

# Black Moms Matter: A Qualitative Approach to Understanding Barriers to Service Utilization at a Children's Advocacy Center Following Childhood Abuse

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## Abstract

Black families are significantly less likely to receive evidence-based trauma treatment services; however, little is known about factors impacting engagement, particularly at Children's Advocacy Centers (CACs). The goal of this study is to better understand barriers and facilitators of service utilization for Black caregivers of CAC referred youth. Participants ( $n = 15$ ) were randomly selected Black maternal caregivers (ages 26–42) recruited from a pool of individuals who were referred to receive CAC services. Black maternal caregivers reported barriers to accessing services at CACs including a lack of assistance and information in the referral and onboarding process, transportation issues, childcare, employment hours, system mistrust, stigma associated with the service system, and outside stressors such as stressors related to parenting. Maternal caregivers also shared suggestions for improving services at CACs including increasing the length, breadth, and clarity of investigations conducted by child protection services and law enforcement (LE) agencies, providing case management services, and having more diverse staff and discussing racial stressors. We conclude by identifying specific barriers to the initiation and engagement in services for Black families, and we provide suggestions for CACs seeking to improve engagement of Black families referred for trauma-related mental health services.

## Keywords

children advocacy centers, Black caregivers, service utilization, provider barriers, client barriers

## Introduction

Upwards of 60–70% of youth ages 10–17 years old experience or witness some form of maltreatment each year, resulting in potentially harmful internalizing and externalizing psychological sequelae (Finkelhor et al., 2011; Kilpatrick et al., 2003). Ethnically minoritized (e.g., Black) youth experience polyvictimization (multiple traumatic events) at disproportionate rates (Finkelhor et al., 2011); further, they are disproportionately identified within the child welfare system (Cénat et al., 2021). However, research suggests that ethnically minoritized youth are less likely to receive services (e.g., mental health assessments and treatment) following trauma exposure (Alegria et al., 2002). Children's Advocacy Centers (CACs) were developed in the late 1980's to improve how children and their families' report and receive support services for experiences with child abuse and trauma (Cross et al., 2007; Herbert & Bromfield, 2016; Jones et al., 2007). To deepen our understanding of why Black youth and families who have experienced victimization may underutilize CAC

services (e.g., forensic evaluations, mental health treatment), and to explore ways of improving existing services to be more engaging for Black clients, it is necessary to conduct research directly with members of this community.

## Children's Advocacy Centers

In the U.S., CACs are community-based organizations that facilitate the interagency coordination of the acute response

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following child maltreatment allegations. According to the National Children's Alliance, there are currently over 900 CACs across the United States, through which 371,060 children were served in 2019 (National Children's Alliance, 2020). Before the existence of the CAC model, child victims of abuse and their families were required to navigate multiple investigative and service systems—frequently re-telling their abuse experiences to various professionals including police, social workers, doctors, attorneys, and mental health professionals (Elmquist et al., 2015; Pence, 1992). Because standard, uncoordinated abuse investigation procedures were reported to have adverse effects on child victims and their families, CACs were developed to establish a collaborative, organized multidisciplinary response to allegations of child sexual abuse (Cross et al., 2007). Since the late 1980's, CACs have expanded to respond to other types of child maltreatment including physical abuse, neglect, interpersonal violence exposure, and drug endangerment (Cross et al., 2007).

The foundation of the CAC model is a multidisciplinary team (MDT) comprised of law enforcement (LE), child protection services, prosecution, medical providers, mental health professionals, victim's advocates, forensic interviewers and other professionals needed to ensure a community's comprehensive, collaborative response to child abuse (Herbert & Bromfield, 2019; Jones et al., 2010; Shelly, 2004). Children's Advocacy Center-Multidisciplinary teams follow standards outlined by the National Children's Alliance (NCA, 2017, 2023). In contrast to the disconnected service systems of the past, CACs provide a child-focused facility designed to bring the MDT and the child and family together in one place where a child's statement of abuse can be elicited in a forensic interview, and where the MDT can work together to coordinate necessary assessments (e.g., physical examination) and subsequent services. Among those services at CACs, MDTs function to ensure that youth and families have access to evidence-based, trauma-informed mental health assessment and treatment. While some CACs utilize referrals via linkage agreements with mental health professionals in their communities, many CACs provide mental health services onsite (NCA, 2017, 2023). As CACs are being widely used both for coordination of the community's response to abuse and for direct services to children and families, including evidence-based treatment of child trauma, it is important to understand and overcome barriers to service access and utilization that are commonly experienced by underserved clients.

### *Disparities in Service Utilization*

Disparities exist in the utilization of child mental health services, with ethnically minoritized families being significantly less likely to receive services including assessments and treatment despite being at greater risk for trauma exposure (Andrews et al., 2015). For example, Black American and Latine populations have significantly lower odds of utilizing specialty services (e.g., treatment by a psychologist) than their

white American counterparts even with geographic location and zone of residence being controlled for (Alegria et al., 2002, 2008; Holden et al., 2012). Previous research demonstrates that CAC-based child abuse investigations result in higher rates of mental health referrals and service utilization than traditional models (Edinburgh et al., 2008; Smith et al., 2006). Given previous research that indicates disparities in service utilization for trauma-exposed ethnically minoritized populations, CACs are an ideal target for community-based research aimed at improving access to services for these youth and families. Consequently, research exploring environmental, organizational, client, and provider barriers and facilitators to service utilization within CACs warrants further investigation.

Regardless of poverty level, ethnically minoritized individuals are less likely to be referred to mental health services, and when they are referred, disparities exist in the rates in which they utilize available mental health services (Cummings & Druss, 2011; Hines et al., 2017; Planely et al., 2019). Although they are at disproportionate risk of experiencing both trauma and associated mental health difficulties, Black Americans have been shown to utilize outpatient mental health services at half the rate of their white counterparts (Finkelhor et al., 2011; Williams, 2014). As such, it is pertinent to explore and understand the perspective of Black caregivers whose children experience trauma and are referred for services at CACs.

### *Clients' Experiences at CACs*

There are unique client, provider, organizational, and systemic barriers that contribute to Black Americans' under-utilization of mental health and other services in comparison to other groups (Maura & Weisman de Mamani, 2017). For instance, caregivers commonly report dissatisfaction with the thoroughness of evidence collection in their case, wanting more thorough and frequent communication about case proceedings, dissatisfaction with the length of case investigations, encountering unsupportive investigators, and a perceived lack of skill in interviewing (Davies et al., 2000; Jones et al., 2010). Therefore, addressing these concerns is necessary to increase service utilization in Black youth and families following trauma exposure. Given that CACs are emerging as the first and coordinated response after allegations of child maltreatment, and that many CACs can provide access to mental health services following necessary investigations and assessments, it is critical to examine barriers to service utilization.

Caregivers report being more satisfied with Child Protective Services (CPS) and LE investigations that are coordinated through CACs when compared with those who do not utilize CACs (Elmquist et al., 2015; Jones et al., 2007). Caregivers reported the quality of emotional support provided by CPS and LE investigators based in CACs to be better than they expected (Jones et al., 2010). Specific to CACs, families

report satisfaction with the process of sexual abuse investigations and describe their interactions with investigators as mostly positive (Davies et al., 2000). Youth in previous studies reported feeling relieved after telling investigators about the abuse they experienced, and they described their investigation experience as less scary and more supportive when conducted through a CAC (Jones et al., 2007).

It is important to note that not all families report satisfaction with their experiences of the CAC-MDT process, and although there is a dearth of literature specific to service utilization (e.g., investigative) of Black youth in CACs, the barriers (e.g., stigma and system mistrust) that prevent these families from utilizing available services may be similar to attitudinal barriers that also affect their service utilization of CACs (Maura & Weisman de Mamani, 2017). Thus, it is critical to further the literature on barriers that exist for Black youth and families who are disproportionately in need of, yet underutilize, services at CACs.

### **Barriers to Service Utilization**

Regarding mental health and healthcare options, ethnically minoritized families have less access to support services (e.g., daycare), receive less comprehensive insurance plans, often reside in impoverished areas that often lack community resources, services, and access to culturally compatible providers (Cook et al., 2017; Copeland & Snyder, 2011). While it is well known that the treatment of ethnically minoritized children in the U.S. child welfare system has been plagued with racism and insufficient services (Mixon-Mitchell & Hanna, 2017), there are specific client, provider, and organizational barriers to service utilization that can be addressed to increase service utilization for those who are referred to CACs.

**Client Barriers.** Given the distinct history of mistreatment, persecution, and racism in the U.S. healthcare system (e.g., the Tuskegee Syphilis Study), Black communities and families have developed attitudinal barriers that prevent them from utilizing the services they need. Kokaliari and colleagues (2019) found that Black parents who were previously involved with the child healthcare system experienced the system as unsupportive and punitive. Additionally, in one study, 35% of Black Americans report racism as a major issue in healthcare (Lanier et al., 2014). Black clients also reported feelings of being mistreated because of their ethnic background when utilizing mental health services (Santiago et al., 2012). As such, establishing trust with Black youth and families is a necessary step in overcoming the uncertainty with engaging in CAC services following child maltreatment (Santiago et al., 2012).

Engagement is a factor that plays a crucial role in continuation of services for clients. To improve client engagement, it is important to address attitudinal barriers to service utilization that might otherwise lead to disengagement

(Ofonedu et al., 2017). For instance, a fear of stigmatization by others regarding their child's mental health acts as a barrier in ethnically minoritized communities, as many parents express concern of a psychiatric diagnosis being attached to their child into adolescence and adulthood (Ofonedu et al., 2017). These attitudinal barriers are important for researchers to understand and for organizations to help clients overcome, especially during referral, intake, assessment and treatment (Metzger et al., 2021).

**Provider Barriers.** Ethnic disparities in mental health service utilization may be explained by provider barriers. For instance, primary support staff who are responsible for providing screening and referrals for services often lack experience and training in dealing with issues common in low-income trauma-exposed clients, and they are often less prepared to offer ethnically minoritized clients the care they need (Santiago et al., 2012). Evidence demonstrates that ethnically minoritized individuals are more likely to utilize mental health services when the demographics of staff and clinicians mirror that of the surrounding community (Chow et al., 2003; Fontes & Tishelman, 2016). Further, the lack of BIPOC service providers and culturally competent services results in ethnically minoritized (specifically, Black) clients receiving services amidst potentially unconscious bias (Fontes & Tishelman, 2016; Santiago et al., 2012). Despite the possible positive effects of increasing diversity in mental health services, cultural matching is not always feasible or sufficient (Williams, 2014), and cultural adaptations of existing services may be necessary to increase engagement and retention of ethnically minoritized groups, especially as it pertains to trauma-related services (Metzger et al., 2021).

**Organizational Barriers.** Organizational barriers including long waitlists, hours of operation, and location or proximity to public transportation also may contribute to under-utilization of services in minority groups (Ofonedu et al., 2017). Low-income adults report various stressors and obligations (e.g., securing food and housing) that lead them to prioritize more immediate concerns over their mental health (Santiago et al., 2012). While rates of non-attendance for the first session vary from 28% to 62% (McKay et al., 2005), existing literature indicates that appointment attendance becomes less likely the longer the length of time between calling to make the first appointment and attending said appointment (Ofonedu et al., 2017).

**Systemic Barriers.** Systemic barriers such as fewer providers of color also hinder utilization of services in minority groups. Parents have listed systemic racism, including a lack of leadership of color, and a lack of staff of color overall within the healthcare industry as a factor in underutilization (West et al., 2022); Black clients also report cultural insensitivity of mental health personnel as a systemic barrier (Holden & Xanthos, 2009; Kawaii-Bouge et al., 2017; Memon et al., 2016). A lack

of cultural humility results in the improper and inadequate care of Black families in the mental health field (Borowsky et al., 2000; Cook et al., 2014; Murry et al., 2011). Furthermore, other systemic barriers such as lack of access to healthcare and limited access to healthcare assistance act as prime contributors to underutilization (Chen et al., 2016).

### Overview of the Study

The primary goal of this qualitative study is to identify and understand barriers to and facilitators of service utilization for Black families who are referred to CACs when there is a concern of child abuse or neglect. Specifically, this study utilized key informant interviews with Black caregivers of CAC-referred youth to identify culturally relevant factors in service utilization from their perspective, to determine: (1) satisfaction with service accessibility, delivery and content, (2) areas to target for improvement regarding cultural considerations, and (3) barriers to and facilitators to utilizing services.

## Methods

### Participants

Individual, semi-structured, telephone interviews were conducted with a sample of 15 caregivers who were referred to the CAC. Participants included caregivers who engaged in a full range of CAC services as well as those who only engaged in mandated investigative services. The sample ( $n = 15$ ) consisted of 100% female, Black maternal caregivers with ages ranging from 26 to 42 ( $M = 33.58$ ,  $SD = 5.25$ ). Regarding education, 9% of participants reported less than high school education, 18% had graduated high school or received a GED, 36% had attended some college, 27% had received a college degree, and 9% had completed a graduate degree. Sixty-four percent of participants were single, 14% were married, and 21% were separated. Fifty-four percent were currently employed. Participants reported having two to six children ( $M = 3.4$ ,  $SD = 1.2$  that ranged in age from 4 months to 23 years old ( $M = 7.86$  years,  $SD = 4.33$ ).

### Procedures

Participants were recruited from an accredited CAC in the southeastern United States that provides multidisciplinary case coordination, victim advocacy, forensic interviews, medical evaluations, and mental health assessment and treatment (NCA, 2017, 2023). Inclusion criteria included males and females who were over 18 years old and caregivers of a Black child that was referred to the CAC in 2015. Exclusion criteria were evident cognitive impairments that precluded providing informed consent and unwillingness to be audiotaped.

Recruitment and data collection occurred between 2016 and 2017. A staff member of the CAC was approved by the

IRB to conduct a chart review of clients served in 2015 by gathering from the client database: age, gender, race/ethnicity, caregiver name, contact information, and type(s) of appointment(s) attended. The staff member then produced a list of Black families referred in 2015 who engaged in at least one service and consented to be contacted for future research at the CAC. Caregivers were randomly selected (numbered and then put into an online randomizer) from this list to be recruited for the key informant interview. After receiving a mailed letter notifying them of the research project, caregivers were contacted via phone by IRB-approved study personnel to assess their interest in participating in the interview. Eligible and interested caregivers were either scheduled for an interview at a more convenient date, or they agreed to participate immediately. Caregivers were provided with logistical information about the format for the interview (e.g., that it will be conducted over the telephone by a researcher in a private office and audiotaped). Participants were then verbally consented before participating in the 25-minute interview and being compensated with a \$15 gift card for their time.

Study personnel continued with this process until reaching the desired target of 15 caregivers to interview. To complete interviews with 15 caregivers, a total of 34 families were contacted. Of these,  $n = 2$  letters were returned,  $n = 6$  messages were left either on voicemail or with a family member and not responded to,  $n = 7$  had either wrong numbers or lines that were no longer in services,  $n = 2$  stated that they had bad experiences and did not want to participate, and  $n = 2$  initially scheduled but then could not be reached at the time of interview.

### Measures

To capture the experiences and perceptions of Black caregivers referred for services at this CAC, the researchers developed a Key Informant Interview that consisted of guided interview questions divided into seven parts: (1) demographics and background information (8 questions); (2) rapport building (2 questions); (3) family experiences with the MDT system (3 questions); (4) family racialized experiences with the CAC services (4 questions); (5) barriers/facilitators to service engagement (3 questions); (6) suggestions for improvement (1 question); and (7) overall impressions (2 questions). Follow-up probes were used to clarify information provided whenever necessary.

**Demographics and Background Information.** Demographic information was acquired through eight questions e.g., “What is your highest level of education attained?”

**Rapport Building.** Two questions were used to build rapport e.g., “Tell us about some previous experiences you’ve had with this service system.”

**Family Experiences Being Referred to the MDT System.** Three questions assessed family referral experiences e.g., “What was your experience in being referred to the CAC? and “Why might some families receive referral information from a CAC and never receive services?”

**Racialized Experiences with the CAC Services.** Families’ race-based experiences with CAC services were assessed using four questions, e.g., “Tell me about any time at the CAC when you felt the care you received was influenced, for good or bad, by your race/ethnicity?” and “Tell me about any conversations the CAC staff had with you about how your upbringing and culture impacts your parenting practices.”

**Barriers/Facilitators to Service Utilization.** Three questions assessed barriers and facilitators to service utilization, e.g., “What, if any, barriers did you have coming to the CAC?”

**Suggestions for Improvement.** One question elicited feedback from the caregivers about how services could be improved at the CAC: “What kinds of things would make services at CACs better for racial/ethnic minority families?”

**Overall Impressions.** Two open-ended questions were used to assess overall impressions of the CAC e.g., “What else would you like to tell me about your experiences, barriers to service engagement, or improving engagement of minority families within the organization?”

## Data Analysis

Data analysis was conducted by two clinical psychologists with expertise in qualitative methods. Analysis consisted of a qualitative deductive content analysis informed by grounded theory with a priori domains determined, while also allowing for the development of inductive categories that emerged through coding (Boyatzis, 1998; Glaser & Strauss, 2017). This method is utilized to test categories via identification of themes/patterns within the qualitative data. Specifically, a three-step approach was utilized, in which each participant’s responses (i.e., raw data) were carefully examined line-by-line to develop a comprehensive codebook of all possible themes emerging from the data. The codebook was then used by the two independent coders to analyze each participant’s responses to the interview questions (Boyatzis, 1998; DeCuir-Gunby et al., 2011). Coders could apply more than one code to participant responses if applicable. Twenty seven percent of the interviews were coded by both coders. The interrater reliability for the double coded interviews was 82% and ranged from 71% to 87%. Inter-rater discrepancies were discussed and resolved by the two independent coders. Finally, themes were refined into sub-themes via collaborative discussion until a comprehensive codebook was developed. For the purpose of understanding implications for ethnic considerations in CAC services, themes were identified at a

semantic level and related to themes in the general research area.

QSR NVivo 11.1 software was used for data management and analysis. Interviews lasted between 11.47 and 47.56 minutes ( $M = 21.14$ ,  $SD = 9.76$ ) and were audio-recorded and transcribed by a paid and reputable transcription service. Demographics and background information were extracted from the transcribed interviews and computed using IBM Statistical Package for the Social Sciences (SPSS) software, version 23. IRB approved study team members coded transcripts from the key informant interviews after they were entered into NVivo.

## Results

### Descriptive Characteristics

Caregivers reported information on descriptive statistics at the beginning of the qualitative interview. Some participants did not answer all questions on descriptive statistics.

**Prior Services Received.** Nine caregivers (60%) discussed services that they received prior to presenting at the CAC. Three caregivers (33% within this theme) had received prior services at the same CAC for a different incident of alleged child abuse or neglect. Three caregivers (33% within this theme) reported being involved with CPS in the past, two participants (22% within this theme) had been involved with the adult justice system/jail. One caregiver (11%) reported prior hospital-based services, one caregiver (11%) reported prior school-based services, and three caregivers (33%) reported other mental health services including therapy (22%) and medication management (11%). One caregiver (11% within this theme) reported that they had never received other services related to child abuse and neglect or mental health prior to their involvement with the CAC.

**Referral Source.** Of the 15 caregivers, 13 (87%) were referred to the CAC directly from CPS, 1 (7%) was referred from the school, and 1 (7%) was referred by a medical provider.

**Referral Reason.** Eleven caregivers (73%) provided information on the reason for their child’s referral and caregivers could report more than one referral reason. Specifically, four families (36%) were referred to the CAC due to allegations of child physical abuse ( $n = 2$  allegedly perpetrated by the primary caregiver,  $n = 2$  allegedly perpetrated by another caregiver), three families (27%) due to physical injury or accident involving another child, three families (27%) for excessive corporal punishment, one family (9%) for disruptive behavior at school, one family (9%) for sexual abuse, and one family (9%) for witnessed domestic violence.

**Services Received at CAC.** Seven caregivers (47%) reported on the services they received at the CAC. Specifically, out of

these 7,  $n = 6$  caregivers (86%) reported their child received a forensic interview, four caregivers (57%) reported their child received a forensic medical evaluation, 1 (14%) reported their child received mental health treatment, 1 (14%) obtained an outside referral for treatment, and one caregiver (14%) received case management services.

### Results from Qualitative Interviews

Seven overarching themes emerged from the semi-structured interviews. These themes are presented below and center around client, provider, organizational, and systemic barriers. Each is described below with representative quotes provided throughout for illustrated purposes (C = caregiver followed by interview number).

**Experience with the Referral Process to the CAC.** Eleven caregivers (73% overall) discussed their experience with the referral process and scheduling at the CAC. Within this theme, all caregivers discussed organizational barriers with the referral process to the CAC. Specifically, one caregiver (9%) discussed a lack of information regarding the reason for the initial report to CPS and four caregivers (36%) mentioned a lack of information regarding the referral to the CAC, including that CPS told the parent to come into the CAC for a forensic interview but provided no explanation for the reason. One caregiver (9%) reported feeling that there was no need for the initial referral. Two caregivers (18%) discussed that they did not receive any assistance in scheduling the initial appointment, stating that they were provided the phone number to the CAC by CPS and asked to make their own appointment. Six caregivers (55%) stated that services at the CAC were mandated (e.g., by LE or CPS). Finally, one caregiver (14%) described their referral to the CAC as a positive experience. Examples of comments made regarding the referral process and scheduling included:

- “I personally thought [the referral] was a waste of time. Yeah. Because it was embarrassing at the time, because I mean there are stuff that are happening to kids. I understand that. It was a waste of time. Which I understand the protocol companies follow too, but yeah.” – C04
- “Yes, I scheduled the appointment. They just gave me the information. Told me I needed to ask for this. Then they came in to take my children.” – C07

**Satisfaction and Dissatisfaction with Services at the CAC.** Fourteen caregivers (67% overall) discussed their satisfaction and/or dissatisfaction with services received at the CAC. Of these, five subthemes revolved around satisfaction and five revolved around dissatisfaction.

Within this theme, most of the responses focused on provider and organizational level factors. Specific to provider factors, 14 caregivers (93%) discussed positive experiences

with the staff interactions. Specifically, 10 caregivers (71%) mentioned that the CAC staff were nice or kind, three caregivers (21%) liked that the staff thoroughly explained the process of the services to be received at the CAC, five caregivers (36%) described that the staff made her feel comfortable and that he/she felt that they could ask questions openly, and two caregivers (14%) appreciated that the staff took their time with the family and they felt listened to. In addition to parents' positive experiences with staff, three caregivers (21% within this theme) mentioned that they appreciated that their child had a positive reaction to the experience at the CAC, including that the child said the staff were nice (7%) and that the child said that the staff made him/her comfortable with discussing sensitive information (14%).

Caregivers also discussed organization level factors to satisfaction with services. Five caregivers (36% within this theme) described positive experiences with the waiting room, mentioning that they liked that there were games (36%), books (7%), or a television (7%) available in the waiting room. Four caregivers (29% within this theme) described that it was positive that the staff provided resources/referrals, including referrals to outside agencies or organizations (14%), and parent resources or handouts (7%). Finally, eight caregivers reported being satisfied with the entire process (57%), including being satisfied with the outcome (36%). Examples of satisfaction with services included:

- “Actually, I mean, it helped me a lot, and I loved it, and it helped my kids get through their time in school. My son really admired [the therapist], because some of the bad things that he could have been doing. In spite of that, she convinced us to come in and she helped him out a lot.” – C02
- “To be honest with you, my daughter, she really wanted to come back here, but she passed everything. I tell her it wasn't a need, but like I said, if she had any questions, any concerns, or any time she wanted to talk, just feel free and I can call and make an appointment. Every time we pass by there, she's like, ‘I love this place!’” – C02
- “It looked like it was pretty nice. It was definitely catered to kids, had kids' toys and books for all age groups. As far as that goes, that's something I could remember.” – C04
- “The staff I spoke to, they gave me ideas of speaking with my child. They gave me other resources of what I could do or who else I could speak to if it wasn't a big help.” – C13

When discussing negative experiences, most of them centered on client level barriers. Specifically, three caregivers (21%) reported that their child felt anxious, unsure, or uncomfortable with the services received at the CAC, including feeling that he/she had done something wrong or was to blame for the suspected abuse (7%), general anxiety (7%), and/or that the staff wanted them to change their answers (14%). Five

caregivers (36%) described dissatisfaction due to general feelings of system mistrust, including feeling as if people at the CAC viewed him/her as a “bad parent” (29%), or that they were not provided with enough resources and felt neglected by the system (21%).

Caregivers also discussed dissatisfaction with services that revolved around organizational barriers. Specifically, five caregivers (36%) reported dissatisfaction with services because they wanted a more in-depth investigation or more involved services, including feeling that there was not enough information provided to the parent throughout the process (21%) and/or that there was not enough follow-up after the investigative portion was completed (7%). In addition, one caregiver (7%) reported dissatisfaction with the medical exam, due to discomfort reported by the child. Finally, one caregiver (7%) reported negative experiences with the physical environment, stating that the temperature at the CAC was too cold. Some specific examples of dissatisfaction described by participants included:

- “I can recall my daughter being highly upset. Because she explained to me that she was asked the same question multiple times. She said that it felt like they wanted her to change her answer. When her answer was the truth. She said it felt like they wanted her to tell a story. Because her mom wasn’t a good person. What she explained to me.” – C07
- “It was not a good experience for me, but I guess it’s just that they are very professional. Me personally, I just really think they need to find a different way before they investigate. Like, I guess I would say probably do a home visit instead of the parents bringing the kids here.” – C10
- “They could’ve done better with explaining.” – C15

**Current Diversity Considerations at the CAC.** All of the comments on diversity considerations focused on organizational level factors. Specifically, 13 caregivers (87% overall) discussed cultural considerations that were currently in place at the CAC. Specifically, within this theme, 13 caregivers (100%) discussed the racial/ethnic composition of the staff, including caregivers reporting that staff was diverse (39%), were predominantly white (46%), or all white (15%). One participant (8%) mentioned the cultural considerations in the waiting room, stating that the waiting room was diverse in regard to pictures and activities available. Some examples of cultural considerations at the CAC mentioned by caregivers included:

- “I have had both African American and Caucasian people there.” – C09
- “I realized that everyone that I seen at the front desk and the counselor that I spoke to, all of them were white or Caucasian.” – C13

**Race/Ethnicity Impact on Services.** Thirteen caregivers (93% overall) discussed whether racial/ethnic composition of the staff had an impact on services, which revolved around provider level factors. Specifically, 12 caregivers within this theme (93%) stated that race/ethnicity did not have any impact on the services that they received. Two caregivers (15%) discussed a cross-cultural disconnect, including a negative response to a white CAC staff providing feedback on behaviors that are reportedly culturally appropriate to the Black parent (e.g., corporal punishment). Two caregivers (15%) mentioned that staff at the CAC did not initiate conversations about how culture impacts their parenting, which the caregivers would have welcomed. Two caregivers (15%) discussed racial experiences with working with same versus different race staff, with one participant mentioning that working with the same race would be a negative experience and one participant stating that working with a different race would be a negative experience. Examples of comments made by caregivers include:

- “I think one of the ladies was kind of prejudice. It was the way that she was speaking. It was like she didn’t really want to see the problem get solved.” – C06
- “I didn’t see color, and I don’t think she saw color neither. We just did what we had to do, whatever, to help me and my child.” – C08
- “In African American home, yes, we got more corporal punishment, versus the way how more Caucasian and their families, other backgrounds, culture, families, how they discipline their kids.” – C11

**Barriers to Accessing Services.** Twelve caregivers (86% overall) discussed barriers to accessing services following trauma exposure, which all focused on client or organizational level barriers. Of these, 92% reported logistical barriers to accessing services, including client level barriers (i.e., transportation, childcare, employment hours, financial situation) and organization level barriers (organization hours of operation, location of CAC, parking at the CAC). Nine caregivers (75% within this theme) discussed client-level attitudinal barriers to accessing services, including system mistrust (42%), mistrust of mental health professionals (8%), stigma associated with service system or mental health involvement (17%), wanting privacy for the family (25%), or staff placing blame on victims (17%). Four caregivers (33%) mentioned outside stressors as a barrier to accessing services, including feeling overwhelmed by general stress (17%), stressors related to parenting (33%), and stress with the system (8%). Examples included:

- “Because my mom was a single parent and we just did everything in-house and we didn’t let anybody else in. What goes on in the home stays in the home, our problems are in home and we’re gonna fix ‘em in the home sort of thing.” – C03

- “I know a lot of black families with moms who doesn’t have transportation. I know that would be an issue as well.” – C07
- “She doesn’t want to lose her kids. She doesn’t want the system to take her children away, but there’s a lack of resources. She’s not getting any answers.” – C12

**Suggestions for Increasing Engagement or Improving Services.** Thirteen caregivers (93% overall) gave suggestions for increasing engagement or improving services at the CAC, which all involved suggestions to address organizational level barriers. Specifically, five caregivers (39% within this theme) suggested that the CAC take more time to understand, evaluate, and assess the concerns, including gathering more information from the family (31% within this theme) or gathering more information from the referral source (15%). Two caregivers (15%) mentioned that the CAC could provide more explanation about the entire process, including explaining the process more fully (8%) and explaining the investigative findings in more detail (8%). Five caregivers (39%) suggested that the CAC could provide more services, including providing reminder calls (15%), offering more counseling services (23%), and/or providing more referrals (15%). Six caregivers (46%) discussed that they would like for the CAC to involve parents more fully, including suggestions to provide periodic check-ins with the parent (23%) or having the parent more involved during the entire process (15%). Two caregivers (15%) suggested that the CAC attend more to child and/or parent anxiety or discomfort. Three caregivers (23%) suggested addressing work hour barriers, including the CAC remaining open in the evening (8%) and/or on weekends (23%). One participant (8%) suggested that the CAC offer outreach services. Some examples of suggestions made by caregivers include:

- “[The CAC] should make sure that they do a better investigation like having a parent conference at school about any concerns that they have.” – C10
- “I really do think they should make phone calls, follow up more, once that foster case, or whatever the issue, has been dismissed. I really think that phone call, maybe once per year.” – C11
- “I think that y’all can bring the parent or guardian and the case workers together, and then y’all can have a meeting, and this would be informative of what is out there and what services y’all have and how it can help. Teach them how it can help.” – C14

## Discussion

Ethnically minoritized individuals experience significant disparities in mental healthcare and are thus at increased risk for negative sequelae of trauma. As stigma, system mistrust, and socioeconomic factors are common in ethnically minoritized communities, cultural factors are particularly relevant to increasing service engagement and improving outcomes following trauma exposure for Black clients. The

primary goal of this study was to identify barriers to and facilitators of service engagement for Black youth and families who are referred for services following allegations of child abuse and neglect. The study was conducted in a CAC, given that this is often the first acute phase of service provision following suspected child abuse or neglect.

Findings from the current study demonstrate that 60% of the sample discussed previous trauma-related services received, with 33% reporting previous CPS involvement. The profound lack of trust of the child welfare system experienced by Black parents (Kokaliari, Roy, & Taylor, 2019; Kokaliari et al., 2019) and close partnership of CACs with CPS can negatively impact minority parents’ trust and perceptions of CAC services. Consequently, these negative perceptions may reduce the likelihood that caregivers will follow through with service recommendations made by CAC staff. Thus, to increase engagement of Black youth and families in subsequent services, including mental health services, CAC staff are suggested to initiate candid discussion of prior experiences with the service system. Qualitative data collected in this study build upon recommendations by Metzger and colleagues (2021) to use part of the assessment phase to identify, clarify, and overcome prior negative experiences of mental health services and indicate the need to consider transparency and openness in all services to foster trust with families following suspected trauma exposure. At the onset, openly addressing potential facilitators and barriers to engagement in families’ previous experiences can help with subsequent engagement, which may be true for all ethnic groups but are particularly salient for ethnically minoritized families.

In addition to addressing previous service experiences, results from this study also suggest providing more psychoeducation and emphasis on clarifying the relationship between CAC and CPS, including issues of confidentiality (Metzger et al., 2021). Given that 87% of the sample of caregivers were referred to the CAC directly from CPS, it is understandable for an increased sense of mistrust to be present upon arriving to the CAC. Thus, clear discussion of mandated reporting is important to review prior to the forensic interview and medical evaluations (86% received a forensic interview and 57% received a medical evaluation). Similarly, discussion of family values should also be important to review at the onset for better case conceptualization and to improve ongoing engagement (Metzger et al., 2021; Padesky, 2020).

Nearly 20% of Black caregivers in the current study also noted that they never received the results from the forensic interview or that the feedback was inadequate. This finding is in line with past research indicating caregivers dissatisfaction with the level of information provided to them regarding the results of their child’s forensic interview (Davies et al., 2000). Given the importance of diagnostic feedback for establishing rapport with therapeutic clients (Allen et al., 2003), these results may further contribute to disengagement, especially among vulnerable families (e.g., those where the child is still residing with the offending caregiver). It is important to note,



however, in the case of CACs, that the forensic interview is not always “diagnostic” in the mental health sense. Given the nature of forensic interviews, the outcome can often leave concerned parents frustrated by the lack of a definitive outcome (i.e., conclusion on whether abuse occurred). Also, it is important to clarify for families that CACs are not investigation agencies, that CPS typically makes the original case determination, and that the trained forensic interviewers conduct the interview and provide CPS with the information the child disclosed.

Conversely, some caregivers reported the stigma of their child being a victim of abuse or receiving a psychiatric diagnosis as a potential barrier to engagement in services. Although the forensic interview is not diagnostic, this can be a common misperception of caregivers that might also impact their willingness to utilize available services. An important aspect of the engagement process is to normalize and provide psychoeducation, evidence-based treatment options, and family resources. Providing comprehensive feedback (e.g., discussing mental health stigma, providing resources, making referrals to advocacy groups) may help with increasing engagement, particularly in Black families that report resistance to the diagnostic process.

Regarding cultural considerations, 87% of the sample noted an aspect of the CAC experience related to culture including racial composition of the staff, staff prejudices, and understanding cultural values and practices (e.g., corporal punishment). In addition, 75% discussed attitudinal barriers (e.g., system mistrust), and 33% mentioned other stressors (unique parenting difficulties) as preventing them from using available services. This is in line with CAC research that indicates that over 52% of CAC clients are ethnic minorities being seen by staff that are mostly from non-minority groups (NCA, 2020).

One of the National Children Alliance’s (NCA, 2017, 2023) standards for accreditation stipulates that, to be considered a provider of comprehensive and coordinated support in response to child abuse, CACs must have consistently available, on-site or by referral, evidence-based trauma-focused mental health services for children and caregivers. Evidence-based culturally tailored interventions exist that can be delivered in CACs to help reduce parenting stress, and the implementation of evidence-based interventions in CAC settings can help reach populations that do not typically have access to effective services. As reported, 93% of caregivers gave suggestions for increasing service utilization at CACs, including more in-depth investigations, explanations, and involvement during the investigative process. Further, several evidence-based treatments like Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen et al., 2006) are referenced in the NCA standards for accreditation (2023) that involve caregivers throughout the treatment protocol. While TF-CBT is widely used across CACs nationally, research on culturally adapting TF-CBT for Black (Metzger et al., 2021) and Latine (de Arellano et al., 2012) youth suggests the benefit

of integrating extended family members into the treatment process to increase engagement of ethnically minoritized clients. These results can inform the use of practice-based enhancements that address disparities in access to care.

### *Practice Implications and Considerations*

The current study expands upon previous research suggesting that improving accessibility is an important component of cultural integration and ensures that services are provided in the community where most of the target population resides (Metzger et al., 2013). Malleable factors related to accessibility that influence Black families’ engagement with mental health systems include physical location, hours of operation, and method (e.g., in-person, telehealth) of service provision (Breland-Noble, 2013; McKay et al., 2004). Community organizations are uniquely positioned to help Black families overcome transportation, child-care, financial, and other significant barriers that exist to accessing available services. Addressing these concerns may increase other minoritized groups’ utilization of mental health and other trauma related services at CACs (Santiago et al., 2012). For instance, providing childcare services (for children not engaged in services) and transportation (e.g., bus tokens, information about Non-Emergency Medicaid Medical Transportation services), and offering flexible scheduling (e.g., evening and weekend hours) are factors that can increase service utilization for racially minoritized groups.

Community organizations and service providers should use different methods to increase engagement and to better align with underserved cultural groups (e.g., using psychoeducational materials with images of Black youth and families; Metzger et al., 2013). As evidenced by caregivers suggesting extended involvement and periodic check-ins, a practical application and future direction of this work is to test the sustainability and efficacy of having family advocates conduct longer-term follow-up calls to check in on family service needs, for example. Further, the current study highlights the lack of clarity about the disciplines that make up the response team within CACs. Thus, it is important for providers operating within CACs to orient families to various disciplines (e.g., LE services, mental health, medical, and victim advocacy), limits of confidentiality, and the roles and mandates of each entity. The information presented in the current study highlights the potential impact of training staff MDT members to identify and target common individual, provider, organizational, and systemic barriers to accessing services. Results suggest that CAC staff should remain open and curious, invite discussion, acknowledge and voice/validate Black caregiver experiences and hesitations, answer frequently asked questions, and help caregivers and youth overcome stigma and mistrust they may be experiencing. Black maternal caregivers in the current study also emphasized the need to integrate culture into conversations with CAC staff. Children’s Advocacy Centers can accomplish this by integrating aspects of

Black culture in services (e.g., distributing psychoeducation in waiting rooms) and treatment components (for instance, by discussing the racial socialization process and facilitating conversations about race) for Black families (Metzger et al., 2021).

Perhaps the most progressive and wide-reaching strategy in overcoming barriers to service utilization is to better clarify the relationships between disciplines, as many caregivers themselves reported going through ‘investigations’ but were unable to distinguish between forensic interviews with CAC staff, mental health assessments, and investigations by CPS and LE. To build trust and encourage engagement in services, it is important to clarify the role(s) of CAC staff and how the CAC mandate differs from other disciplines. Because caregivers seem to view CACs as part of CPS, CAC staff can help to educate parents on how various disciplines within the service system work together in child abuse investigations and help prevent the “cold handoff” referrals from CPS that were described by parents above in the “referral/scheduling” theme. Similarly, while CACs work to clarify the distinctions of each agency’s role at intake, it is also recommended that CPS and LE do a more thorough job of explaining their roles at their first contact with the family so that CACs are then reiterating that message at intake, feedback, and throughout CAC services.

### *Limitations and Future Directions*

Findings from the current study contribute to the field’s insight in augmenting engagement of minority families in CAC services, but results should be interpreted in the context of some limitations. One important limitation is that the current study was conducted at only one CAC. However, all accredited CACs follow the same set of standards for accreditation (NCA, 2017, 2023), they all facilitate a multidisciplinary, coordinated response to child abuse, and they all follow a similar process and flow of services including forensic interview, medical examination if needed, victim advocacy, and access to mental health assessment and treatment. This attests to the generalizability of study results that identify common malleable targets that other CACs and community-based organizations can apply in the future. Future studies should explore the perspective of caregivers and multidisciplinary professionals across CACs, including both Black and white staff. Second, to better characterize referred families in future studies, additional demographic information should be collected including SES, employment status, and other factors that can impact service utilization. Subsequent studies should also explore quantitative data from a larger sample to identify ethnic differences in service utilization across client populations. Additionally, quantitative analyses of service utilization and attrition should explore the type of services

clients can engage in at CACs including those that are mandated, recommended, self-sought, and those that are designed to be short-versus long-term.

Additionally, information gathered in this study was according to caregiver report as collected through the interviews. The authors did not have information on the actual referrals provided to the 15 caregivers by the referral source, but only on the services that caregivers reported being offered and receiving. Future studies could better assess service utilization by gathering information from the CAC on referrals provided and received.

Further qualitative exploration of the themes and sub-themes could also help identify modifiable processes and/or components of CAC services to begin developing implementation goals to better serve Black families. Gaining similar insight to potential barriers to service utilization from other marginalized communities with increased rates of trauma exposure (e.g., Latine, American Indian) will also be valuable next steps to improving CAC services for minority youth. As suggestions have been made in the literature about how to modify evidence-based trauma treatments (e.g., TF-CBT; Metzger et al., 2021), an important next step is for suggestions herein to be disseminated empirically and followed practically, for instance in the Standards for Accreditation that govern CACs through the National Children’s Alliance.

### *Conclusion*

Healthcare disparities in access to and engagement of services related to child maltreatment warrants significant attention. Results from the current qualitative study highlight the potential role of CACs in the improvement of service engagement to trauma-exposed minority youth. In addition to organizational changes to increase engagement of Black youth and families, CAC-MDTs should begin with more defined agency roles (e.g., distinction between CAC and CPS), psychoeducation, and candid discussion (e.g., addressing culture and stigmas) during the family’s initial involvement with the CAC while implementing initiatives across CACs to overcoming client barriers and utilizing evidence-based trauma-focused interventions in community settings. To ensure that families heal from their child’s experiences of child abuse and neglect are engaging in services, it is essential that we begin improving transparency and opening more clear lines of communication about the people and processes responding to their needs. It is then with increased transparency that clients begin to trust the larger systems, thus increasing service utilization and continuing to increase the effectiveness of CACs.

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