

# Help-Seeking Steps and Service Use for Children in Foster Care

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## Abstract

*This study describes help-seeking steps and service-use patterns for school-age children in foster care. It also examines how these access indices are moderated by sociodemographic, enabling, and child disorder factors. Two home interviews and a telephone teacher interview were conducted using a sample of 302 randomly selected children (age 6-12 years) in foster care. The majority of children (80%) were given a psychiatric diagnosis, and 43% of the foster parents perceived a need for mental health services for the child. In the past year, about one-half of the children had received mental health (51%) and special education services (52%). Age and ethnicity, foster parent education, placement history, level of monthly benefits, number of caseworker visits, and disorder characteristics were related to help-seeking steps and mental health service use. Strategies to improve access to mental health services for children in foster care should include interventions at the caregiver and system levels.*

Children in foster care are reported to have a high level of unmet need for mental health services,<sup>1,3</sup> yet little is known about factors related to the help-seeking process that underlie their poor access. Information about this critical first phase of accessing services is, however, fundamental to the future work of developing strategies for improving the quality of care for this vulnerable population. Additionally, as publicly funded mental health services are being reorganized under managed care,<sup>4</sup> the need to identify malleable factors that may improve access to care and the cost-effectiveness of specialty mental health services for this population has intensified.<sup>5,6</sup>

Help-seeking pathway models conceptualize the important links between the initial recognition of a child mental health problem and the use of mental health services (Figure 1).<sup>7</sup> In general, such pathways are defined as “a sequence of contacts with individuals and organizations prompted by the distressed persons’ efforts, and those of his/her significant others, to seek help as well as the help that is supplied in response to such efforts.”<sup>7</sup> For children in foster care, the detection of a mental health problem by a foster parent, teacher, or caseworker may serve as an initiator of this process. In this study, the intervening phases of this trajectory include the caregiver’s perception of a need for spe-

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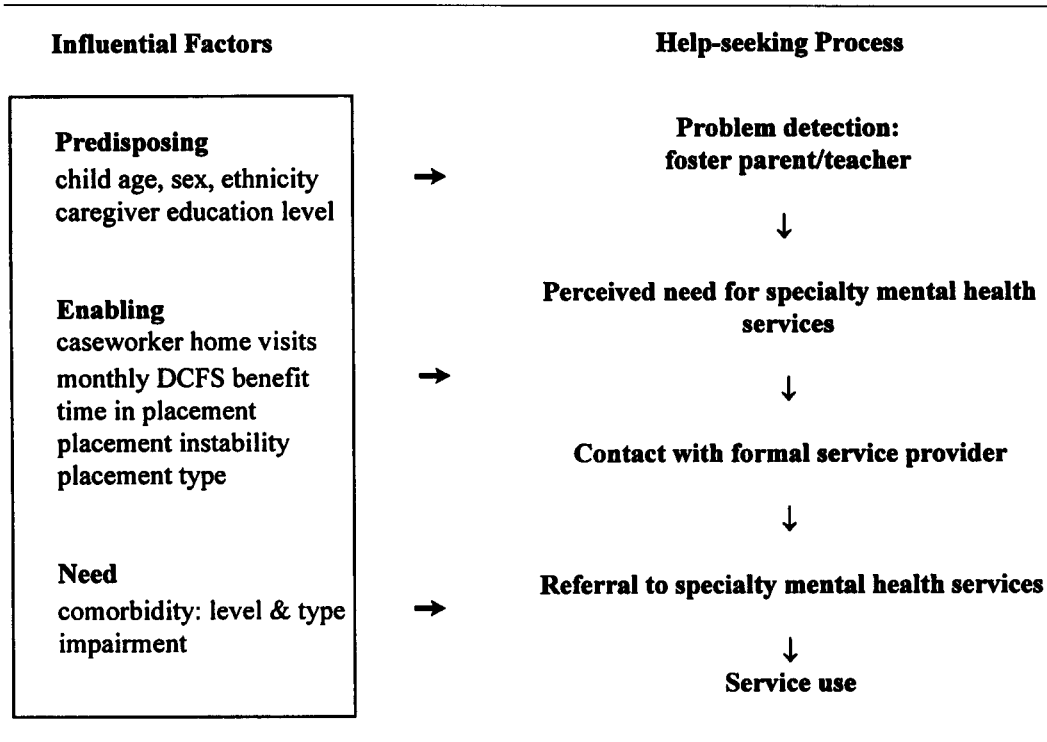
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**Figure 1**  
**Access to Care for Children in Foster Care**



cialty mental health services, advice seeking from informal and formal providers of help,<sup>8</sup> and referral.<sup>9, 10</sup>

Throughout the help-seeking process, predisposing, enabling, and need factors are theorized to be influential.<sup>11, 12</sup> Adapting Andersen's model of access to care for children living in out-of-home placements, predisposing characteristics include a child's sociodemographic characteristics as well as the foster parent's level of education. Ethnicity may play a moderating role in that those children in foster care from minority backgrounds are less likely to receive a referral before or after removal from their homes.<sup>13</sup> Other help-seeking steps also may be affected by ethnicity, as McMiller and Weisz found that Latino caregivers were less likely than those from Caucasian backgrounds to seek advice from formal sources of help for their child's mental health problems.<sup>14</sup> Gender also has been found to be influential in access to care in that girls, as well as those from minority backgrounds, were more likely to be undertreated among school-based epidemiological samples.<sup>15, 16</sup>

Additionally, factors that enable foster children and their caregivers to take help-seeking steps or receive specialty mental health services are proposed in this study to include child protective agency characteristics, most notably the number of caseworker home visits, level of placement stability, amount of time in placement, level of restrictiveness in the foster care setting, and the level of monthly benefit. Stone and Stone<sup>17</sup> note that the degree of caseworker contact is related to greater placement stability, as it provides an environment that may allow caregivers more time to detect a child's mental health problem and seek care. Given this mechanism, caregivers of children who are in placement for longer periods of time would be expected to be more likely to take help-seeking steps and use specialty mental health services; however, this relationship has not been established. Furthermore, statewide mechanisms for additional benefits and therapeutic foster homes for chil-

dren with special health needs have been implemented.<sup>18</sup> Yet, how these improvements affect the access process and service use have not been explored.

Likewise, although the relationship between child problem and service use has been established in clinical and community-based samples,<sup>19,22</sup> the question of how disorder characteristics, particularly comorbidity and impairment, relate to the help-seeking process for children in foster care merits investigation.<sup>23</sup> Comorbidity, or level of co-occurring psychiatric disorders, is a potentially influential factor because child psychiatric disorders commonly cluster,<sup>24</sup> and the presence of associated disorders can negatively affect clinical prognosis.<sup>25,26</sup> Additionally, Costello and colleagues, using a large epidemiologic sample of children in two primary care settings, recently demonstrated that childhood level of functional impairment was predictive of psychiatric disorders during adolescence.<sup>27</sup> Among children in foster care, those with disruptive behavior disorders or aggressive symptoms have been reported as more likely to be referred to<sup>28,29</sup> or use mental health services.<sup>30</sup> Together, such findings suggest the potential effect of disorder variables on the help-seeking pathways.

In addition to examining how disorder characteristics may influence help-seeking steps and service use, stratifying data on the presence of a tracer condition such as attention-deficit/hyperactivity disorder (ADHD) can lay the groundwork for future research that examines the quality of care for children in foster care.<sup>31</sup> Tracer conditions are those disorders that are common and have established practice parameters. Such characteristics make it feasible to study the process of care with emphasis on quality-of-care indicators. For children, ADHD fits such criteria because it affects an estimated 3% to 5% of children,<sup>24</sup> the efficacy of treatment is well established,<sup>32</sup> and practice parameters are available.<sup>33</sup>

The purpose of this cross-sectional study is to describe help-seeking steps and service-use patterns among a sample of school-age children in foster care as identified under usual care conditions, stratified by the presence of an ADHD diagnosis. This study also will explore how these indices of access are moderated by predisposing, enabling, and need characteristics. It is hypothesized that help-seeking steps and service use are more likely among children who come from Caucasian backgrounds, are male, have enabling factors, and manifest greater disorder severity than children without such characteristics.

## Method

### Sampling

Using the Los Angeles County Department of Children and Family Services (DCFS) Management Information System (MIS), children ages 6 through 12 years living in out-of-home placement from three of the eight county service areas between July 1996 and March 1998 were identified. Service areas with the highest rates of out-of-home placements were selected. For each region, the sample was stratified into acute (6 to 12 months) and chronic (>12 months) placement groups, from which equal numbers of children were randomly selected. Children were eligible for the study if they had lived in an out-of-home placement for 6 months or more, were between the ages of 6 and 12 years, spoke English or Spanish, lived no more than 15 miles outside Los Angeles County, and had a foster parent who could be reached by telephone or through a neighbor. The child's age and placement status were verified by the DCFS caseworker prior to being entered into the sample. This sampling strategy was repeated at two-month intervals to better represent children in unstable placements and those who more recently had entered the foster care system.

### Procedures

Two home interviews of the foster parent and child and a telephone interview of the child's teacher were conducted following informed consent procedures approved by the UCLA Human Subjects Protection Committee and the LA County Department of Mental Health Human Subject

Research Committee. During the first home interview, a trained lay interviewer administered structured surveys to the child and his or her foster parent. The caregivers' survey form included inquiries into child and foster parent sociodemographic characteristics, awareness of a child mental health problem, number of caseworker visits, help-seeking steps, and child use of services. The second home interview was a clinical evaluation, following the Los Angeles County Department of Mental Health protocol. This assessment thus served as a proxy for how mental health problems and service needs are identified under usual care conditions. The clinician obtained information about the child's psychiatric, social, and developmental history from the foster parent, as well as conducted a mental status examination. A mental status examination includes a clinical assessment of the child's behavior, speech, mood, affect, and thought processes and content. From these data, the clinician made Axis I through V diagnoses, recommended specific services, and rated the child's level of functional impairment. County clinicians conducting the evaluations were blind to the initial interview information and testing results. The survey was translated and back-translated into Spanish, and clinical interviews in Spanish were completed by bilingual county clinicians. The child's teacher was interviewed by telephone to assess whether he or she detected a serious behavior problem and to confirm the child's use of school-based mental health services and special education interventions.

The trained lay interviewers had a minimum of four years of college education. They completed a four-day training session covering general survey administration, standardized child mental health measures, consent process, and emergency triage procedures. The clinician team was composed of four licensed clinical psychologists and three licensed social workers with an average of nine years of experience conducting mental health evaluations for children in foster care. Following a brief overview of the administrative procedures, emergency triage protocols, and county assessment forms, clinicians received one half day of training on the Child and Adolescent Functional Assessment Scale (CAFAS) following manualized training procedures.<sup>34</sup> Surveys from the field were proofread twice prior to data entry. Errors were corrected by follow-up home or telephone interview, and lay interviewers were retrained as needed throughout the data collection period.

## Participation

From a population of 2,103 children between the ages of 6 and 12 years who were living in foster care and were placed from the three county service areas, 472 children were randomly selected. Eligibility was verified by the caseworker for 70% of the selected children ( $n = 330$ ), and 92% of these children and their foster parents (302/330) completed the first home interview. For the follow-up clinical interview, 266 of the 302 children (88%) who participated in the first interview remained eligible, and of these, 96% ( $n = 255$ ) of the children and their foster parents completed a mental health evaluation. More than one-half ( $n = 21$ , or 58%) of the 36 children who became ineligible had been reunited with their families or adopted, and the remaining no longer met other eligibility criteria. Of the 255 children who completed both interviews, 92% ( $n = 234$ ) of their teachers were surveyed by telephone. The average amount of time between home interviews was 2 months ( $SD = 1.8$ ). Overall, the completion rate for both home interviews was 77% (255/330). Participants and nonparticipants of the first home interview, the clinical evaluation, and teacher interview did not vary by child sociodemographic characteristics or placement history.

## Measures

### MODERATORS OF HELP-SEEKING STEPS AND SERVICE USE

Predisposing characteristics—namely, child sociodemographic characteristics and level of caregiver education—were assessed by foster parent report. The evaluation of enabling factors was conducted using both the caregiver's report and agency records. The number of caseworker visits in the previous year was assessed by foster parent report. The frequency of caseworker visits should be

viewed as conservative, because they may be underreported for children who changed placement frequently or who had lived less than one year with the foster parent. Using the DCFS MIS, the amount of time in foster care, number of out-of-home placements, type of placement, and level of benefit were verified. The length of time and the level of instability in foster care were underestimated because children who reenter foster care do not maintain their original case number in the DCFS MIS.

The child's disorder profile was assessed by the county clinician using the existing system-of-care protocol. The clinician was allowed to specify up to three Axis I and II diagnoses. Additionally, the child's level of impairment was evaluated using the CAFAS, a multidimensional measure of functioning divided into five main domains: Role Performance, Behavior toward Self and Others, Moods/Emotions, Thinking, and Substance Use.<sup>35, 36</sup> The clinician rated the child's most severe level of dysfunction in the previous three months, with higher scores corresponding to greater functional impairment. A total score between 40 and 60, for example, corresponds to moderate impairment and the need for outpatient services on at least a weekly basis.<sup>34</sup> Interrater reliability among the clinicians in this study, using the total scores on five case vignettes for school-age children in foster care, was good (intraclass correlation = .70).<sup>37</sup> The validity of this measure has not been established for children in foster care. The CAFAS was chosen for its comparability because it is being used statewide as an outcome measure for children receiving ongoing mental health services in the public sector.

#### HELP-SEEKING STEPS AND SERVICE USE

*Problem Detection.* Foster parents were identified as being aware of a mental health problem if they reported having any worries or concerns that their child might have a problem with their feelings, behavior, nerves, or learning. Detection of a behavior problem by the teachers was assessed using the acting-out behavior subscale of the Teacher-Child Rating Scale (T-CRS),<sup>38</sup> which includes symptoms of aggression, disruptiveness, and impulsivity. Using a five-point Likert-type scale, the teachers were asked to rate the child's level of behavior problems. Teachers were identified as being aware of a behavior problem if they rated the child at or below the 15th percentile. In a large, ethnically diverse sample of children from 22 elementary schools, the reliability ( $\alpha = .85-.91$ ) and validity (Acting Out domain:  $r = .85$ ) was high.<sup>39</sup> The psychometric properties of this measure have not been established for children in foster care.

*Perceived Need for Specialty Mental Health Services.* Perceived need for services was assessed by foster parent report. Using the open-ended question, "Thinking about [child name], what service or services do you feel [child name] needs most?" the foster parents were classified as perceiving a need for specialty mental health services if at least one of their responses was counseling for problems with feelings, behavior or nerves, medication for problems with feelings, behavior or nerves, inpatient psychiatric care, or training to care for the child's emotional or behavioral problems. Up to three responses were allowed.

*Advice-Seeking, Referral and Service Use.* Advice-seeking behavior was evaluated by asking the foster parents to identify with whom they would talk about their worries or concerns from a list of informal support networks and service providers from multiple sectors. To assess whether the child had received a referral for mental health services in the previous year, the foster parents were asked whether anyone had suggested that their child receive treatment for a problem with his or her feelings, behavior, nerves, or learning. For each type of specialty mental health service and special education intervention, the foster parents were asked whether the child had received such services in the previous year. A child was identified as receiving a school-based mental health service or special education intervention if the teacher or foster parent reported such use. Service use was not con-

firmed by medical or school records because of budget limitations and therefore may be underestimated, especially among those children with greater residential instability.

## Data Analysis

The analysis was restricted to those children who completed a clinical evaluation ( $n = 255$ ). Bivariate analyses were conducted using the chi-square test of proportions for discrete variables and analysis of variance (ANOVA) for continuous variables. Teacher and caregiver responses were combined using a simple additive model called the either/or rule.<sup>40</sup> A child was identified as having a detected problem if either the foster parents endorsed concerns that their child had a mental health problem or his or her teacher reported a clinical level of behavior problems. However, debate about whether this method may mask associations between correlates and outcomes exists.<sup>41</sup> The distribution of the potential moderators and access to service variables were stratified by the presence of a tracer condition, ADHD. Stepwise logistic regression analyses with a forward variable selection procedure ( $\alpha \leq .05$  for entry) was used to assess the contributions of candidate predictor variables on the likelihood of taking each of the help-seeking steps and receiving any specialty mental health services. The candidate predictors were child and foster parent predisposing characteristics (child age, sex, ethnicity using Latino as the reference group, foster parent education level), enabling factors (level of DCFS benefit, number of caseworker home visits, lifetime amount of time in placement, lifetime number of placements, placement type using therapeutic/group home as the reference group), and child clinical profile (presence of a comorbid disorder, presence of an oppositional or conduct disorder, and level of impairment). The outcome variables were the individual help-seeking steps taken (detection problem, perceived need for specialty mental health services, sought advice from any formal service provider, received referral to any specialty mental health service) and the use of any specialty mental health service in the previous year. The help-seeking step and service use variables were dichotomously coded (yes/no).

## Results

### Predisposing, Enabling, and Need Factors

The distribution of potential predictors of help-seeking steps and use of specialty mental health services among children with ADHD, other psychiatric disorders, and no disorders are described in Table 1. Most of the children ( $n = 203$ , or 80%) were from minority backgrounds, and 64% of the foster parents (163/253) were high school graduates. The monthly payment from DCFS to care for the child ranged from \$0 to \$5,013. Only 12% of the children (29/247) had received more than 12 caseworker visits in the previous year. Most of the children ( $n = 229$ , or 90%) had lived with their present foster parent for more than two years, and the mean amount of time living together was almost three years ( $M = 2.9$ ,  $SD = 2.7$ ). Almost 60% of the children ( $n = 152$ ) were living with a relative in family foster care. Eighty percent of the children ( $n = 203$ ) were identified by a county clinician as having at least one psychiatric diagnosis. Of these, the most common diagnoses were disruptive behavior disorders (83/203, 41%) and affective disorders (65/203, 32%), followed by anxiety disorders (40/203, 20%), adjustment disorders (26/203, 13%), and learning disorders (25/203, 12%). Forty-seven percent of the children (95/203) who received a diagnosis were identified as having at least one comorbid disorder.

Children with ADHD were significantly more likely to be identified as having an oppositional defiant or conduct disorder than children with other psychiatric diagnoses (28% vs. 16%;  $\chi^2 = 4.01$ ,  $p = .045$ ). Compared to children with other or no psychiatric diagnoses, those who were identified as having ADHD were more likely to be receiving a higher level of benefits ( $F = 5.90$ ,  $p = .016$ ), be in foster care longer ( $F = 15.85$ ,  $p < .001$ ), have greater placement instability ( $F = 6.03$ ,  $p = .015$ ), live in

a therapeutic or group home ( $\chi^2 = 10.994, p = .001$ ), have a comorbid oppositional defiant or conduct disorder ( $\chi^2 = 9.489, p = .002$ ), or be more severely impaired ( $F = 45.51, p = .0001$ ).

### Help-Seeking Steps and Service Use

Help-seeking steps and service use among children with ADHD, other psychiatric disorders, and no disorders are described in Table 2. Foster parents most commonly reported mental health services as the service their child needed most, followed by special education and social services. They specifically identified needs for counseling services, while parent training and psychotropic medication were infrequently mentioned even among foster parents who had children with ADHD. Children who received a clinician diagnosis of ADHD were more likely than those with other or no psychiatric diagnoses to have a parent or teacher aware of a mental health problem ( $\chi^2 = 8.16, p = .004$ ) and to have used any specialty mental health services in the previous year ( $\chi^2 = 14.53, p = .001$ ). Less than one-third of children with ADHD ( $n = 22$ ) had visits for psychotropic medications in the previous year. Perceived need for specialty mental health services and seeking advice from a formal service provider did not vary by having an ADHD diagnosis. Compared to children without a psychiatric diagnosis, referrals for specialty mental health or special education services were more common (mental health:  $\chi^2 = 10.71, p = .001$ ; special education:  $\chi^2 = 18.17, p = .001$ ) among children with a psychiatric diagnosis.

The relationship of predisposing, enabling, and need factors to help-seeking steps and use of specialty mental health services are summarized in Table 3. The largest effect sizes were seen for children with clinician-diagnosed ADHD, in that boys had almost 19 times the odds of having a caregiver view them as having a mental health problem compared to girls, and Caucasian children had 5 times the odds of using specialty mental health services in the previous year than those from Latino backgrounds. Among foster parents of children with a clinician diagnosis of ADHD, those who had four additional years of education had 3 times the odds of perceiving a need for specialty mental health services and obtaining a referral than caregivers with less education. Foster parent education for children with other diagnoses also was associated with problem detection and referral, but the effect sizes were small. Similarly, facilitating factors that were related to either help-seeking steps or past-year use of specialty mental health services (i.e., placement history, level of benefits, number of caseworker visits) increased the odds of having such an outcome by less than two.

Help-seeking steps also were associated with previous-year use of specialty mental health services. For children with clinician-diagnosed ADHD, those who had a caregiver who detected a problem, perceived a need for specialty mental health services, sought advice from a formal source of help, or received a referral were more likely to have used specialty mental health services in the previous year than those children of caregivers who had not taken such help-seeking steps (problem detect:  $\chi^2 = 9.99, p = .002$ ; perceived need:  $\chi^2 = 8.11, p = .004$ ; sought advice:  $\chi^2 = 11.41, p = .001$ ; referral:  $\chi^2 = 22.47, p = .001$ ). Likewise, these steps were significantly associated with previous-year use of specialty mental health services for those identified as having other disorders (problem detect:  $\chi^2 = 10.86, p = .001$ ; perceived need:  $\chi^2 = 4.29, p = .038$ ; sought advice:  $\chi^2 = 7.15, p = .007$ ; referral:  $\chi^2 = 26.81, p = .001$ ).

### Implications for Behavioral Health Services

Findings from this study suggest that predisposing, enabling, and child need factors are influential in the help-seeking process for school-age children in foster care. The policy implications are that these characteristics should be considered during the development and evaluation of interventions to improve access to care for children in foster care who have psychiatric disorders. Such interventions might include efforts to improve the caregiver's sensitivity in detecting a problem and perceiving a need for specialty mental health services. One possible mechanism to achieve this goal

**Table 1**  
**Distribution of Predictor Variables for Access to Care among Children in Foster Care with Attention-Deficit/Hyperactivity Disorder (ADHD), Other Psychiatric Diagnoses, and No Diagnosis**

	Diagnosis													
	ADHD ( <i>n</i> = 60)		Other ( <i>n</i> = 143)		None ( <i>n</i> = 52)		Statistic			Total ( <i>n</i> = 255)				
	<i>M</i>	( <i>SD</i> )	%	<i>M</i>	( <i>SD</i> )	%	<i>M</i>	( <i>SD</i> )	%	<i>F</i> , $\chi^2$	<i>p</i>	<i>M</i>	( <i>SD</i> )	%
Predisposing child														
Age (y)	8.1	(1.7)		8.5	(1.8)	43	8.5	(1.7)	44	1.21	.300	8.4	(1.8)	47
Male ( <i>n</i> = 119)			58							4.33	.115			33
Ethnicity										13.28	.103			33
African American ( <i>n</i> = 84)			42			26			43					31
Latino ( <i>n</i> = 79)			25			36			25					19
Caucasian ( <i>n</i> = 48)			17			23			12					12
Biracial ( <i>n</i> = 31)			12			13			12					4
Other ( <i>n</i> = 9)			3			2			8					
Foster parent														
Education (y)	12.2	(3.2)		11.4	(3.4)		11.9	(2.7)		1.25		11.7	(3.2)	
Enabling														
Monthly DCFS benefit**	\$988	(1,151)		\$730	(961)		\$425	(327)		5.04	.007	\$727	(936)	
Number of caseworker home visits/y	5.5	(7.8)		8.3	(12.6)		7.1	(5.1)		1.57	.210	7.4	(10.5)	
Time in placement/lifetime (y)***	3.5	(2.7)		2.3	(2.4)		3.8	(3.1)		8.04	<.001	2.9	(2.7)	
Number of placements/lifetime*	4.0	(2.4)		3.1	(2.0)		3.4	(2.5)		3.37	.036	3.4	(2.2)	



Type**					17.07	.002	
Family (n = 176)	55	72	90				72
Therapeutic (n = 26)	19	9	4				11
Group (n = 44)	26	19	6				18
Need							
Comorbidity*						< .001	
Level***							
None (n = 160)	25	65	NA			38.28	53 <sup>b</sup>
One (n = 65)	40	29					32
Two (n = 25)	30	5					12
Three (n = 5)	5	1					2
Type							
ODD/CD (n = 40)***	28	16	NA			.001	20 <sup>b</sup>
Any other disorder (n = 152)***	52	85				.001	75 <sup>b</sup>
Impairment***	43.2 (24.9)	26.4 (22.8)	3.5 (8.1)			< .001	25.7 (24.9)

NOTE: Percentages rounded to next whole number. DCFS = Department of Children and Family Services; ADHD = attention deficit hyperactivity disorder; ODD/CD = oppositional defiant disorder or conduct disorder; NA = not applicable.

a. Distribution of all clinical diagnoses available on request.

b. Denominator excludes those with no diagnosis (n = 203).

c. Assessed by the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1995). Missing cases: ethnicity (n = 5), placement type (n = 9). \*\*p ≤ .05. \*\*\*p ≤ .001.

**Table 2**  
**Help-Seeking Steps and Service Use among School-Age Children in Foster Care with Attention-Deficit/Hyperactivity Disorder (ADHD), Other Psychiatric Diagnoses, and No Diagnosis**

	Diagnosis (%)			Statistic		Total (%) (n = 255)
	ADHD	Other	None	$\chi^2$	p	
	(n = 60)	(n = 143)	(n = 52)			
<b>Problem detection</b>						
By foster parent <sup>a</sup> (n = 134)*	67	51	21	13.63	.034	53
By teacher <sup>b</sup> (n = 82)***	57	35	15	19.03	.001	36
By either informant (n = 160)**	78	62	46	12.38	.002	63
<b>Perceived need for services<sup>c</sup></b>						
<b>Specialty mental health</b>						
Counseling (n = 106)	50	42	31	4.26	.119	42
Parent training (n = 4)	3	1	0	2.07 <sup>h</sup>	.356	2
Psychotropic medication (n = 6)	5	2	0	3.12	.210	2
Inpatient hospitalization (n = 3)	2	1	0	0.80 <sup>h</sup>	.669	1
Any (n = 110)	52	44	31	5.07	.079	43
Special education (n = 67)	33	26	19	2.89	.236	26
Social services <sup>d</sup> (n = 58)	17	25	23	1.75	.418	23
General health <sup>e</sup> (n = 23)	8	10	6	1.08	.583	9
<b>Advice seeking<sup>f</sup></b>						
<b>Informal</b>						
Family/friends (n = 53)	33	39	52	4.47	.346	39
Clergy (n = 8)	8	4	10	1.09	.580	6
Any (n = 55)	35	39	57	2.96	.228	41
<b>Formal</b>						
Mental health professional (n = 61)	45	51	29	3.22	.200	46
School personnel (n = 55)	43	37	52	1.65	.439	41
Social services caseworker (n = 43)	33	34	24	0.82	.664	32
General health care provider (n = 10)	13	7	0	3.20	.202	7
Juvenile justice personnel <sup>g</sup> (n = 6)	5	5	0	1.18	.554	4
Any (n = 116)	93	86	71	5.10	.078	86
No one (n = 6)	5	5	10	1.79	.408	4
<b>Referral</b>						
Inpatient psychiatric hospitalization (n = 16)	12	4	6	5.14	.273	6
Residential treatment facility (n = 9)	7	4	0	4.28	.369	4
Outpatient mental health treatment (n = 116)	48	50	29	8.73	.068	45
Any specialty mental health (n = 122)*	53	52	31	7.67	.022	48
Special education intervention (n = 102)*	50	42	23	13.08	.011	40
<b>Service use/12m</b>						
<b>Specialty mental health</b>						
In-home therapist/family preservation (n = 39)*	27	13	10	7.22	.027	16

**Table 2 Continued**

	Diagnosis (%)			Statistic		Total (%) ( <i>n</i> = 255)
	ADHD ( <i>n</i> = 60)	Other ( <i>n</i> = 143)	None ( <i>n</i> = 52)	$\chi^2$	<i>p</i>	
<b>Service use/12m</b>						
<b>Specialty mental health</b>						
Private office therapist ( <i>n</i> = 68)**	32	33	10	10.38	.006	28
School counselor ( <i>n</i> = 50)*	31	22	8	8.88	.012	21
Community mental health center ( <i>n</i> = 16)	7	7	6	0.09	.958	7
Hospital psychiatric clinic ( <i>n</i> = 2)	0	1	1	1.59	.452	1
Day treatment program ( <i>n</i> = 1)	2	0	0	3.45	.178	0
Visit for psychotropic medication ( <i>n</i> = 35)***	37	8	2	36.22	.001	14
Residential treatment facility ( <i>n</i> = 9)	5	4	0	2.58	.275	4
Any ( <i>n</i> = 131)***	70	52	27	20.84	.001	51
<b>Special education</b>						
In class special help ( <i>n</i> = 103)**	50	45	20	12.46	.002	41
Special education program ( <i>n</i> = 52)***	31	23	2	14.96	.001	21
Home-based tutoring ( <i>n</i> = 12)	5	6	2	1.20	.549	5
Alternative school for emotional disorders ( <i>n</i> = 7)	2	4	0	1.85	.397	3
Any ( <i>n</i> = 130)***	62	57	24	20.20	.001	52
Specialty mental health and special education ( <i>n</i> = 90)***	52	38	10	22.44	.001	35
General health ( <i>n</i> = 241)	100	98	100	2.37	.305	99

NOTE: Percentages rounded to next whole number. Missing data: teacher problem detect (*n* = 25), informal sources (*n* = 121), formal sources (*n* = 121), in-home therapist (*n* = 10), private office therapist (*n* = 10), school counselor (*n* = 5), community mental health center (*n* = 11), hospital psychiatric clinic (*n* = 12), day-treatment program (*n* = 11), residential treatment facility (*n* = 12), in-class special help (*n* = 3), special education program (*n* = 3), home-based tutoring (*n* = 10), alternative school (*n* = 5), any special education (*n* = 2), general health (*n* = 11).

a. Worries or concerns the child might have a problem with his or her feelings, behavior, nerves, or learning/12m.

b. Less than or equal to the 15th percentile on the Acting Out subscale of the Teacher-Child Rating Scale.

c. Foster parent report of up to three services child needs most.

d. Assistance with parental visitation, placement change, adoption or legal guardianship, transportation, recreational activities, respite care, child care, legal problems, or financial hardship.

e. Medical or dental care, or medication for illness or injury.

f. Among foster parents who detect problem, person contacted/12m.

g. Child's legal advocate, lawyer, probation officer, or judge.

h. Chi-square test may not be valid because 50% of cells have expected counts less than five.

\**p* ≤ .05. \*\**p* ≤ .01. \*\*\**p* ≤ .001.

would be an educational intervention for foster parents, as their level of education was related to help-seeking steps and service use.

Within such an educational program, information about treatment options for child psychiatric disorders, as specified by practice parameters and supported by efficacy studies,<sup>42</sup> should be

**Table 3**  
**Significant Predictors of Help-Seeking Steps and Specialty Mental Health Service Use among Foster Care Children with Attention-Deficit/Hyperactivity Disorder (ADHD) and Those with Other Psychiatric Diagnoses**

Outcome	ADHD ( <i>n</i> = 60)			Other Diagnosis ( <i>n</i> = 143)		
	Significant Predictors	OR	CI	Significant Predictors	OR	CI
Problem detection by foster parent or teacher	Male	18.78	1.76, 199.90	Foster parent education	1.58	1.00, 2.50
	Number placements/lifetime	0.71	0.50, 1.00	Impairment	1.28	1.05, 1.56
	Impairment <sup>a</sup>	1.90	1.20, 2.99			
Perceived need for any specialty mental health service	Foster parent education <sup>b</sup>	3.59	1.78, 7.27	Impairment	1.36	1.15, 1.61
	Time in placement/lifetime	0.81	0.67, 0.97			
Sought advice from any formal source of help	Level of benefits <sup>c</sup>	1.50	1.01, 2.51	None		
Received referral to any specialty mental health service	Foster parent education	3.05	1.58, 5.91	Foster parent education	1.75	1.11, 2.77
	Time in placement	0.83	0.69, 0.99	Level of comorbidity	2.62	1.37, 4.97
Use of any specialty mental health service/y	Age	1.58	1.20, 2.08	Foster parent education	1.54	1.05, 2.24
	Caucasian	5.13	1.29, 20.47	Number of caseworker visits	1.04	1.00, 1.08

NOTE: OR = odds ratio; CI = 95% confidence interval. Odds ratios derived from stepwise logistic regression model. Independent variables were child age, sex, ethnicity (Latino = 1), foster parent education, monthly Department of Children and Family Services benefit, number of caseworker visits/year, time in placement/lifetime, number of placements/lifetime, placement type (therapeutic/group = 1), comorbidity level and type (ODD/CD = 1), and level of impairment.

a. Corresponding to 10-point difference on the Child and Adolescent Functional Assessment Scale.

b. Corresponding to four-year difference in years of education.

c. Corresponding to \$200 difference in monthly benefits.

included. The large proportion of foster parents studied who felt that their child needed counseling may be understandable, as psychotherapy is commonly viewed as a panacea for maltreated children<sup>1</sup> when it is not necessarily the appropriate care.<sup>43</sup> Instead, foster parent awareness about psychosocial interventions for children with ADHD<sup>44</sup> should be raised, because very few caregivers perceived the need for parent training. Information on the efficacy of stimulant medication<sup>32</sup> also should be included in an educational intervention, as few of the children with a clinician diagnosis of ADHD had seen a doctor for such treatment in the previous year. Furthermore, the combined findings that a considerable proportion of children studied received a referral for specialty mental health services and that the referral rate did not differ by the presence of a clinician diagnosis suggests that a similar educational program should be adapted for formal service providers.

Interventions to improve access to care for children in foster care also should take into account child gender and cultural differences of their caregivers.<sup>14, 45, 46</sup> Among children in this study with ADHD, boys were more likely to be viewed as having a problem than girls, a finding consistent with studies of other samples of children at risk for ADHD.<sup>47</sup> Children studied from Caucasian backgrounds also were more likely to use specialty mental health services in the previous year compared to Latino children. Because slightly more than one-half of the Latino children in this study (55/101, 54%) were first-generation Americans, such differences must be further explored to determine how cultural beliefs and the level of acculturation among Latino foster families may influence use of specialty mental health services.

In comparison, the role of enabling factors in improving access to care for children in foster care is less clear because their effect size was small. The relationship between placement history and the reduced likelihood of help-seeking steps for children with a clinician diagnosis of ADHD raises the question of whether interventions should be prioritized for those children who have greater placement instability and who are in placement longer. Conclusions about the efficacy of higher monthly benefits, more caseworker visits, or placement in therapeutic or group homes also cannot be made from this study's cross-sectional design. Future research using a larger sample size that compares changes in access to services over time between those receiving and not receiving a proposed enabling factor is needed.

### **Limitations and Areas of Future Research**

Two additional limitations of this study are the use of a county clinician diagnosis and the inability to establish a temporal relationship between help-seeking steps and service use. Conclusions about the level of appropriateness of the help-seeking process or the level of unmet need for services among children in foster care should not be made because clinical diagnosis alone is a limited proxy for a child's need for mental health services and does not have established reliability.<sup>48, 49</sup> To address these questions, a child's need for specialty mental health services should be identified by using a structured diagnostic interview and applying additional impairment criteria.<sup>50</sup> This study's underlying assumption that caregivers of children in foster care who took help-seeking steps were more likely to access services also cannot be tested by its cross-sectional design. Help-seeking steps were associated, however, with previous-year use of specialty mental health services.

Children in foster care represent a vulnerable population that is dependent on having their needs for specialty mental health services met in the public care sector. Such needs create a strong impetus to further pursue research questions raised by this descriptive study. Differences in potential moderators of access to care, help-seeking steps, and service use among children with clinician-diagnosed ADHD demonstrate the utility of using this treatable condition<sup>51</sup> as a tracer condition and the applicability of this approach to children in foster care. As pathways to specialty mental health services are organized within managed-care models, information on how to improve access to these services for children with psychiatric disorders is needed.

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