Journal of Social Service Research

ISSN: 0148-8376 (Print) 1540-7314 (Online) Journal homepage: https://www.tandfonline.com/loi/wssr20

Caseworker Perspectives on Mental Health Disparities Among Racial/Ethnic Minority Youth in Child Welfare

Christina DeNard, Antonio Garcia & Elizabeth Circo

To cite this article: Christina DeNard, Antonio Garcia & Elizabeth Circo (2017) Caseworker Perspectives on Mental Health Disparities Among Racial/Ethnic Minority Youth in Child Welfare, Journal of Social Service Research, 43:4, 470-486, DOI: 10.1080/01488376.2017.1299827

To link to this article: https://doi.org/10.1080/01488376.2017.1299827

JOURNAL OF SOCIAL SERVICE RESEARCH
2017, VOL. 43, NO. 4, 470–486
https://doi.org/10.1080/01488376.2017.1299827

Routledge
Taylor & Francis Group

Caseworker Perspectives on Mental Health Disparities Among Racial/Ethnic Minority Youth in Child Welfare

Christina DeNard, Antonio Garcia, and Elizabeth Circo

School of Social Policy and Practice, University of Pennsylvania, Philadelphia, Pennsylvania, USA

ABSTRACT

Disparities in mental health service use exist for children of color in the child welfare system. Studies exploring a theoretical link of provider racial bias to disparities in service use recommend further inquiry into this association. Since measuring caseworker racial bias may be difficult, examining language, particularly as to whether caseworkers attribute racial disparities to structural mechanisms or individual agency and beliefs, may illuminate unconscious racial bias that caseworkers have towards their clients. Therefore, this study employed discourse analysis to examine child welfare caseworker racial explanations of mental health disparities. Qualitative data derived from focus group transcripts of 36 caseworkers who discussed barriers and facilitators of mental health service use were used in this study. Results showed that caseworkers cited factors at the institutional, community, and organizational levels as causes of racial disparities, but also ascribed ultimate responsibility for service use on clients and on caseworkers to facilitate access to services. Integrating anti-racist perspectives into caseworker training and agency policies can challenge racial stereotypes and empower caseworkers and agencies to address structural-level racial disparities. Future research should examine the impact of caseworker referrals on mental health disparities and evaluate the effectiveness of anti-racist training in reducing caseworker racial bias.

KEYWORDS

Child welfare; racial bias; mental health; disparities

While close to half of the children involved in the child welfare system are diagnosed with clinically pervasive mental health problems (Burns et al., 2004), only about a third of them receive mental health services to address these issues (Hurlburt et al., 2004). This disparity among mental health service need and use is even greater among children of color within the child welfare system (Garcia, Aisenberg, & Harachi, 2012; Garcia & Courtney, 2011; Garcia, Palinkas, Snowden, & Landsverk, 2013; Garland, Landsverk, & Lau, 2003; Gudiño, Martinez, & Lau, 2012; Horwitz et al., 2012; Hurlburt et al., 2004). A large body of research supports the link between mental health service use and child and family demographics and child welfare case characteristics (e.g., type of placement, length of stay in out-of-home care) (Villagrana, 2010). However, these studies do not explain why disparities in access to services linger. Studies have found that child welfare caseworkers facilitate access to mental health services for children involved in the child welfare system and that their referral decisions have implications for the timeliness and quality of mental health services received (Fedoravicius, McMillen, Rowe, Kagotho, & Ware, 2008; Stiffman, Pescosolido, & Cabassa, 2004). A small number of studies have explored the theoretical link of provider racial/ethnic bias to disparities in mental health service use and all recommend further inquiry into this potential causal mechanism (Snowden, 2003; Staudt, 2011; van Ryn & Fu, 2003). To that end, this study seeks to examine the role that child welfare caseworker racial bias may have in the disparity in mental health service use among children of color in the child welfare system. There is some difficulty in directly measuring racial bias among child welfare caseworkers, as most individuals tend to provide non-prejudicial responses when asked directly about their own racial/ethnic bias. But examining caseworker language can illuminate unconscious racial bias that caseworkers may have towards the clients they serve since language is used to construct societal identities, structures, and practices and can reflect perceptions and biases (Gee, 2011). Therefore, the

CONTACT Christina DeNard cdenard@sp2.upenn.edu University of Pennsylvania, 3701 Locust Walk, Philadelphia, PA 19104.

objective of this study is to elucidate caseworker implicit racial biases that may contribute to mental health disparities by examining whether caseworkers' language attributes the disparities to institutional, societal, or system structures (structuralist language) and/or to individual choice and agency (individualist language).

Background and Significance

Mental Health Disparities

Several studies have documented the gap between mental health need and mental health service use (Burns et al., 2004; Garland et al., 2003; Hurlburt et al., 2004; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004). Many of these studies used nationally representative surveys to examine mental health service use among children involved in the child welfare system. Researchers found that nearly half of the children (40–47%) had emotional problems and behaviors that met clinical levels for need as measured by scores on the Child Behavioral Checklist (CBCL) (Burns et al., 2004; Hurlburt et al., 2004). However, only roughly a third of children who met clinical need for mental health services received them (Hurlburt et al., 2004). When examining child, family, and child welfare case characteristics that are correlated with mental health service use, race/ethnicity emerged as a determining factor.

In Hurlburt's study in 2004, researchers found that for children in involved in child welfare services, African-American and Hispanic children were less likely to receive mental health services than non-Hispanic White children. In a similar study, Leslie et al. (2004) found that African-American children in foster care were less likely to receive mental health services than non-Hispanic White children in foster care at all levels of clinical need as measured by the CBCL. In this same study, researchers also found that the gap between non-Hispanic White and African-American mental health service use was more salient at higher levels of need, meaning that a higher proportion of African American children who have severe emotional and behavioral problems are not receiving mental health services at the same rate as non-Hispanic white children who have the same level of clinical need (Leslie et al., 2004). Garland et al. (2003) conducted a study and found that even after the removal of potentially confounding variables, race/ethnicity still significantly contributed to the likelihood of mental health service use for youth involved in public systems of care, including the child welfare system. Non-Hispanic White youth had the highest overall mental health service use for any mental health service when compared to African-Americans, Hispanics, and Asian/Pacific Islanders. This differential rate of receipt of services along racial/ethnic lines constitutes a disparity according to Hill (2007). Hill defines a disparity as, "unequal treatment through differences in services provided to minority children as compared to those provided to similarly situated White children" (2007, p.53). Since this disparity in mental health service use has been established, researchers have been called upon to learn more about the factors contributing to and causing these disparities to enact practices and policies to ameliorate them.

Focus on Child Welfare Caseworkers

One method of determining the causal mechanisms of racial disparities in mental health service use is to explore the pathways that children take to receive mental health service. One pathway that has gained traction is the Gateway Provider Model developed by Stiffman et al. (2004). This model is premised on the notion that children usually do not seek mental health services on their own but typically access services through adults in their lives. The adults that serve children in this capacity are called "gateway providers." In a preliminary study testing the Gateway Provider model, Stiffman et al. (2001) found that 55% of the variance in child mental health service provision was explained by the Gateway Provider Model. For children in the child welfare system, their gateway providers to mental health services are their child welfare caseworkers. Even if the courts and preliminary psychological evaluations initiate mental health services, child welfare caseworkers are responsible for securing those services, determining the best provider and service for their clients, and making the subsequent referral (Fedoravicius et al., 2008; Dorsey, Kerns, Trupin, Conover, & Berliner, 2012; Fitzgerald et al., 2015; Pinna et al., 2015; Whitaker, Rogers-Brown, Cowart-Osborne, Self-Brown, & Lutzker, 2012; Whitaker, Rogers-Brown, Cowart-Osborne, Self-Brown, & Lutzker, 2015). Focusing on child welfare caseworkers

can shed light on why mental health disparities linger as they serve as the gateway to mental health services for children and families in the child welfare system.

Child Welfare Caseworkers and Racial Bias

Individual racial bias within the child welfare system has been widely conceptualized as an implicating factor in racial disparities (Boyd, 2014). Within the child welfare context, individual racial bias can be defined as "a positive or negative attitude, assumption or judgment of any particular racial or cultural group that affects child welfare decision-making practices and policies" (Miller, Cahn, Anderson-Nathe, Cause, & Bender, 2013, p. 1635). Proponents of racial bias as an explanatory factor draw from social cognitive science to explain how bias enters into decision-making (Burgess, Fu & van Ryn, 2004; Azar & Goff, 2007). Azar and Goff (2007) developed a social information processing framework that is comprised of schemas, weak executive functioning, and a combination of those two. Schemas are templates that are used to process incoming information and provide shortcuts that determine how individuals respond to new information. These schemas grow out of individuals' experiences, whether they are in-person, cultural or from the media. Regarding biases, schemas can be connected to certain groups as well as frame how individuals believe interactions between professionals and clients should work. In the case of bias, if schemas about professional-client interactions or about a certain group of people are too rigid or contain biased information, then an individual practitioner's decision-making can be affected. For instance, schemas held by Whites that are tainted with negative images of minorities can affect the associations and interactions they have with them. Executive functioning is a higher cognitive function that encompasses basic mental capacities such as problem solving and flexibility. When an individual is under stress, executive functioning may wane. Specifically, executive functioning is likely to diminish when practitioners are under constant stress from negotiating multiple demands in the context of a stressful working environment. Under these circumstances, mental shortcuts, or schemas may be used instead, which may lead to decisions being made based on split-second appraisals and racial/ethnic stereotypes.

Both Burgess, Fu, and Ryn (2004) and Azar and Goff (2007) suggest that even though practitioners like to believe that they treat each client individually and impartially, evidence has shown that as a result of the cognitive processes of rapid decision-making, humans unconsciously and automatically apply stereotypes about groups of people on different domains on individuals. This can occur regardless of whether the individual fits those stereotypes or not and regardless of the motivation of the practitioner to use individual information. Additionally, practitioners may have conscious egalitarian and non-prejudice beliefs about racial minorities while simultaneously having unconscious automatic negative beliefs about minorities. This is one reason why racial/ethnic bias may be imperceptible to those who hold these beliefs. When providers have to make quick decisions with limited information under stress, they may use beliefs about specific social groups, including racial/ethnic stereotypes, that a patient belongs to.

Child welfare caseworkers specifically are prone to making quick decisions in duress due to the nature of their jobs. As explained by the street level bureaucrat model that Lipsky (1980) proposed, child welfare casework is characterized by large amounts of work with insufficient resources to meet those demands. As a result, child welfare professionals create and take mental shortcuts to maximize efficiency. Fedoravicius et al. (2008) found this to be true in their qualitative study examining pathways to mental health services for children in the child welfare system. The study reported that while caseworkers reported a desire to make mental health referrals based on individualized assessments, quality of the provider, and fit of the intervention, they find themselves choosing mental health providers based on their ability to make court deadlines and to align with caseworker recommendations. While these mental and procedural shortcuts may maximize efficiency for the caseworker, it is important to know whether these shortcuts are imbued with racial stereotypes as they may be contributing to racial disparities in service use for children.

Racial bias in decision-making can occur even when caseworkers are not under duress. van Ryn and Fu (2003) created a multi-step model that illustrates how perceptions, characteristics and interactions between providers and clients can lead to disparate use in mental health service. van Ryn and Fu (2003) named the perceptions, conscious or unconscious, that the practitioner may hold about the client as the primary mediator of the effect of the client's

race/ethnicity on provider behavior. Subsequently, the provider's interpretation of the client's problems or symptoms is influenced by their perceptions/beliefs about the client. These beliefs that the provider holds about the client's social and behavioral characteristics directly affect their professional and clinical decision-making. This typically happens in two ways: moral rationalizing and appropriateness. In moral rationalizing, the practitioner decides whether a person is deserving of treatment or not, based on the person's characteristics. Regarding appropriateness, a practitioner uses a characteristic of a client to determine whether that person is more or less likely to benefit from a particular treatment. Providers' conscious beliefs and unconscious stereotypes about clients may influence their interpersonal behavior with them, and clients are subsequently likely to recognize these interactions. For instance, a client may pick up on a practitioner's distant behavior, which in turns affects the client's comfort and subsequent interactions with that provider. Thus, a client's sense of satisfaction, attitudes, trust, and behavioral intentions can be influenced by providers' behavior towards them. van Ryn and Fu (2003) then bring their model full circle as client's behaviors shape provider's beliefs about them, which can reinforce previously held biases and stereotypes. This circuitous model demonstrates the influence of provider perceptions on subsequent decision-making and client interactions, which, in turn, may affect client behavior to reinforce provider-held perceptions and stereotypes.

Staudt (2011) explains that examining practitioner biases is salient as practitioner explanations for child behavioral problems and treatment can affect the practice and referral decisions and subsequent quality of treatment that the child receives. While unconscious and unintentional, individuals use bias and errors in the form of stereotypes when processing information. This is true of social workers as well. Subsequently, biased information based on race, age, gender, and socioeconomic status can be used to make treatment recommendations, leading to disparities in mental health service use. Potential consequences include inappropriate treatment recommendations, if referred at all, and lack of parent and child engagement in both child welfare and mental health services, leading to poorer outcomes.

Yet, there is minimal research on child welfare caseworker racial bias and its role in mental health disparities (Fluke, Harden, Jenkins & Ruehranz, 2011). Much of the literature to date has focused on racial bias among community members and mandated reporters in making reports to the child welfare system (Chaffin & Bard, 2006; Goerge & Harden, 1993; Harris & Hackett, 2008). Studies that do focus on caseworker racial bias focus on decision-making around investigating reports of child maltreatment and foster placement (Howell, 2008; Levine, Doueck, Freeman, & Compaan, 1996; Rolock & Testa, 2005). Studies exploring the role of child welfare caseworkers as gateway providers to mental health services examined caseworker skill in screening for mental health problems, knowledge of available services, and attitudes towards mental health services and evidence-supported interventions (Dorsey et al., 2012; Fitzgerald et al., 2015), not the potential role that child welfare caseworker racial bias may have in their decisions to refer to mental health services. Thus, this current study seeks to extend the literature by examining the role that child welfare caseworker racial bias may have on mental health disparities for children of color in the child welfare system.

The Current Study

As previously mentioned, racial biases and use of stereotypes can be conscious or unconscious and individuals tend to provide egalitarian and non-prejudicial responses when asked directly about their own racial/ethnic bias and if that affects their decision-making and interactions with others. An alternative method of eliciting bias is to examine caseworker language. According to Gee (2011), language is not just used to provide information, but it is also used to construct social, cultural, and political identities, relationships, institutions and practices; this is called language-in-use. Language is used to say, do and be, which then enacts certain practices. These practices give language-in-use meaning because the practices always belong to certain social groups, cultures, or institutions (Gee, 2011). Thus, when individuals enact these practices- using language-in-use- these social groups, cultures, and institutions are sustained. To that end, examining caseworker language can illuminate biases that contribute to mental health disparities as exploring caseworker language can reveal caseworker orientations, and ultimately practices, that may not emerge when individuals are directly questioned.

Structuralist and Individualist Orientations

Examining child welfare caseworkers' orientation matters, as their pivotal role as gateway providers to mental health services can be affected by the racial bias inherent in individualist orientations. Hay (1995, p. 189) posits that "every time we construct, however tentatively, a notion of social, political or economic causality we appeal, whether explicitly (or more likely) implicitly, to ideas about structure and agency" (Hay, 1995, p.189). Those with structural orientations or structuralists, believe that institutions and societal structures constrain human behavior and that humans are essentially coerced into action (Wight, 2003). Individuals with individualist orientations, also known as methodological individualism or agency, see all social actions as the result of individual actions which are determined by personal beliefs and desires (Wight, 2003). The danger in an individualist orientation is that blaming racial disparities on individual and attitudinal factors is what Bonilla-Silva (2014) describes as colorblind racism- using nonracial factors and dynamics to explain current-day racial inequality. Through Bonilla-Silva's lens, an individualist orientation is inherently racist, as it does not attribute racial inequalities to structural racist mechanisms, but rather to cultural and individual beliefs and actions. For child welfare caseworkers, an individualist orientation minimizes the role of institutional racism that still exists in society and shifts the focus from addressing systemic barriers to individual-level intervention. An individualist orientation can also contribute to racial disparities as caseworkers may fail to address structural barriers to service use, further disadvantaging children of color.

Therefore, the current study seeks to answer the following question: To what extent do child welfare caseworkers attribute mental health disparities to institutional, societal, or system structures (structuralist language) or to individual choice and agency (individualist language)? The study uses qualitative data (Garcia, Circo, DeNard, & Hernandez, 2015) examining barriers and facilitators to mental health services for children of color involved in the child welfare system. Garcia et al.' (2015) study illuminated caseworker experiences, barriers and perceptions of mental health disparities but did not address the role that individual caseworkers may play in perpetuating racial disparities. Therefore, this study seeks to further extend Garcia et al.' (2015) study findings by examining potential causal factors of mental health disparities not explored in the original study.

Methods

Larger Study

As previously mentioned, this study analyzes qualitative data from a larger study examining barriers and facilitators to mental health services for children of color involved in the child welfare system (Garcia et al., 2015). This larger study involved engaging with child welfare system leaders in a large Mid-Atlantic city who were charged with the responsibility to increase positive outcomes for children involved in the child welfare system by contracting case management services out to one of the newly developed decentralized Community Umbrella Agencies (CUAs). The intent of the CUA model was to ensure children and families access services within their own communities. The larger study was created to inform city administrators on the needs and potential solutions to ensure that children receive needed mental health services within their communities as the Department of Human Services (DHS) continues with this organizational change. In this particular city, there is a substantial minority population in the child welfare system where in all of the districts except for one, the majority of children served by the child welfare system are African-American and Latino (H. Kline, personal communication, 2014). Situated in a large urban area with a significant minority population, this particular setting provided an opportunity to examine racial disparities in mental health access and use for children of color within the child welfare system. The study received approval from all appropriate Institutional Review Boards.

Participants

Between October 2013 and January 2015, participants consisted of 36 child welfare caseworkers employed by the newly contracted CUAs that participated in one of five focus groups, at their respective CUAs, to discuss barriers and facilitators to mental health service use for children of color within the child welfare system. Researchers worked with CUA supervisors to recruit caseworkers that were knowledgeable about the study topic. Interested caseworkers signed informed consent forms and comprised the focus group. Participants were provided food and were compensated for their

participation. The majority of participants were women (n = 32) and identified as Black/African-American ($n = 24$). Other participants identified as Caucasian (n = 5), Latino ($n = 5$), Asian ($n = 1$) and other ($n = 1$). Caseworkers in the study reported having an average of 8.2 years of experience working with clients and the majority ($n = 33$) of caseworkers reported having at least a Bachelor's degree, with thirteen reporting attaining a master's degree in social work or a related field.

Data Collection and Analysis

In the parent study, researchers conducted focus groups using a semi-structured focus group guide created to generate discussion on mental health disparities within the child welfare system. Each focus group was 90 to 120 minutes long and was audio recorded, professionally transcribed, and reviewed for accuracy by the research assistants who were present at the focus groups.

Current Study

The focus group transcripts from the parent study were imported into Atlas.ti, a qualitative data management software, for analysis. Since this project examines how language can directly influence action, discourse analysis was used to analyze the data. Discourse analysis focuses on how language is used to shape social norms, personal and group identities, and social and political relationships (Starks & Trinidad, 2007). This analysis enabled the researchers to pinpoint how provider language translates into client perception and thus, client interaction. In order to elicit these perceptions, targeted questions were developed based on the seven building tasks of language, which are the linguistic tools society uses to build and design our worlds (Gee, 2011). The seven tasks are significance, activities, identities, relationships, social goods, connections, and sign systems and knowledge. Based on the research question, this study examines how language is used to build (a) activities: recognize that someone or something is engaging in an activity or practice; (b) identities: recognize that someone or something is taking on an identity or role; (c) connections: build connections; (d) relationships: signal what sort of social relationship exists; and (e) social goods: describe the nature of the distribution of social goods (Gee, 2011). Using these building tasks, questions were developed to examine caseworker language around individual level and system- level causes of mental health disparities and their role in facilitating access or mitigating mental health disparities. The questions were then used to develop codes, which were then applied to how child welfare caseworkers responded to solicitations for explanations of mental health disparities among children of color (see appendix A for the list of questions). Caseworker responses were then organized into structuralist and individualist categories based on where caseworkers attributed blame for mental health disparities. For rigor in this analysis, triangulation and peer debriefing and support were used. Reflexivity was achieved by keeping memos and journaling throughout the analysis, and by peer debriefing.

Results

The responses from these direct questions have been organized into structuralist and individualist responses. Structuralist responses include (1) institutional and community level factors that impact social work practice, including availability of services, funding, institutional racism, and community-level sentiments about mental health and (2) organizational factors, which includes the role of mental health agencies, the role of the CUA and DHS, interagency collaboration and agency culture, and cultural competency of practitioners and agencies. Individualist responses encompass individual choice, the role of the parent and financial incentives, how caseworkers talked about compliance, accountability and empowerment, and what caseworkers perceive their role is, if any, in facilitating mental health service use for children.

Structuralist Responses

Institutional and Community Factors

Availability of Services. In all five focus groups, caseworkers described the lack of mental health services in certain communities that their clients reside in. One caseworker shared that the "resources in the neighborhoods that we work with, they're just very limited." Certain services are only located in certain sectors of the city and for specialty mental health services, specialized therapy for child victims of sexual abuse for example, there may only be one agency with one location servicing the entire city. Caseworkers explained

that "it's really difficult for a lot of our families to get to and if there were more of these services in other areas of the city that would make things a lot easier."

Lack of Funding. Lack of funding was also a reoccurring theme throughout the focus groups. Caseworkers attributed the absences of services to lack of available funding for programs in the communities that they work in. This lack of funding can also be connected to the larger policy initiatives such as the transition from DHS to the CUAs, as one caseworker described: "And losing funding because, more funding from their organizations are now being fed into what the City is doing with CUA. So now they have less money, they are laying off more people and making it not able for them to service all the people we need them to service again…"

Institutional Racism. Additionally, some caseworkers related these large-scale issues to race and the effect that structural discrimination has on mental health service use. In one focus group, caseworkers present at the meeting discussed the impact of institutional racism and the isolation of minority populations in resource-poor areas. They conveyed that concepts of racism, lack of funding, and subsequent lack of services in certain communities are inter-related. One caseworker cited poverty and miseducation as factors that comprise the framework of institutional racism, and argued that these factors contribute greatly to mental health disparities. The caseworker then goes on to describe the role disenfranchisement has on access to mental health services: "…you have a community that lacks so many resources and opportunities, we are talking about unemployment, underemployment, access to resources…because when you go to affluent areas, they have those things and they thrive."

Community Sentiments Around Mental Health (Stigma). Stigma within the American population as a whole and within minority communities was offered by several caseworkers as an explanation for mental health disparities. Caseworkers described how mental health in general is stigmatized, contributing to a lesser likelihood of individuals seeking and using mental health services when in need. In addition, caseworkers shared that this stigma of mental health disorders and service use is intensified in the African-American and Latino communities. One caseworker offered her perspective on mental health disparities: "A lot is cultural too. If you don't buy into the therapy you're not going to stick to it, that's a really big issue with a lot of Latin or Black people, they don't buy into it."

Organizational Factors

Role of Mental Health Provider. Caseworkers shared that mental health provider characteristics can be to blame for mental health disparities. Agencies may have long waiting lists, specific insurance criteria, or may have staffing issues that affect a child's ability to access and consistently receive mental health services. Caseworkers spoke at length about the challenges that mental health providers cause families and caseworkers themselves. Frustrations with mental health providers came through in caseworker discourse when directly asked about barriers to mental health use and about mental health disparities. A caseworker shared her frustration with mental health providers accordingly: "…one of my kids was on a waiting list to be assigned a psychiatrist for like three months. She went three months without medication. So I mean a lot of the times a lot of the agencies you know, don't really have it together."

Role of Child Welfare Agencies. Caseworkers described the role that child welfare agencies, public and private, play in contributing to mental health disparities. This includes the organizational structure of DHS and the CUA (such as insurance changes when children come into foster care), job support to reduce caseworkers constraints that prevent them from doing the research to connect families with needed services, and the relationship between the CUAs and outside agencies. Caseworkers described how children may lose mental health services when they enter foster care due to changes in insurance and due to issues in the transfer of cases between child welfare agencies, as eloquently described: "There is different insurance when a child is placed [in foster care as] opposed to—informal placement—that has been significant, so like my kids are already connected to a mental service already but then they're placed and then that medical kicks in but no one has the numbers, and DHS isn't doing what they are supposed to do."

Cultural Competency. Caseworkers shared stories of the difficulty mental health therapists had in connecting with the children who are of a different race, culture, or SES. This cultural divide can lead to clients not wanting to attend therapy as one caseworker illustrated: "…there are a lot of places that may just not particularly fit that client's need and especially when you deal with a lot of the inner city kids that we deal with and you take them to some of these agencies where, they can't identify with our kids and the kids know it, so therefore they're not buying into the therapy." But in this instance, caseworker language places the responsibility on the mental health agencies and subsequently providers to account for cultural and racial differences by having providers become fluent in different languages and become aware of different cultural practices.

Individualist Responses

Individual Choice

A few caseworkers believed that there are mental health disparities because parents do not prioritize mental health services for children or because the children do not want to go. Even when caseworkers discussed systemic, community, and organizational factors that impede mental health service use, some caseworkers countered with explanations such as: "… it's not that hard for them to get to [the sexual abuse treatment center], they don't want to go…people make time. They get to where they want to go and want to do. Downtown is not that far, I don't care where you live. If you have a child that needs sex therapy, you're going to get them there. I'm just not buying that you can't get there, especially when we give you [bus fare] so you [can] get there."

Role of the Parent

Caseworkers also described how parents must get to a place where their family functioning or ability to parent effectively is disrupted before they will seek mental health services. Once a caregiver's life starts to become impacted, as one caseworker described it by "constantly getting called by the school to come down there every single day to pull the kids out or they are just making their house too disruptive and they can't even get anything done," then that caregiver will access mental health services for their child. This language expresses the impact a child's behavior has on the parent, not the child, before parents decide to take children to receive mental health services.

Financial Incentive

Caseworkers in several focus groups cited the financial incentive for minority parents to take their children to mental health appointments. When children are eligible for Supplemental Security Income (SSI), they are required to be seen by mental health providers, according to caseworkers. If parents do not take their children to these appointments, they are at risk of losing their financial benefits. Thus, the benefits, as opposed to the wellbeing of the child, are incentives for minority parents to seek mental health services for their children. Caseworkers see this as an individual choice as parents are selective in which appointments they will make the effort to attend. Those appointments where there is financial benefit take precedence over other appointments that solely focus on child wellbeing. One caseworker describes this phenomenon: "…if their welfare check was told they are being cut off, they will be at that office [at] eight o'clock in the morning. Let somebody tell you that your son is flunking out of school or not doing something, 'Well I can't make that appointment.'"

This notion of racial and ethnic minorities choosing to attend appointments for financial gain is in contrast to caseworkers' belief that Caucasian families access mental health services for the wellbeing of their children. A racial minority caseworker illustrates this belief: "I think that one thing is that, when I was reading some things that we are not as receptive to therapy as Caucasian are because a lot of our people - a lot of us want it so that our kids can get SSI. I have a lot times seen if they get therapy they get SSI but they're not really invested into it. The Caucasian ones, they are more open to the mental health aspect to make sure that their foster child is getting the proper attention that they need…"

Talk of Who is Responsible for Mental Health Service Receipt

The following discourse emerged when caseworkers were discussing mental health service use for the families that they serve in general. As they shared some of the difficulties in having children that they work with receive mental health services, caseworkers used language that at a fundamental level placed responsibility for using mental health services on primary caregivers.

This language is not only used in regard to mental health service use, but is pervasive within the child welfare system (Atkinson & Butler, 1996; Famularo, Kinscherff, Bunshaft, Spivak, & Fenton, 1989).

Compliance Talk. Within child welfare, compliance is usually defined as caregivers adhering to court orders, attending groups and treatment as prescribed, and completing other agency mandated directives (Atkinson & Butler, 1996; Famularo et al., 1989). The term compliance assumes the responsibility for completing agency and court mandates within the child welfare system is with the caregiver, regardless of environmental or systemic issues. Examining how child welfare caseworkers use the language of compliance may reveal whether they hold caregivers responsible for accessing and using mental health services. During the focus groups, caseworkers repeatedly described the need for parental compliance and the impact it has on court and other child welfare decisions. One caseworker described how parents involved in the child welfare system are familiar with the term *compliance*, and have accepted the individual responsibility of completing activities that they have been mandated to do, including using mental health services for themselves or their children. This caseworkers shared, "I had two families and they didn't take me as serious and now I'm pulling them to court, and now it's, 'I'm going to cooperate, I'm going to do everything, I want to be compliant,' because they didn't realize that we had that type of power; it was before like 'Oh! You know, y'all going to be here, how long? When you going to discharge my case? When you going to close out my case?' even if you hadn't done anything you are supposed to…"

Accountability Talk. Another emerging theme was caseworkers' use of accountability language regarding who is responsible for ensuring children in the child welfare system receive mental health services. While caseworkers acknowledged that there are other systemic and organizational factors that affect mental health service, several caseworkers agreed that "it goes back to accountability as parents," as individual caregivers are ultimately responsible for their child(ren)'s mental health service use. Regarding caregivers, one caseworker said, "Because at the end of the day you brought your child into the world…This is your job, we're here to support you, but if you don't take [your children] to the appointment, if you don't follow up the recommendations, if you don't take them to school, if you don't help with the homework, your child is going to fail because you're the main support; we are here to help you."

Empowerment Talk. Thus while caseworkers seem to hold parents ultimately responsible for knowing what is best for their child and taking steps to meet those needs, their use of empowerment language is also indicative of a non-punitive stance that parents are the experts regarding their children and should have a voice when discussing their children. This caseworker illustrates the importance of providers and child welfare officials communicating with parents when making decisions about their children: "So, you should be directing it to the parent because they're the actual experts. Like when I'm long and gone they'll still be with this child. So, I think it is important for the state to communicate with the parents and not just talk to each other and nobody is asking the parent when they're the expert because they're the ones that's been with the child the longest and will still be with the child. I think that's important." Even when caseworkers used language affirming caregivers' integral role and advocating for caregiver participation in making decisions for their children, child welfare caseworkers still place the responsibility for action on individual caregivers instead of other larger systems and organizations. This language was minimally present when caseworkers were directly asked to provide their explanations and thoughts on mental health disparities; rather it emerged when caseworkers discussed barriers to mental health service use for all children involved in the child welfare system.

Caseworker Role

Even while discussing systemic, organizational, and client level factors that contribute to mental health disparities, caseworkers still inserted themselves as integral players in mental health service use. The role that caseworkers described that they have in facilitating mental health service use among children that they work with can be used as their recommendations to address individual level causes for mental health disparities. Caseworkers described themselves as conduits of and advocates for mental

health service use. They also described how their relationship with clients can facilitate mental health service use.

Caseworker Role as Conduit

Caseworkers see themselves as the conduit for the clients that they work with to access different services, including mental health services. They take this responsibility seriously, and even with structural and organizational issues, caseworkers perceive they are held responsible for clients having access to mental health services. Whether it is finding appropriate services and making referrals to providing transportation to children to mental health appointments, caseworkers perceive themselves as the channel through which children can access services. One caseworker shared: "So they don't have resources, they don't have family supports and you are all they got and it's taking a lot of your time. So I help them and link them to resources."

Caseworker Role as Advocate

Caseworkers take their role as a conduit of services for families seriously as they not only connect families with services, but they also seek to connect families with the best services available. Caseworkers describe how they "have to make sure that our clients are getting the best possible services because in the end it's our job to ensure that—that's one of the goals of the service plan." Several caseworkers described how they try to find accessible and effective services in hopes that clients will make progress and continue to attend therapy because they are seeing positive changes.

Caseworker Relationship with Client

Caseworkers relied upon their one-on-one working relationships with their clients to facilitate mental health service use. One caseworker, who currently sees a counselor, shared that with her clients, she uses appropriate self-disclosure to alleviate fears of mental health treatment and to promote mental health use for children that need it. Caseworkers discussed how once trust is established between families and caseworkers, families are more open to adopting their recommendations. A caseworker describes this process: "…a lot of times they are not very receptive initially but we make them—once you build a rapport with them you kind of get a little—they get to know you a little bit better. They start taking your advice…" (Garcia et al., 2015).

Discussion

The purpose of this study was to illuminate whether and how caseworker's structuralist and/or individualist language explain pathways that lead to mental health disparities in the child welfare system. Both types of language were offered by caseworkers, as well as language describing their role as caseworkers in facilitating access to mental health services for children.

Structural Orientation

Institutional, community, and organizational factors were offered by those who adopt the structuralist orientation. Relying upon nationally representative longitudinal data of children referred to the child welfare system due to reports of maltreatment, Garcia, Kim, and DeNard (2016) showed that disparities in utilization of services are no longer detected after taking into account organizational climate, suggesting indeed that "structural" dynamics play a fundamental role in reducing disparities. Difficulties of collaborating with other child-serving agencies, navigating payment and reimbursement for mental health services, and worker overload/burden were some of the specific organizational barriers they referenced.

A robust body of research validates caseworkers' reporting of the other structural factors they cited (Aarons & Palinkas, 2007; Garcia et al., 2015). For example, accessibility and proximity to effective and culturally applicable services is impossible without adequate funding to serve the disproportionate number of youth and families of color in the child welfare system (Garcia et al., 2015; Horwitz, Hurlburt, & Zhang, 2010). Institutional racism endures in light of the overwhelming number of road-blocks communities of color experience in the system compared to their Caucasian counterparts (e.g., disproportionate exposure to poverty, unemployment, crime, and lack of insurance, resources and transportation) (Garcia, 2009; Hines, Lemon, Wyatt, & Merdinger, 2004; McCabe et al., 1999). The roadblocks are often met with unjustifiable and often punitive mental health treatment, as indicated by, for example, caseworkers' descriptions of long waiting lists to be seen by a mental health provider and their tendency to engage in

ways that are not culturally applicable. What these findings add to prior research, beyond validating previous findings, is that the caseworkers relied on specific discourses, often implicitly, to articulate deep-seated organizational and community factors that significantly impact mental health service use; yet felt they are outside the realm of their individual control. What can be surmised from this is the need to mobilize resources, funding, and leaders to eradicate these barriers and, in turn, pave "gateways" for caseworkers to deliver services.

Individual Orientation

While many caseworkers believe the root causes of disparities are attributable to lack of structural gateways or opportunities, they also contend that it is rooted in individualistic orientations. In this study, caseworker language around compliance, accountability, and empowerment reflect individualist orientations. A salient example of this orientation is exemplified by the language used by this caseworker: "they don't want to go to therapy, and they don't want to go to parenting classes, they don't want to do all these things. They don't think they need it." In these exemplars, the caseworker explains lack of mental health service use with caregiver apathy and caregiver choice. This reflects the methodological individualism description Wight (2003) gives as it highlights behavior due to individual belief and desires. Caseworkers' use of compliance terms and ultimately holding primary caregivers responsible for recognizing changes in their child and advocating for them to get needed services illuminates an individualist orientation as well. Even with the caregiver-affirming language of empowerment, the outcome of mental health service use is still placed in the individual caregiver's control. A number of scholars recognize the salient role parents and caregivers play in whether and to what extent their respective children engage in mental health treatment (Alegria et al., 2008; Attride-Stirling, Davis, Farrell, Groark, & Day, 2004). Beyond providing transportation, skills and resources that encourage parents to actively participate in the process are needed. Both mental health and child welfare providers, for example, can encourage parents to ask questions about the therapeutic process; and provide feedback on agreed upon goals, tasks, and homework activities between sessions. Monitoring progress and the interactional nature of the working alliance are also integral to continued engagement in mental health services (McKay & Bannon, 2004; Platt, 2012).

While these parent engagement activities may increase intrinsic motivation to actively engage in the therapeutic process, some caseworkers reported financial incentive as the reason for minority caregivers to seek and engage in mental health services for their children. While this may be indicative of methodological individualism (Wight, 2003), it is worth acknowledging also that poverty may coerce parents to make decisions based on government eligibility (e.g., SSI) for income assistance. The caseworkers' language conceptualizes the financing within an individualistic orientation, arguing that it is "the wrong reason" for accessing mental health services.

Explicit and implicit language used by caseworkers pinpoint the salience of colorblind or "cultural" racism in the context of mental health service delivery. Bonilla-Silva (2014) defines colorblind racism as the belief held by society that "minorities' standing is a product of their lack of effort, loose family organization, and inappropriate values," (pg. 88). According to his theoretical lens, it is assumed that minorities are to blame for their lesser standing. This argument was exemplified by the language caseworkers used to conclude that Blacks and Latinos are less likely to seek out mental health services and that there is a greater stigma in their communities around mental health. The tendency for some providers to shift the blame for racial disparities on parents by assuming they have less intention to engage in their children's treatment is supported by scholars (Alegria et al., 2008; Dovidio et al., 2008; Van Ryn & Fu, 2003). However, scholars, as well as other caseworkers in the current study, are quick to point out that their "lack of" intention may be due to stigma associated with professional help-seeking (Corrigan, 2004; Nadeem et al., 2007; Sykes, 2011).

Individualistic orientation is also pervasive by the discourses caseworkers used to describe themselves as conduits and advocates for clients. Some caseworkers considered the burden of clients completing tasks on their case plan, which includes completing mental health services, as a significant aspect of their job. Dorsey and colleagues (2012) research is grounded in the assumption that caseworkers serve as gateway providers to mental health services; and thus, must be trained in and/or be aware of evidence-supported

interventions. Her efforts send a clear message to caseworkers' that their intentions and behaviors must be modified to promote mental health service delivery. This assumption, coupled with intrinsic intentions to adhere to agency mandates to promote safety, permanency, and wellbeing, supports this individualistic orientation. Undertaking or "shouldering" the responsibility, they view themselves as the conduit or salient driving force toward the promotion of children's mental health. This belief is further reinforced, as caseworkers described devoting hours beyond their regular schedule to cultivate and sustain a working alliance with children and families to engage them in mental health treatment.

The Individualistic Versus Structuralist Debate

The individualistic orientation, as exemplified by the themes described above, shifts the focus away from structural changes to combating disparities. Their implicit language highlights that as conduits and advocates, while they are responsible for facilitating mental health service use, it is ultimately up to their clients to seek treatment, and remain engaged in the therapeutic process. It is worth considering whether an individual caseworker's position on the individualist-structuralist debate contributes to mental health disparities among children of color in the child welfare system. Based upon an appraisal of individual responses in this study, one can conclude that a caseworker's position will largely dictate whether their role as a gateway provider to mental health services is informed by racial bias inherent in individualist orientations. The data gathered in this study reinforces the previously mentioned social information processing and multistep model frameworks in that individuals hold beliefs and stereotypes about groups of people that are unknown to them, and that these beliefs influence practice decisions and behaviors in high stress situations (Azar & Goff, 2007; Burgess et al., 2004; van Ryn & Fu, 2003). According to Snowden (2003), these unconscious decisions can lead to faulty judgments and inappropriate actions. Inappropriate actions could include caseworkers advocating for change strictly at the individual practice level, blaming clients for not being able to access services or ultimately failing to provide needed mental health referrals because they are relying on biased beliefs and stereotypes about minorities.

Implications for Practice and Policy

The findings suggest that administrators and supervisors need to be aware of caseworker's positionality on the individualist-structuralist spectrum. Unexpectedly, caseworker language revealed that stereotypes about African Americans and Latinos, and individual and cultural explanations holding primary caregivers accountable for mental health service use primarily emerged organically and when caseworkers were *not* directly asked about mental health disparities. Moreover, when describing their everyday practice, caseworkers were naturally inclined to recommend implementing individual level interventions to improve mental health service use among their clients, even when acknowledging the powerful impact of structural and institutional inequalities. This may be the case due to numerous organizational challenges that caseworkers expressed during the focus groups, such as large caseloads, lack of familiarity with the resources in the communities they work in, lack of direction from supervisors, and numerous time constraints (Garcia et al., 2015). The disparate shift toward discussing individualist in comparison to structuralist recommendations may be due to not feeling empowered or qualified to address institutional, policy, or agency issues that influence mental health disparities, rendering individual-level interventions as their only course of action.

Due to the potential consequences of unaddressed child welfare caseworker racial bias, additional practice and policy recommendations are suggested. Regarding practice, integrating Critical Race Theory (CRT) and anti-racist perspectives into any training that caseworkers may receive on diversity and multiculturalism should be explored. Critical Race Theory, which originated in the legal profession, posits that racism is not abnormal, but a part of the fabric of American society, and thus appears natural and normal to individuals (Ladson-Billings, 1998). Thus, the goal for CRT theorists is to unmask and expose the racism that is embedded in the United States' social order (Ladson-Billings, 1998). While cultural competency trainings and courses are status quo in schools of education and agencies, cultural competency oftentimes focuses on individual attitudes, leaving social workers ill-equipped to address broader systems issues (Abrams & Moio, 2009). Furthermore, inherent in cultural competency training is a diffusion of

dimensions of diversity, which has the propensity to encourage an equality of oppressions that can negate the persistent legacy of racism that is interwoven in the fabric of American society and reinforce color-blind racism (Schiele, 2007). By integrating Critical Race Theory elements into training or by teaching caseworkers to critically analyze systems and policies, caseworkers can begin to reframe racial disparities as complex and embedded issues and can have a framework with which to take action to address structural barriers (Abrams & Moio, 2009). Such actions can include advocating for policy change within their child welfare organization and within the mental health agencies that provide their clients' services; petitioning for the expansion of services into historically resource-scarce communities; and collaborating with mental health agencies to facilitate awareness of immersion in racial and ethnic cultures to increase engagement of minorities in mental health services.

With regards to policy, child welfare agency administrators and supervisors can create a culture incorporating an anti-racist perspective on child welfare practice. To incorporate this perspective, staff must have the ability to critically analyze their own biases and to appropriately assess the needs of their clients. Since caseworkers are more likely to revert to stereotypes and biases when making decisions in high stress situations (Azar & Goff, 2007), child welfare administrators can increase job support and implement effective diversity training that incorporate CRT, within child welfare agencies to reduce the influence of racial biases. Increasing job support will provide caseworkers the time to focus on meeting the unique needs of clients as opposed to simply making decisions based on generalizations to maximize efficiency (Fedoravicius et al., 2008). As previously mentioned, integrating CRT based programs can assist in creating a race-conscious organizational culture, where biases and individualist frameworks around racial disparities are questioned and challenged. This will mostly likely require additional funding and restructuring within the agency to provide a less stressful and engaging organizational climate and culture.

Finally, caseworkers offered a wealth of suggestions to address individual-level barriers (e.g., support caseworkers' role as conduits and advocates, sustain a positive helping relationship with clients, and increase parent engagement). The discourse alludes to the fact that these suggestions were made, with the assumption that they would then increase individual choice, motivation, and intrinsic incentive as a "responsible" parent to ensure that their children's mental health need are met. While the dialogue largely focused on these individual orientations, it is notable that they offered a couple of ideas to modify structural conditions. They first suggested that it is essential to educate the community and other systems of care at large about child welfare practice and policy in general, and about the new privatized system in particular. Developing a central database to increase caseworkers' awareness of available services and service receipt in other sectors of care was also discussed.

Future Directions for Research

Future research should examine referral patterns and mental health service use outcomes based on caseworker bias as this can further demonstrate whether child welfare caseworker bias is a causal mechanism for mental health disparities. This could be accomplished using ethnographic methods, where one observes caseworker interaction with clients as well as probes caseworkers about their decision making around referral to mental health services for children on their caseload. Research is also needed to develop measures for racial bias in referral making as well as interventions to address bias for child welfare caseworkers. For example, creating and testing the effectiveness of CRT-based trainings and interventions for use in child welfare agencies is another area of research that is integral to addressing implicit racial bias in child welfare caseworkers. Abrams and Moio (2009) call for research to identify how best to address implementation barriers (training facilitators in CRT methods, costs of training, helping white individuals in their journey towards race consciousness) for these types of trainings. For theory advancement, future research should consider the role of the race/ethnicity of the practitioner or caseworker. In this study, the majority of the caseworkers were racial/ethnic minorities. While the social information processing and multistep model frameworks imply that service providers are White, this study provides initial support for the notion that these biases are used regardless of the provider's race/ethnicity. Future research can explore this line of inquiry further to see if the race/ethnicity of the caseworker is of significance in examining racial bias and the trainings created (CRT training) to reduce them.

Additionally, research can also examine the role of individual-level interventions in perpetuating individualist orientations and to some respect, colorblind racism. While it may be difficult for frontline caseworkers to focus their work on organizational and system levels when their jobs by nature are individual-level interventions, attributing individual actions to "subjective beliefs, wants, and desires" (Bonilla-Silva, 2014) presupposes a nonracial cause for a racial disparity. Research further exploring individual-practice level orientations and behaviors of social workers may reveal recommendations and/or practical training interventions to mitigate colorblind racism as a tool to ameliorate racial disparities. If such a relationship is found, research examining this same relationship in other direct practice occupations is warranted.

Limitations

This study has several limitations. One limitation is that there is no data on the actual caseworker-client interactions. The source of data is the retrospective report of child welfare caseworkers in how they seek to ameliorate mental health disparities, without any documentation or observations of these interactions. Additionally, due to the setting of this study, most of the caseworkers that attended the focus groups were not Caucasian. Responses may have been different if more of the caseworkers were Caucasian. Another consideration is the effect of the race and ethnicities of the researchers who conducted the focus groups. All of the researchers are racial or ethnic minorities, which may have affected the openness of caseworkers to talk about race and disparities. The researchers were aware of this potential influence, and discussed its impact openly. Additionally, the interpretation of the discourses in this study relied on the subjective biases of the first author. While this is normative in discourse analysis, peer debriefing was used to support and maintain the rigor of the analysis. Furthermore, findings should be interpreted in the context of privatized child welfare agencies that are in the midst of transitioning services.

Despite these limitations, the study offers a valuable contribution by relying upon a novel methodology (discourse analyses) to unravel why racial disparities in mental health service use lingers in the child welfare system. Findings pinpointed implicit and explicit language used by caseworkers to highlight the impact of individual and structural barriers. In addition, the study lends a voice that is often silenced to those who are on the frontline, serving some of this country's most vulnerable youth and families in stressful and overburdened organizational and agency contexts. Nonetheless, caseworkers were capable of stepping away from their insider roles to elucidate the structural conditions and capacities they need to ensure youth and families receive effective and applicable services. Finally, by capitalizing on caseworker discourse and prior research finding, the study lends specific research, practice, and policy recommendations to reduce racial disparities in mental health services for youth served in the child welfare system. It is incumbent upon researchers, system leaders, and community stakeholders to take stock of the recommendations presented, and decide to what extent it would be advisable to implement them in a local context.

Conclusion

Examining caseworker discourse on mental health disparities revealed structural and individual orientations within caseworkers and that implicit biases embedded within individualist orientations arose, which can affect caseworker recommendations and decision-making. It was concluded that equipping child welfare caseworkers with the racial lens and tools to have awareness of their own biases and to advocate for clients in the policy and agency levels are ways to address the effect of caseworker bias. Future research is recommended to create interventions integrating Critical Race Theory into diversity trainings, examine caseworker implicit bias on mental health referrals and service use outcomes and to explore the relationship between social work direct practice and the perpetuation of colorblind racism.

References

Aarons, G. A., & Palinkas, L. A. (2007). Implementation of evidence-based practice in child welfare: Service provider perspectives. *Administration and Policy in Mental Health and Mental Health Services Research*, *34*, 411–419.

Abrams, L. S., & Moio, J. A. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education*, *45*, 245–261. doi: 10.5175/JSWE.2009.200700109

Alegría, M., Polo, A., Gao, S., Santana, L., Rothstein, D., Jimenez, A., … & Normand, S. L. (2008). Evaluation of a patient activation and empowerment intervention in mental health care. *Medical Care*, *46* (3), 247.

Atkinson, L., & Butler, S. (1996). Court-ordered assessment: Impact of maternal noncompliance in child maltreatment cases. *Child Abuse & Neglect*, *20*, 185–190. doi: 10.1016/S0145-2134(95)00146-8

Attride-Stirling, J., Davis, H., Farrell, L., Groark, C., & Day, C. (2004). Factors influencing parental engagement in a community child and adolescent mental health service: A qualitative comparison of completers and non-completers. *Clinical Child Psychology and Psychiatry*, *9* (3), 347–361.

Azar, S. T., & Goff, P. A. (2007). Can science help Solomon - child maltreatment cases and the potential for racial and ethnic bias in decision making. *St. John's Law Review*, *81*, 533.

Bonilla-Silva, E. (2014). *Racism without racists: Color-blind racism and the persistence of racial inequality in the United States*. Boulder, CO: Rowman & Littlefield Publishers.

Boyd, R. (2014). African American disproportionality and disparity in child welfare: Toward a comprehensive conceptual framework. *Children and Youth Services Review*, *37*, 15–27.

Burgess, D. J., Fu, S. S., & Ryn, M. (2004). Why do providers contribute to disparities and what can be done about it? *Journal of General Internal Medicine*, *19* (11), 1154–1159. doi: 10.1111/j.1525-1497.2004.30227.x

Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*, 960–970. doi: 10.1097/01.chi.0000127590.95585.65

Chaffin, M., & Bard, D. (2006). Impact of intervention surveillance bias on analyses of child welfare report outcomes. *Child Maltreatment*, *11* (4), 301–312.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*, 614–625.

Dorsey, S., Kerns, S. E. U., Trupin, E. W., Conover, K. L., & Berliner, L. (2012). Child welfare caseworkers as service brokers for youth in foster care findings from project focus. *Child Maltreatment*, *17* (1), 22–31. doi: 10.1177/1077559511429593

Dovidio, J. F., Penner, L. A., Albrecht, T. L., Norton, W. E., Gaertner, S. L., & Shelton, J. N. (2008). Disparities and distrust: The implications of psychological processes for understanding racial disparities in health and health care. *Social Science & Medicine*, *67* (3), 478–486.

Famularo, R., Kinscherff, R., Bunshaft, D., Spivak, G., & Fenton, T. (1989). Parental compliance to court-ordered treatment interventions in cases of child maltreatment. *Child Abuse & Neglect*, *13*, 507–514. doi: 10.1016/0145-2134(89)90054-9

Fedoravicius, N., McMillen, J. C., Rowe, J. E., Kagotho, N., & Ware, N. C. (2008). Funneling child welfare consumers into and through the mental health system: Assessment, referral, and quality issues. *The Social Service Review*, *82*, 273–290. doi: 10.1086/589780

Fitzgerald, M. M., Torres, M. M., Shipman, K., Gorrono, J., Kerns, S. E., & Dorsey, S. (2015). Child welfare caseworkers as brokers of mental health services a pilot evaluation of project focus Colorado. *Child Maltreatment*, *20* (1), 37–49.

Fluke, J., Harden, B. J., Jenkins, M., & Ruehrdanz, A. (2011). Research synthesis on child welfare disproportionality and disparities. *Disparities and Disproportionality in Child Welfare: Analysis of the Research*, 1–80. Retrieved from http://www.cssp.org/publications/child-welfare/alliance/Disparities-and-Disproportionality-in-Child-Welfare_An-Analysis-of-the-Research-December-2011.pdf

Garcia, A. (2009). Contextual pathways to Latino child welfare involvement: Intersecting place, culture, and socio-structural factors. *Children and Youth Services Review*, *31*, 1240–1250.

Garcia, A., Aisenberg, E., & Harachi, T. (2012). Pathways to service inequalities among Latinos in the child welfare system. *Children and Youth Services Review*, *34*, 1060–1071. doi: 10.1016/j.childyouth.2012.02.011

Garcia, A., Circo, E., DeNard, C., & Hernandez, N. (2015). Barriers and facilitators to delivering mental health practice strategies for youth and families served by the child welfare system. *Children and Youth Services Review*, *52*, 110–122

Garcia, A., & Courtney, M. (2011). Prevalence and predictors of service utilization among racially and ethnically diverse adolescents in foster care diagnosed with mental health and substance abuse disorders. *Journal of Public Child Welfare*, *5*, 521–545. doi: 10.1080/15548732.2011.617277

Garcia, A. R., Kim, M., & DeNard, C. (2016). Context matters: The state of racial disparities in mental health services among youth reported to child welfare in 1999 and 2009. *Children and Youth Services Review*, *66*, 101–108.

Garcia, A. R., Palinkas, L. A., Snowden, L., & Landsverk, J. (2013). Looking beneath and in-between the hidden surfaces: A critical review of defining, measuring and contextualizing mental health service disparities in the child welfare system. *Children and Youth Services Review*, *35*, 1727–1733. doi: 10.1016/j.childyouth.2013.07.013

Garland, A. F., Landsverk, J. A., & Lau, A. S. (2003). Racial/ethnic disparities in mental health service use among children in foster care. *Children and Youth Services Review*, *25*, 491–507. doi: 10.1016/S0190-7409(03)00032-X

Gee, J. P. (2011). *An introduction to discourse analysis: Theory and method*. London, UK: Routledge.

Goerge, R. M., & Harden, A. (1993). *The impact of substance-affected infants on child protection services and substitute care caseloads: 1985–1992*. Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

Gudiño, O. G., Martinez, J. I., & Lau, A. S. (2012). Mental health service use by youths in contact with child welfare: Racial disparities by problem type. *Psychiatric Services*, *63*, 1004–1010. doi: 10.1176/appi.ps.201100427

Harris, M. S., & Hackett, W. (2008). Decision points in child welfare: An action research model to address disproportionality. *Children andYouth Services Review*, *30* (2), 199–215.

Hay, C. (1995). Structure and agency. In D. Marsh & G. Stoker (Eds.), *Theory and methods in political science* (pp. 189–207). Basingstoke: Macmillan.

Hill, R. B. (2007). An analysis of racial/ethnic disproportionality and disparity at the national,state, and county levels. *Casey-CSSP Alliance for Racial Equity in Child Welfare*, *27*. Retrieved from http://www.fellows.mobile.aecf.org/m/resourceimg/aecf-AnalysisofRacialEthnicDisproportionality-2007.pdf

Hines, A. M., Lemon, K., Wyatt, P., & Merdinger, J. (2004). Factors related to the disproportionate involvement of children of color in the child welfare system: A review and emerging themes. *Children and Youth Services Review*, *26*, 507–527.

Horwitz, S. M., Hurlburt, M. S., Goldhaber-Fiebert, J. D., Heneghan, A. M., Zhang, J., Rolls-Reutz, J., … & Stein, R. E. K. (2012). Mental health services use by children investigated by child welfare agencies. *Pediatrics*, *130*, 861–869. doi: 10.1542/peds.2012-1330

Horwitz, S. M., Hurlburt, M. S., & Zhang, J. (2010). Patterns and predictors of mental health service use by children in contact with the child welfare system. In M. B. Webb, K. Dowd, B. J. Harden, J. Landsverk, & M. F. Testa (Eds.), *Child welfare and child well-being: New perspectives from the national survey of child & adolescent well-being*, pp. 279–329. New York: Oxford University Press.

Howell, M. L. (2008). Decisions with good intentions: Substance use allegations and child protective services screening decisions. *Journal of Public Child Welfare*, *2* (3), 293–316.

Hurlburt M. S., Leslie L. K., Landsverk J., et al. (2004). Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry*, *61*, 1217–1224. doi: 10.1001/archpsyc.61.12.1217

Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education? *International Journal of Qualitative Studies in Education*, *11* (1), 7–24.

Leslie, L. K., Hurlburt, M. S., Landsverk, J., Barth, R., & Slymen, D. J. (2004). Outpatient mental health services for children in foster care: a national perspective. *Child Abuse & Neglect*, *28*, 697–712. doi: 10.1016/j.chiabu.2004.01.004

Levine, M., Doueck, H. J., Freeman, J. B., & Compaan, C. (1996). African American families and child protection. *Children and Youth Services Review*, *18* (8), 693–711.

Lipsky, M. (1980). *Street-level bureaucracy.: Dilemmas of the individual in public service*. New York, NY: Russell Sage Foundation.

McCabe, K., Yeh, M., Hough, R. L., Landsverk, J., Hurlburt, M. S., Culver, S. W., & Reynolds, B. (1999). Racial/ethnic representation across five public sectors of care for youth. *Journal of Emotional and Behavioral Disorders*, *7* (2), 72–82.

McKay, M. M., & Bannon W. M. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America*, *13*, 505–521.

Miller, K. M., Cahn, K., Anderson-Nathe, B., Cause, A. G., & Bender, R. (2013). Individual and systemic/structural bias in child welfare decision making: Implications for children and families of color. *Children and Youth Services Review*, *35*, 1634–1642.

Nadeem, E., Lange, J., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and US-born black and Latina women from seeking mental health care? *Psychiatric Services*, *58* (12), 1547–1554.

Pinna, K. L., Lewis, L. K., Karatekin, C., Lamb-Onyiga, A., Hirilall, A., & Jones, S. D. (2015). Evidence-based parenting programs for maltreating parents: Views of child protective services caseworkers. *Journal of Public Child Welfare*, *9* (4), 362–381.

Platt, D. (2012). Understanding parental engagement with child welfare services: An integrated model. *Child & Family Social Work*, *17* (2), 138–148.

Rolock, N., & Testa, M. F. (2005). Indicated child abuse and neglect reports: Is the investigation process racially biased. In D. Derezotes, J. Poertner, & M. Testa (Eds.), *Race matters in child welfare: The overrepresentation of African American children in the system* (pp. 119–130). Washington, DC: Child Welfare League of America.

Schiele, J. H. (2007). Implications of the equality-of-oppressions paradigm for curriculum content on people of color. *Journal of Social Work Education*, *43* (1), 83–100. doi: 10.5175/JSWE.2007.200400478

Snowden, L. R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*, *93*, 239–243.

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, *17*, 1372–1380. doi: 10.1177/1049732307307031

Staudt, M. (2011). Practitioner biases and child service use disparities: Implications for social work education. *Journal of Teaching in Social Work*, *31*, 145–162. doi: 10.1080/08841233.2011.562108

Stiffman, A. R., Pescosolido, B., & Cabassa, L. J. (2004). Building a model to understand youth service access: The gateway provider model. *Mental Health Services Research*, *6*, 189–198.

Stiffman, A. R., Striley, C., Horvath, V. E., Hadley-Ives, E., Polgar, M., Elze, D., & Pescarino, R. (2001). Organizational context and provider perception as determinants of mental health service use. *The Journal of Behavioral Health Services & Research*, *28*, 188–204. doi: 10.1007/BF02287461

Sykes J. (2011). Negotiating stigma: Understanding mothers responses' to accusations of child neglect. *Children and Youth Services Review*, *33*, 448–456.

Van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health*, *93*, 248–255.

Villagrana, M. (2010). Pathways to mental health services for children and youth in the child welfare system: A focus on social workers' referral. *Child and Adolescent Social Work Journal*, *27*, 435–449. doi: 10.1007/s10560-010-0215-8

Whitaker, D. J., Rogers-Brown, J. S., Cowart-Osborne, M., Self-Brown, S., & Lutzker, J. R. (2015). Public child welfare staff knowledge, attitudes, and referral behaviors for an evidence

based parenting program. *Psychosocial Intervention*, *24* (2), 89–95.

Whitaker, D. J., Ryan, K. A., Wild, R. C., Self-Brown, S., Lutzker, J. R., Shanley, J. R., … & Hodges, A. E. (2012). Initial implementation indicators from a statewide rollout of SafeCare within a child welfare system. *Child Maltreatment*, *17* (1), 96–101. doi: 1077559511430722.

Wight, C. (2003). The agent–structure problem and institutional racism. *Political Studies*, *51*, 706–721. doi: 10.1111/j.0032-3217.2003.00454.x

Appendix A. Tasks, codes, and quotes.

Building Task	Subsequent Question	Atlas Code
Activity: What activity or activities is this piece of language being used to enact?	What is a mental health disparity?	MH disparity definition
Activity: (see above)	How do caseworkers talk about compliance?	Compliance talk
Activity: (see above)	How do they caseworkers about accountability?	Accountability talk
Activity: (see above)	How do caseworkers talk about empowerment?	Empowerment talk
Identity: What identity or identities is this piece of language being used to enact?	Who attends therapy and who does not?	Therapy attendance
Connection: How does this piece of language connect or disconnect things?	How does language connect the role of the state and mental health disparities?	Role of state and MH disparity
Connection: (see above)	How does language connect the role of the parent and mental health disparities?	Role of parent and MH disparity
Connection: (see above)	How does language connect the lack of appropriate services and mental health disparities?	Lack of appropriate services and MH disparity
Connection: (see above)	How does language connect the role of cultural competency and mental health disparities?	Cultural competency and MH disparity
Connection: (see above)	How does language connect institutional racism and mental health disparities?	Role of institutional racism and MH disparity
Connection: (see above)	How does language connect the CUA/DHS and mental health disparities?	Role of CUA/DHS and MH disparity
Connection: (see above)	How does language connect the mental health service providers and mental health disparities?	Role of MH service provider and MH disparity
Relationship: What sort of relationship or relationships is this piece of language seeking to enact with others (present or not)?	What is the relationship between the caseworker and the client? How does this impact mental health service use?	Caseworker and client relationship and impact on MH use
Identity: (see above)	What is the caseworker's identity as an advocate?	Caseworker identity as advocate
Identity: (see above)	What is the caseworker's identity as a conduit (referral source, etc)?	Caseworker identity as conduit
Social Good: What perspective on social goods is this piece of language communicating?	How do caseworkers explain the phenomenon of mental health disparities among children of color in the CW system?	Caseworker explanation of MH disparity
Social Good: (see above)	What do caseworkers recommend to address mental health disparities among children of color in the CW system?	Caseworker Recommendation