareness about racial/ethnic disparities in the interest of equalizing access to services. Simply raising awareness of the documented disparities may promote closer inspection of referral decisions, and a greater availability/accessibility of culturally sensitive services. Attention to barriers to service access should also be encouraged. Research suggests that barriers to children's mental health services include pragmatic structural barriers (e.g., knowledge of available services, transportation, fiscal), as well as perception barriers (e.g., lack of confidence in services, previous negative experiences) (Owens et al., 2002). Education for child welfare personnel, as well as foster families, is necessary to address attitudinal and knowledge-based barriers in access to care. Education for policy makers and service providers is needed to encourage the funding and development of culturally sensitive, accessible services.

Future research should include greater attention to potentially confounding factors such as type of foster care placement (e.g., kinship versus nonkinship care), length of time in placement, and number of placement episodes. Few studies have included these factors, although one study did report that children in kinship care were less likely to receive mental health services. However, even when this variable was included, significant racial/ethnic disparities in mental health service use were found (Leslie et al., 2000).

Future research should also attempt to dissect the system-level decision points that may perpetuate bias in referral or delivery of services. This might include assessing gatekeepers' (e.g., case-workers', judges') assumptions about racial/ethnic differences in need, access, and benefits of psychotherapeutic services and the extent to which these assumptions are based on preconceived attitudes versus direct input from the family or child.

In addition, more research is needed on how family and cultural attitudes, preferences, and beliefs affect help seeking, service utilization, and engagement in services. It is likely that system-level factors and family/cultural fac-
tors interact in complex ways to drive disparities. To complicate the picture further, there may be different factors driving disparities for different racial/ethnic groups. For example, access to linguistically appropriate services is likely a significant determining factor for many Latino American families, but not necessarily for African Americans. Furthermore, most of the research to date has been limited to the three largest racial/ethnic groups (Caucasian, African American, and Latino American), due to statistical power restrictions. Very little is known about potential disparities among other racial/ethnic groups and among families of mixed racial/ethnic heritage.

In conclusion, more research is needed to understand the dynamic, interacting processes by which mental health service referral and utilization decisions are made for children in foster care. More systematic and comprehensive efforts to screen for developmental and mental health services are needed to ensure that problems are identified as early as possible. Given the level of identified need among children in foster care, it is critically important that services be delivered equitably. Of course, access is a necessary, but not sufficient step. Greater attention to the quality and effectiveness of these services is also warranted.

References


Needell, Brookhart, & Lee, this issue


