

Rapid and Deferred Help Seeking Among African American Parents of Children With Emotional and Behavioral Difficulties

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Objective: Little is known about the factors African American parents consider when seeking care for their child after emotional and behavioral difficulties emerge. This study aimed to examine factors associated with seeking professional care within 30 days after identifying a child's need (i.e., rapid care seeking) and with deferring care for ≥ 1 year.

Methods: This cross-sectional study surveyed African American parents raising a child with emotional or developmental challenges (N=289). Logistic regression was used to examine associations of parent activation, medical mistrust, and care-seeking barriers with two outcomes: rapidly seeking care and deferring care seeking.

Results: About 22% of parents rapidly sought care, and 49% deferred care for 1 year or longer. Parents were more likely to rapidly seek care if they had higher parent activation scores;

lived with other adults with mental health challenges; or, contrary to the authors' hypothesis, mistrusted doctors. Parents were less likely to rapidly seek care if the challenge did not initially bother them much or if their health insurance would not cover the service. Parents were more likely to defer care if they feared involuntary hospitalization for their child or if their health insurance would not cover the service. Parents were less likely to defer care if they had at least some college education or lived with other adults with mental health challenges.

Conclusions: Community-based pediatric and child welfare professionals should be informed about facilitators and barriers to mental health care seeking as part of efforts to develop interventions that support African American families.

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Children with mental health challenges, such as extreme mood swings, anxiety, and difficulty learning or talking, face complex obstacles when engaging with the health care system (1). About one in six U.S. children have been diagnosed with a mental, behavioral, or developmental disorder, and many of these children experience an unmet need for care (2–4). Research investigating these unmet needs must consider factors that influence help seeking among parents and caregivers, the key gatekeepers to care for children (5).

Barriers to mental health care are greater for African American parents, who are more likely than White parents to experience structural obstacles that hinder timely diagnosis (e.g., cost issues) (6–10). African American children are also exposed to systemic racism and other harmful structures in the health care system (e.g., disproportionate contact with juvenile legal systems and diagnostic biases) (9, 11–14). As a result, African American children with emotional and behavioral challenges are more often misdiagnosed and less likely to receive early intervention than are White children (7, 14–17). Few studies examine the

factors that African American parents consider when deciding to seek care for their child after emotional and behavioral difficulties emerge—a time when clinical intervention can be critical for childhood development.

HIGHLIGHTS

- Among 289 African American parents raising a child with emotional or developmental challenges, 22% rapidly sought care (i.e., within 30 days) after identifying a need for help, whereas 49% deferred care for ≥ 1 year.
- Parents were more likely to rapidly seek care if they had higher activation scores, lived with other adults with mental health challenges, or mistrusted doctors.
- Parents were more likely to defer care if they feared involuntary hospitalization for their child.
- Child welfare professionals should be informed about factors associated with mental health care seeking to support African American families.

Furthermore, scholars often explore delayed or deferred health care utilization, frequently defined as waiting ≥ 1 year to seek care for a medical need (18, 19). However, it is also important to address the opposite phenomenon—rapid care seeking. Understanding both help-seeking pathways—rapid and deferred care seeking—may inform interventions that respond to the distinct pathways to proactive and deferred care.

The Andersen behavioral model of health services use is one framework that can inform research focused on rapid and deferred care seeking. This model posits that use of health services is determined by predisposing factors (e.g., sociodemographic characteristics), enabling factors (e.g., health insurance status), and need factors (e.g., symptom severity) (20). Godoy and Carter (21) drew on the Andersen model and other health-related theories to present a comprehensive model of parental help seeking for children. In Godoy and Carter's model, parental help seeking is determined by several factors, such as parent appraisal processes (e.g., parent activation and the degree to which parents possess the capacity, knowledge, and willingness to manage their child's needs), predisposing and contributing influences on parent appraisal processes (e.g., sociodemographic characteristics), and core pediatric contextual influences (e.g., access barriers). The model also highlights parents' trust in medical doctors as a key factor influencing help seeking. Godoy and Carter's model has been applied to assess parental appraisals of child behavioral problems in racially diverse samples, but findings were not disaggregated by race (22–24). Thus, additional research is needed to explore how parental concerns about child mental health needs may uniquely influence help seeking for African American families.

This study aimed to address these gaps in the literature by examining factors related to rapidly seeking care (i.e., seeking care within 30 days of personally identifying their child's need) and deferring care (i.e., waiting 1 year or longer to seek care) among African American parents and caregivers (hereafter referred to as "parents") of children with emotional and behavioral health needs. Informed by the two aforementioned theoretical models, we developed four hypotheses. First, we hypothesized that African American families with higher parent appraisal scores (i.e., higher parent activation) would have higher odds of rapid care seeking and lower odds of deferred care seeking. Second, we hypothesized that parents who reported negative appraisal processes (e.g., worry about their child being involuntarily hospitalized) would have lower odds of rapid care seeking and higher odds of deferred care seeking. Third, we hypothesized that parents who cited pediatric contextual barriers to care, such as health insurance challenges, would have lower odds of rapid care seeking and higher odds of deferred care seeking. Fourth, we hypothesized that parents who mistrusted doctors would have lower odds of rapid care seeking and higher odds of deferred care seeking.

METHODS

Study Population and Recruitment

We used data from the Teaching Advocacy Skills for Kids study, a cross-sectional study conducted in 2010–2011 that enrolled African American parents living in North Carolina who were raising a child with emotional or developmental challenges. This study aimed to recruit parents who recognized that their child was having mental health or developmental challenges (e.g., extreme anger, mood swings, or difficulty talking), regardless of whether the child had received a formal diagnosis. We identified mental health needs as "challenges" to capture the broad ways parents may characterize their child's behavior. Participants were eligible if they were ages ≥ 18 years, identified as African American, were a parent of a child (ages ≤ 25 years) with emotional or developmental challenges, and spoke English. Parents of children ages ≤ 25 were eligible to capture the full age range of children enrolled in school.

Study staff distributed recruitment fliers to early intervention and social service agencies, school special education directors, advocacy organizations, and mental health agencies. After providing informed consent, eligible parents completed a 45-minute computer-assisted telephone interview and received a \$40 incentive. This study was approved by the institutional review board at the University of North Carolina at Chapel Hill. Additional study details are published elsewhere (25).

Measures

Outcome variables. Parents answered the question, "How long had you been thinking that [the child] needed to see a professional before you made the first appointment?" Consistent with previous literature, we created two binary outcome measures to assess factors associated with rapidly seeking care (i.e., making an appointment in ≤ 30 days after identifying the need) and deferring care (i.e., waiting ≥ 1 year to make an appointment) (18, 19). All parents in the sample eventually sought care for their child.

Independent and control variables. Mistrust of doctors was assessed with the question, "Are there any people you would not trust to talk to about your child's emotional or developmental challenges?" Participants were characterized as mistrusting doctors if they did not trust their child's doctor or their own doctor. Parent activation was measured with the 13-item parent-focused Patient Activation Measure (Cronbach's alpha in current study = 0.88) (26). As an example, one item from the Patient Activation Measure asks, "When all is said and done, I am the person who is responsible for managing my child's health and well-being and service use." Total scores ranged from 38.7 to 100.0, with higher scores indicating greater activation.

Parents were also given a list of reasons why people sometimes put off getting help for their children and indicated whether each reason applied to them. We used this

question to assess negative appraisal processes and pediatric contextual barriers. For example, one listed reason related to negative appraisal was, “I was scared about my child being put in a hospital against my will.” An example reason related to pediatric contextual barriers was, “My health insurance would not cover the service.” We also assessed sociodemographic variables, including the child’s sex, child’s age at diagnosis, parent education level, household income, whether the child had a serious mental disorder (defined as a serious mood or anxiety disorder, psychosis, autism, traumatic brain injury, or other unspecified serious mental health issue) and whether there were other adults or children in the household with mental health challenges.

Analytic Approach

We used descriptive statistics to characterize the study sample. In unadjusted analyses, we used t tests and chi-square tests to examine whether there were significant differences between parents who did and those who did not rapidly seek care (the first outcome) and between parents who did and those who did not defer care (the second outcome). We used logistic regression to examine adjusted associations of parent activation, negative appraisal processes, pediatric contextual barriers, and mistrust of doctors with our two outcomes. We controlled for parent and child sociodemographic characteristics, presence of a serious mental disorder, and whether the household had other adults or children with mental health challenges. We examined model fit by using the c-statistic and Cox-Snell version of R² (27). We used the Hosmer-Lemeshow test to assess model goodness of fit. Analyses were conducted with SAS, version 9.4.

RESULTS

Participant Characteristics

In total, 289 parents provided information about the outcome variables, and their data were included in analyses. Table 1 presents the demographic and other characteristics of the study participants. Most children were male (69%), and the mean age at diagnosis was 6 years. About 43% of participants selected high school or less as the highest level of education in the household, and approximately 80% had an annual household income below \$35,000.

Unadjusted Associations Between Sample Characteristics and Help Seeking

Table 2 presents the unadjusted associations between sample characteristics and both rapid and deferred help seeking.

TABLE 1. Characteristics of African American parents in North Carolina raising a child with emotional or developmental challenges and their families (N=289)

Characteristic	N	%
Demographic		
Child’s sex		
Female	91	32
Male	198	69
Child’s age at diagnosis (M±SD years) (N=287) ^a	6.0±4.1	
Highest education level of adults in household (N=275)		
Less than high school	32	12
High school diploma	84	31
Some college	101	37
College diploma or higher	58	21
Annual household income, in \$ (N=285)		
<35,000	229	80
35,000–50,000	37	13
>50,000	19	7
Child has serious mental disorder	121	42
Other adults in household have mental health challenges	39	14
Other children in household have mental health challenges	73	25
Parent activation and mistrust		
Parent activation score (M±SD) ^b	65.1±14.1	
Parent mistrusted doctors (N=286)	46	16
Negative appraisal processes^c		
Parent did not think help would make any difference	65	23
Child received help before, and it did not work	61	21
Parent was concerned about what people would think if they found out the child was getting help	72	25
Parent was scared about their child being put in a hospital against the parent’s will	47	16
Parent was scared about Department of Social Services involvement	48	17
Parent thought the issue would get better by itself	148	51
The challenge did not bother the parent very much at first	134	46
Parent wanted to handle the challenge on their own	150	52
Pediatric contextual barriers^c		
Parent’s health insurance would not cover the service	61	21
Parent was concerned about cost	83	29
Parent had problems such as transportation or scheduling challenges that made it hard to get to the help	115	40
Parent was unsure about where to go or who to see	164	57
Parent thought it would take too much time or be inconvenient	35	12
Parent could not get an appointment	39	14
Parent was not satisfied with available services	57	20

^a Range 0–23 years.

^b Scores on the 13-item parent-focused Patient Activation Measure ranged from 38.7 to 100.0, with higher scores indicating greater activation.

^c Participants could endorse more than one process.

About 22% (N=62) of parents rapidly sought care. These parents had significantly higher mean±SD activation scores (68.7±16.2) than those who did not rapidly seek care (64.1±13.3) (p=0.02). Additionally, a smaller percentage of parents who rapidly sought care reported that they thought the issue would get better by itself or that they wanted to handle the challenge on their own compared with parents who did not rapidly seek care (p<0.05). Similarly, a smaller percentage of parents who rapidly sought care reported that they had problems with transportation or were unsure about where to go (p<0.05). A smaller percentage of parents who

TABLE 2. Unadjusted associations of parent, child, and family characteristics with rapid or deferred care seeking

Characteristic	Rapid care					Deferred care				
	Yes		No		p ^a	Yes		No		p ^a
	N	%	N	%		N	%	N	%	
Total (N=289)	62	22	227	79		141	49	148	51	
Parent activation and mistrust										
Parent activation score (M±SD) ^b	68.7±16.2		64.1±13.3		.022*	63.4±13.1		66.7±14.8		.043*
Parent mistrusted doctors (N=286)	13	21	33	15	.210	20	14	26	18	.418
Negative appraisal processes										
Parent did not think help would make any difference	12	19	53	23	.505	33	23	32	22	.717
Child received help before, and it did not work	12	19	49	22	.703	34	24	27	18	.222
Parent was concerned about what people would think if they found out the child was getting help	12	19	60	26	.254	36	26	36	24	.813
Parent was scared about their child being put in a hospital against the parent's will	8	13	39	17	.419	27	19	20	14	.194
Parent was scared about Department of Social Services involvement	7	11	41	18	.204	28	20	20	14	.147
Parent thought the issue would get better by itself	21	34	127	56	.002**	79	56	69	47	.110
The challenge did not bother the parent very much at first	18	29	116	51	.002**	70	50	64	43	.275
Parent wanted to handle the challenge on their own	22	36	128	56	.004**	76	54	74	50	.507
Pediatric contextual barriers										
Parent's health insurance would not cover the service	8	13	53	23	.074	35	25	26	18	.131
Parent was concerned about cost	12	19	71	31	.066	42	30	41	28	.695
Parent had transportation or scheduling challenges to getting the help	15	24	100	44	.005**	66	47	49	33	.017*
Parent was unsure about where to go or whom to see	24	39	140	62	.001***	89	63	75	51	.033*
Parent thought service would take too much time or be inconvenient	7	11	28	12	.823	17	12	18	12	.978
Parent could not get an appointment	7	11	32	14	.567	12	9	27	18	.016*
Parent was not satisfied with available services	8	13	49	22	.128	32	23	25	17	.215
Demographic characteristics										
Sex of child, male	41	66	157	69	.649	91	65	107	72	.156
Age of child at time of diagnosis (M±SD years) (N=287)	5.8±4.9		6.1±3.9		.596	6.5±3.8		5.5±4.3		.043*
Some college or more education (N=275)	35	59	124	57	.792	67	49	92	67	.003**
Annual income >\$50,000 (N=285)	6	10	13	6	.263	5	3	14	10	.043*

continued

TABLE 2, continued

Characteristic	Rapid care					Deferred care				
	Yes		No		p ^a	Yes		No		p ^a
	N	%	N	%		N	%	N	%	
Child has serious mental disorder	23	37	98	43	.390	62	44	59	40	.479
Other adults in household have mental health challenges	13	21	26	12	.052	13	9	26	18	.038*
Other children in household have mental health challenges	13	21	60	26	.380	42	30	31	21	.084

^a p values are based on chi-square tests for categorical variables and independent-samples t tests for continuous variables.

^b Scores on the 13-item parent-focused Patient Activation Measure ranged from 38.7 to 100.0, with higher scores indicating greater activation.

*p<0.05, **p<0.01, ***p<0.001.

rapidly sought care reported that the challenge did not initially bother them compared with parents who did not rapidly seek care ($p=0.002$).

Nearly half of the parents ($N=141$, 49%) deferred care for ≥ 1 year. Mean activation scores were lower for parents who deferred care (63.4 ± 13.1) than for those who did not defer care (66.7 ± 14.8) ($p=0.04$). Additionally, parents who deferred care reported higher mean ages at child diagnosis than those who did not defer care (mean=6.5 years vs. mean=5.5 years, $p=0.04$). A greater percentage of parents who deferred care reported that they had problems with transportation or were unsure about where to go compared with those who did not defer care ($p<0.05$). A smaller percentage of parents who deferred care reported that they could not get an appointment or that there were other adults in the household with mental health challenges compared with parents who did not defer care. Parents who deferred care had lower education and income levels than parents who did not defer care ($p<0.05$).

Adjusted Associations Between Sample Characteristics and Help Seeking

In the adjusted model for rapid care seeking (left side of Table 3), parents were more likely to rapidly seek care if they had higher activation scores (odds ratio [OR]=1.03, 95% confidence interval [CI]=1.00–1.05), mistrusted doctors (OR=4.13, 95% CI=1.56–10.95), or lived with other adults with challenges (OR=5.42, 95% CI=1.90–15.49). Parents who thought seeking help would take too much time or be inconvenient also had higher odds of rapidly seeking care (OR=7.42, 95% CI=1.99–27.71). Parents were less likely to rapidly seek care if their child's emotional or developmental challenges did not bother them much at first (OR=0.28, 95% CI=0.12–0.65) or if their health insurance would not cover the service (OR=0.28, 95% CI=0.09–0.88).

In the adjusted model for deferred care seeking (right side of Table 3), parents were more likely to defer care if they were scared about their child being involuntarily hospitalized (OR=2.72, 95% CI=1.13–6.53) or if their health insurance would not cover service (OR=2.45, 95%

CI=1.07–5.63). Parents were less likely to defer care if they could not get an appointment (OR=0.19, 95% CI=0.07–0.51), had some college or more education (OR=0.52, 95% CI=0.29–0.94), or lived with other adults with challenges (OR=0.32, 95% CI=0.14–0.77).

DISCUSSION

This study is among the first to examine factors among African American parents that are associated with rapidly (i.e., within 30 days) seeking care and with deferring care for ≥ 1 year after a mental health need was identified for a child with emotional and behavioral difficulties. Only 22% of parents rapidly sought care, whereas 49% deferred care. This finding is in line with previous literature citing widespread unmet treatment needs among children with mental health challenges (3, 4).

Consistent with previous studies and our first hypothesis, parents with higher activation scores were more likely to rapidly seek care. Indeed, findings from several studies suggest that people with higher patient activation have better health outcomes and care experiences (28–31). However, parent activation was not associated with deferred care (i.e., the second outcome). Most research on patient activation has focused on receipt of health care services but not on timeliness of service initiation. Future research is needed to understand the mechanisms by which parent activation may be differentially associated with rapid versus deferred care seeking.

Consistent with our second hypothesis, we found associations between negative parental appraisals of care processes and help seeking. Specifically, parents who feared that their child may be involuntarily hospitalized were more likely to defer care. Previous studies have highlighted that involuntary commitment for mental health needs is highly racialized (32–34). For example, African Americans, including youths, are overrepresented among those receiving involuntary psychiatric hospitalization (32–34). Accordingly, concerns regarding involuntary hospitalization may uniquely influence help seeking among African American parents.

TABLE 3. Adjusted associations of parent, child, and family characteristics with rapid and deferred care seeking (N=267)

Characteristic	Rapid care ^a			Deferred care ^b		
	OR	95% CI	p	OR	95% CI	p
Parent activation and mistrust						
Parent activation score	1.03	1.00–1.05	.024*	.99	.97–1.01	.212
Parent mistrusted doctors	4.13	1.56–10.95	.004**	.63	.29–1.38	.250
Negative appraisal processes						
Parent did not think help would make any difference	2.07	.76–5.64	.153	.69	.34–1.43	.321
Child received help before and it did not work	2.63	.96–7.20	.059	.87	.41–1.84	.713
Parent was concerned about what people would think if they found out the child was getting help	1.24	.47–3.31	.663	.63	.29–1.37	.248
Parent was scared about their child being put in a hospital against the parent's will	.69	.21–2.28	.546	2.72	1.13–6.53	.025*
Parent was scared about Department of Social Services involvement	.44	.11–1.71	.233	1.30	.53–3.19	.568
Parent thought the issue would get better by itself	.86	.36–2.02	.727	1.39	.73–2.63	.317
The challenge did not bother the parent very much at first	.28	.12–.65	.003**	1.14	.63–2.08	.670
Parent wanted to handle the challenge on their own	.47	.19–1.12	.088	1.11	.58–2.11	.759
Pediatric contextual barriers						
Parent's health insurance would not cover the service	.28	.09–.88	.029*	2.45	1.07–5.63	.035*
Parent was concerned about cost	.98	.36–2.63	.960	.83	.40–1.74	.626
Parent had transportation or scheduling challenges to getting to the help	.45	.19–1.05	.066	1.60	.85–2.99	.144
Parent was unsure about where to go or whom to see	.81	.36–1.84	.616	1.35	.72–2.51	.354
Parent thought it would take too much time or be inconvenient	7.42	1.99–27.71	.003**	.60	.22–1.60	.306
Parent could not get an appointment	1.57	.50–4.93	.437	.19	.07–.51	.001***
Parent was not satisfied with available services	.28	.07–1.04	.057	1.74	.72–4.21	.221
Demographic characteristics						
Sex of child, male	.78	.36–1.70	.537	.71	.39–1.29	.256
Age of child at diagnosis	1.01	.92–1.10	.918	1.03	.96–1.11	.394
Some college or more education	.96	.46–2.01	.918	.52	.29–.94	.031*
Annual income >\$50,000	3.23	.88–11.84	.077	.45	.13–1.52	.198
Child has serious mental disorder	.45	.20–1.02	.055	1.58	.85–2.93	.151
Other adults in household have mental health challenges	5.42	1.90–15.49	.002**	.32	.14–.77	.011*
Other children in household have mental health challenges	.90	0.37–2.19	.814	1.00	.52–1.92	.993

^a Model fit statistics for the rapid care model: $c=0.811$, pseudo $R^2=0.199$, Hosmer-Lemeshow $p=0.746$.

^b Model fit statistics for the deferred care model: $c=0.741$, pseudo $R^2=0.175$, Hosmer-Lemeshow $p=0.978$.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

Our third hypothesis assessed whether pediatric contextual barriers, such as access issues, were associated with help seeking. We found that parents whose health insurance would not cover care had lower odds of rapid care seeking and higher odds of deferred care seeking. This result was consistent with previous literature citing cost as a barrier to mental health care (35, 36). Contrary to our hypothesis, parents who endorsed that they could not get an

appointment had lower odds of deferred care. Parents who endorsed this statement may have been actively attempting to get an appointment, and this determination resulted in lower odds of deferred care. One possible interpretation is that enhancing patient and family navigation services for mental health care may support help seeking (e.g., by helping parents make appointments with providers who accept their insurance) (37, 38). Future research is needed to assess interaction effects and subgroup differences regarding how pediatric contextual barriers may differ depending on child characteristics, such as age and gender. For example, parents may face different barriers when seeking care for younger versus older children.

Also in contrast to our third hypothesis, endorsing that seeking help would take too much time or be inconvenient was associated with higher odds of rapidly seeking care. This endorsement may be precipitated by past negative experiences with the health care system and difficulty scheduling appointments, which may motivate parents to seek care for their child soon after identifying a need, given challenges they expect to face during the process. If so, it is possible that previous negative health care experiences may be a frustrating yet motivating factor for parents when seeking care for their

research suggests that mistrust of medical professionals is associated with delays in help seeking (39–42). However, most research on medical mistrust has focused on adults seeking care for themselves and not on parents making decisions for their children (43). It is possible that parents who mistrust doctors make different choices for their children than for themselves. For example, parents who mistrust doctors, perhaps because of previous negative health care experiences, may be more motivated to advocate for their child to receive rapid, high-quality care so that their family can avoid further negative experiences. Future work is needed to understand how medical mistrust may affect parental help seeking and to improve the trustworthiness of the mental health care system.

Our results also suggest that mental health knowledge and awareness play important roles in help seeking. Parents were more likely to rapidly seek care and less likely to defer care if there were other adults in the household with mental health challenges. Parents were also less likely to defer care if they had at least some college education. When other adults in the household have mental health challenges, parents may have increased awareness of the importance of seeking help and may already be connected to the mental health care system. Similarly, higher education levels may promote mental health awareness. Future interventions are needed to promote awareness about mental health. School districts can also promote mental health awareness by offering tests for emotional and developmental challenges, sponsoring information sessions, and following up with parents whose children may have an unmet need.

Our study had several limitations. First, we recruited a convenience sample of African American parents in North Carolina who were raising a child with emotional or developmental challenges. Educational attainment in our sample was close to the state average (21% with a college diploma or higher vs. 26% among all state residents in 2010–2014) (44). This robust distribution of education underscores the appropriateness of our sample for examining help seeking. However, our sample was more likely than the general public in the state to have low income (80% below \$35,000 vs. 50% below \$43,300 among all residents in 2010) (45). Additionally, the results may not generalize to other populations, and the cross-sectional study design limited our ability to establish causal relationships. Parents also self-reported data about barriers to help seeking and how long they waited before seeking care. Therefore, recall and other self-report biases may have affected results. We also did not have access to information about provider availability, which may influence help seeking (46).

Despite these limitations, our findings advance the literature beyond documentation of racial differences in help seeking. African American children are rarely prioritized in psychiatric research, and our study was among the first to assess factors associated with help seeking among African American parents—a population disproportionately exposed to structural barriers to receiving care. To our knowledge, this study was the first to use a theory-driven approach to test

specific hypotheses about factors associated with help seeking and to jointly assess factors associated with rapid and deferred care seeking. Our findings indicate that a broad array of factors is associated with rapid and deferred care seeking and suggest that a range of strategies are needed to address unmet mental health needs. Additional research is necessary to prioritize the mental health needs of African American children and to test novel hypotheses with clear public health implications (e.g., regarding the effect of new interventions).

CONCLUSIONS

About one-fifth of African American parents raising a child with emotional or developmental challenges sought help for their child's difficulties within 30 days, whereas almost one-half deferred care for ≥ 1 year. Given the low percentage of parents who rapidly sought care and the high percentage who deferred care, it is vital that child welfare professionals be informed about facilitators and barriers to mental health care seeking among African American families. Broader awareness of these factors could lead to interventions that facilitate rapid access to care and prevent deferred care (e.g., by removing cost-related obstacles).

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