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Barriers and facilitators for access to mental health services by traumatized youth

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Abstract

Polytrauma is a highly prevalent public health problem in the U.S. with even higher rates in urban areas. Children with polytrauma often end up in multiple child-serving systems (e.g., mental health, child welfare, education, juvenile justice) with needs that are both complex and severe. Providers within these child-serving systems have potential to serve as gatekeepers to trauma services by linking youth with trauma-informed treatments and supports that promote recovery. The purpose of our study was to assess the perspective of providers who participated in a nine-month, trauma-informed care (TIC) training intervention on 1) their capacity to make referrals to trauma-specific services following the training, and 2) factors external to the training intervention that supported or hindered their ability to link traumatized youth with services. A subset of sixteen participants from the TIC training completed individual interviews. These participants were predominantly female, African American, and based in the social services sector. The constant comparative method was used to derive three thematic domains related to participant perceptions regarding youth referrals: 1) Organizational and provider capacity to provide trauma treatment or to make referrals to trauma-specific services, 2) Barriers to youth accessing trauma services, and 3) Suggestions for improving coordination of care and referrals. Our study highlights the influence of contextual factors on whether a TIC training can improve the capacity of agencies and individual providers to support traumatized youth in accessing appropriate services. The development of a structure that formally connects youth-serving agencies and providers with specialists trained in addressing traumatized youth is recommended.

1. Introduction

Polytrauma is a highly prevalent public health problem in the U.S. (Ko et al., 2008), with higher rates in urban areas than rural (Child and Adolescent Measurement Initiative, 2014). Children with polytrauma often end up in multiple child-serving systems (e.g., mental health, child welfare, education, juvenile justice) with needs that are both complex and severe (SAMHSA, 2014). Fortunately, effective trauma-focused treatments exist (Cohen, Mannarino, Kliethermes, & Murray, 2012; Gurwitch et al., 2016; Lucio & Nelson, 2016). Thus, there is a need to train service providers in trauma-informed care (TIC), specifically, how to recognize and respond to youth in a way that does not re-traumatize them, as well as how to promote referrals of trauma-affected youth to the appropriate support systems to heal

from trauma (SAMHSA, 2014). Non-clinical service providers are potential gatekeepers to TIC services and social support systems that can help youth heal from trauma.

A growing body of literature has assessed referral-related outcomes of TIC trainings. Several quantitative and mixed methods studies have found TIC trainings to be an effective starting point for screening and identifying traumatized youth and making referrals to appropriate trauma treatment and services (e.g. Fraser et al., 2014; Kramer, Sigel, Conners-Burrow, Savary, & Tempel, 2013; Lang, Campbell, Shanley, Crusto, & Connell, 2016). There has been a variety of TIC trainings that have been implemented, including one-day didactic trainings on basic TIC principles (Conners-Burrow et al., 2013; Fraser et al., 2014; Kramer et al., 2013), small group discussions over several months on TIC as it pertains to working with individuals with mental/behavioral health challenges (Kerns et al., 2016), and a two-year hybrid training comprised of didactic sessions and small group discussions among social service workers (Lang et al., 2016).

Although prior studies have added to our understanding of how TIC trainings can potentially serve as an effective tool for addressing the unique needs of youth who have experienced trauma, the literature in this area has several limitations. For example, some studies only focused on organizational and provider level barriers to referrals (Conners-Burrow et al., 2013; Fraser et al., 2014; Lang et al., 2016), without taking into consideration barriers at the level of youth and families. In addition, several studies only included participants from rural, predominantly white settings (Conners-Burrow et al., 2013; Henry et al., 2011; Kramer et al., 2013) and others did not report the sociodemographic characteristics of their target populations (Fraser et al., 2014; Kerns et al., 2016; Lang et al., 2016). As a result, perspectives on TIC trainings in urban communities of color are not well represented in the literature. Some studies were also limited by the design of their training interventions, which only included participants from the mental health and/or child welfare systems, many of whom already have prior exposure to trauma-related concepts (Conners-Burrow et al., 2013; Fraser et al., 2014; Kerns et al., 2016; Kramer et al., 2013; Lang et al., 2016). Moreover, with the exception of one mixed methods study conducted by Fraser et al. (2014), prior studies have primarily relied on pre-post quantitative surveys to assess barriers and facilitators to TIC referrals.

This qualitative evaluation of a nine-month cross-sector citywide TIC training in Baltimore City for urban youth-serving agencies addressed the limitations of prior studies by evaluating barriers to screening, identifying, and referring traumatized youth to appropriate treatment and services at the organizational, provider, and youth/family levels. Our use of qualitative methods allowed us to explore and obtain depth of understanding as to the reasons for referral success or failure to identify strategies for facilitating improved referral of traumatized youth to appropriate services. Moreover, qualitative analysis provides detailed descriptions or narratives regarding the process of referral, as well as training participants' perceptions and experiences in implementing lessons learned from the training to their respective workplaces (Creswell & Plano Clark, 2011). Additionally, this study's focus on an urban-based TIC training enriches the literature by exploring perspectives of providers who work predominantly with low-income, youth of color. Our study had two main objectives. First, we obtained participants' perspectives on how participation in a nine-

month, trauma-informed care training intervention influenced their capacity to make referrals to trauma-specific services. Second, we explored participants' perspectives on factors external to the training intervention that supported or hindered their ability to link traumatized youth with appropriate services.

2. Methods

2.1. Study context

After the Baltimore unrest in April 2015, the Baltimore City Health Department, together with its quasi-governmental partner Behavioral Health System Baltimore, developed the Healing Baltimore initiative with support from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services, National Center for Trauma Informed Care. An important commitment to Healing Baltimore was the pledge by former Baltimore City Mayor Stephanie Rawlings-Blake in July 2015 to have all frontline city workers trained in TIC, making Baltimore the first U.S. city aiming to provide TIC training for all government employees.

The Baltimore City Health Department (BCHD), in collaboration with SAMHSA's National Center for Trauma Informed Care (NCTIC) and Behavioral Health System Baltimore (BCHB), led a nine-month comprehensive, evidence-based trauma-informed implementation training and learning collaborative to agencies across Baltimore City (Institute for Healthcare Improvement, 2003). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (SAMHSA, 2014) provided the framework for this training intervention. NCTIC consultants conducted the monthly training at the BHSB office, and focused on educating and providing technical assistance to participants in implementing the six TIC principles outlined by SAMHSA: 1) Safety, 2) Trustworthiness and Transparency, 3) Peer Support, 4) Collaboration and Mutuality, 5) Empowerment, Voice and Choice, and 6) Cultural, Historical and Gender Issues.

Under this multi-systemic, multi-agency collaborative, government agencies and youth-serving organizations across Baltimore City participated in several activities including a series of monthly technical assistance, coaching, and feedback sessions from national trauma experts on how to utilize trauma-informed practices at their agency. Participants represented a wide range of government agencies and nonprofit organizations that interact with traumatized persons across Baltimore on a daily basis. Participating agencies can be categorized as falling within the following domains: Law Enforcement, Social Services, and Health and Education. Participants in the nine-month training (N = 90) were identified by their respective agencies to lead and implement trauma-informed approaches at their respective workplaces. No predetermined, uniform selection criteria were used across all agencies; rather, selection of participants was at the independent discretion of the participating agencies. All participants were over 18 years of age and English speaking. The Institutional Review Board at the Johns Hopkins Bloomberg School of Public Health approved all study procedures, and all research participants provided informed consent.

2.2. Sampling and recruitment

As part of a larger mixed methods observational study (N = 88) examining the effects of the TIC training on organizational and individual level factors, including knowledge, attitudes, and beliefs associated with implementation of TIC policies and practices, a subset (n = 16) of participants completed a 30–45 min, semi-structured interview two months following completion of the training. This study reports on findings derived from interviews with that subset of TIC participants. BCHD and BHSB staff overseeing the TIC intervention described the study to all trainees who met the inclusion criteria, asked them if they were interested in learning more about the study, and shared the contact information of interested trainees with the research team. Snowball sampling was used to recruit additional participants; initial interviewees were asked to recommend others from their respective agencies who might be interested in participating in the training. The lead author explained the study, obtained informed consent, and conducted all interviews. No incentives were offered for participating in the study. Interviews were digitally recorded and transcribed. Any identifying information, such as the names of individuals or places, was removed in the transcription process.

2.3. Measures

This study focuses on a subset of referral-related questions from the semi-structured interview guide. Sample questions are: *Does your organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services? How does your organization identify community providers and referral agencies that have experience delivering evidence-based trauma services? How has your opinion of traumatized youth access to services changed because of the training? What are some of the barriers in traumatized youth being able to access treatment and/or trauma-related services?*

2.4. Qualitative analysis

Qualitative analysis was conducted by two trained coders. The coders independently used the constant comparative method, moving iteratively between codes and text to derive themes related to participant perceptions of the intervention. Originally developed as part of the grounded theory method of Glaser and Strauss (1967), the constant comparative method involves selecting one component from the data, such as a theme, and comparing it to the rest of the data to develop conceptualizations about possible relations across various data components (Boeije, 2002). We focused our attention on responses related to how the intervention influenced participants' organizational capacity to provide treatment or make referrals to trauma-related services, as well as perceived barriers and facilitators to traumatized youth being able to access services.

3. Results

Most of the sixteen participants in this qualitative substudy were female (87.5%) and African-American (81.3%). The majority worked in the social services sector (75.0%), while other participants worked in law enforcement (12.5%) and other government agencies (12.5%).

The following section discusses themes that emerged from the qualitative interviews. We identified three categories of themes: 1) organizational and provider capacity to provide trauma treatment or to make referrals to trauma-specific services, 2) barriers to youth accessing trauma services, and 3) suggestions for improving coordination of care and referrals. The themes within each of these three categories are discussed in detail below.

3.1. Organizational and provider capacity to provide trauma treatment or to make referrals to trauma-specific services

Some participants reported that their participation in the TIC training made them *more likely to refer traumatized youth to the appropriate services* (n = 4). One participant from social services reported:

It has increased the likelihood of the referrals because of the fact that you get a greater sense of what it takes to refer a client to another program, what expectations are, and how they differ from our program... because of the training, you now know of other services that might better suit your clients.

Similarly, another social services participant described an increase in referrals of affected families as having taken a greater priority at her agency:

I believe our referrals have increased. I think we are referring for therapeutic services more often, and probably as a direct result of the trauma-informed care training. That is high priority for us to ensure that our families are getting community mental health services.

Another interviewee from social services explained how the cross-sector, multi-agency design of the training was an opportunity for her agency to network with other agencies that have the capacity to support traumatized youth:

If it's another agency that we've made connections with, sometimes when we do workshops or programs, we'll invite them in and they can speak to clients as a whole and not just target a specific individual and discuss the resources that are available.

In contrast, the majority of participants (n = 12) noted no major change in their organization's response to address the needs of trauma-affected youth for a variety of reasons, as summarized below. Several participants explained that their agency still *lacked the capacity to provide treatment or make referrals* (n = 5). As one social services professional put it, "I don't think there are enough trained clinicians in trauma. I think that the clinician should be a trauma specialist and they don't exist. Your psychotherapists have treatment modalities, but that doesn't make them a specialist in trauma." Another participant from law enforcement described the structural challenges, specifically lack of a formalized referral system, which hindered him and his agency from being able to connect traumatized youth with the appropriate services. He explained:

I don't know that we have a good transition or follow-up program from a city government point of view to where some kind of social work organization or youth work organization follows up with those three witnesses to kind of talk, you know, talk to them about the trauma they're involved in, the shooting victim, and the

trauma that he was involved in. The state's attorney's office does have resources and I guess counseling and different things, but I don't know that if it gets tied in real well.

Another interviewee from social services described that the challenges lay in not having been informed of the resources that exist to support youth that have experienced trauma:

I don't think that anything has changed because we still are not aware of the resources. It's almost like there is nothing to change because other than the available providers, out of the training, we weren't even given a list of providers that do trauma informed care that we could use to refer.

A few participants reported that their participation in the *TIC training made no difference in their agency's referrals of traumatized youth since their agency had already taken actions to formalize a means of connecting affected youth to the appropriate trauma treatment and services* (n = 3). One participant from social services noted:

No it (referral process post-training) hasn't changed because they um, once they're here I meet with them individually and if they've got kids or family or children, school-aged, it's standard protocol for me to refer the kids for counseling, and that's always been, you know, get their babies evaluated.

Similarly, another social services interviewee explained how referring youth in need of special services was already part of her professional routine:

I speak with every family or unaccompanied minor or youth and I make sure that they're getting services and a lot of that would pertain to getting therapy in schools and a referral would be made and knowing their rights as a young unaccompanied minor or parents knowing their rights as a homeless parent. And so you know advocating with them. I feel like it just reinforced what we are doing, and I know that it's helped keep it in the forefront I just don't have any specifics. I don't think that we have changed anything that I can think of at the trainings.

3.2. Themes of barriers to youth accessing trauma services

The most commonly reported barrier to youth accessing trauma services was *lack of coordination among services* (n = 5). One social services participant described that many clients are served by multiple systems, but that those systems do not engage with each other: "I think that the other piece is that in working in health welfare there is such a duplication, like so many clients who are involved in services in so many areas. So then there is a lack of collaboration between services." A participant who works in for the parks and recreation sector described having a lack of knowledge of where to refer, in addition to not knowing when making a referral is appropriate:

I don't think that there's any reluctance or resistance. It's the knowledge, not knowing where exactly to refer, not knowing what exactly the situation may be, we experience children who may be homeless, but there is some resistance on the parents part in exposing that. There are some barriers in establishing the trust to know that the person needs that type of service.

Another social services participant pointed out the inconsistency in the availability of trained personnel to support traumatized youth: “The barriers to these programs are more systemic issues, like Baltimore City schools when the kids are in the schools, maybe the therapist that they see isn’t there, how is the school handling that.” A member of law enforcement reported a similar challenge with competing responsibilities that make it difficult to take the time to refer traumatized youth to needed treatment and services: “We, as police, don’t interact with them (other services), especially in Baltimore City because we’re on to the next crime, we’re on to the next shooting. The staffing in our department is falling, so everybody’s working doubles.”

Other participants described *workforce shortage* as a barrier to ensuring that traumatized youth get referred ($n = 4$). One social services worker emphasized the lack of financial resources for hiring additional staff: “It comes down to money, I need additional staff, I need to lower the staff to client ratio, I need to increase funding so that clients don’t have financial stress in addition to traumatic stress. I need to have resources out in the community that work with clients who have trauma.” A participant from the social services sector noted that even when traumatized youth are linked to the appropriate services, the staff shortage prevents youth from being able to access care in a timely, consistent manner. She explained:

Let’s say there’s a client and they’re feeling depressed and they’re put on medication – being able to get the medication, prescribe, ... I mean, it takes forever to have an appointment with a psychiatrist, right? Plus a counselor. And then they only see them sometimes once a month. You know, it’s not intensive enough.

Socioeconomic constraints of traumatized youth and families themselves are key barriers impeding access of traumatized youth to treatment and services, according to some of the interviewees ($n = 4$). One social services worker pointed out the logistical barrier in traumatized youth being able to access service, particularly amidst other familial demands: “Transportation is the biggest one. I’m looking for a therapist that will go into the community. Because if they are able to go to the home of the family, then transportation is no longer an issue nor is child care because children are home.” Another social services worker expanded on this point by noting a shortage of trained staff to assist trauma-affected youth and families:

There are many, including agencies to which we refer clients have waitlists, lack of funding, and staff shortage. Also, physical access—distance & lack of transport. They may have a waitlist or they may not have funding or they may not have someone available. Like for instance, I referred a client for mental health services to this one professional but they were too far for them to get to, like there wasn’t a bus line so we had to look for something else. So it was not only access, it was how to get there.

Another provider from the social services sector described the challenges that traumatized youth and their families face in navigating the healthcare system as a structural barrier to care:

The medical assistance. Their coverage. Because most of them that come in have already been connected to a therapist and just lost contact and their name is still in

the system with the previous agency. By the time I get ready to refer them to a new therapist they have to contact, it's up to the client to contact the old therapist and discharge them when half the time they don't even remember where the office was, who the therapist was, because they were so young.

3.3. Themes of suggestions for improving coordination of care and referrals

Participants proposed several solutions for how to improve traumatized youth's access to appropriate treatment and services. Several participants suggested the *development of a formalized system to link service agencies* ($n = 6$). One social services professional provided the following example from healthcare to illustrate this approach:

Hopkins uses a software called EPIC and anyone who comes into the system and is in EPIC, their chart provides you with what services they are provided from what department. I don't know if the counties could do it by county. But a software that would let people know what services, especially for the Medicaid patients who are sent all over the place, wouldn't it make sense to have their Medicaid number in the system to show what services they're receiving and where, which would hold people responsible for collaborating with each other.

Another social services worker explained that such a formalized system would allow agencies to learn from the best practices of other organizations that are already successful in supporting youth that have experienced trauma: "I would like to know because again, there are different either shelters or facilities that do different things with their clients so I just want to see the differences they made with them." A professional from parks and recreation proposed that something as basic as a directory of available providers and services would help her agency in linking youth with a history of trauma to treatment and services:

What we were hoping that comes out of the training is a directory of services, I know a few organizations locally that we can refer to that are attached to a school. We work with a school and we work together with the school therapists that participants have. But we really hope that we can get a directory so that we can refer because we don't have those services and we aren't trained to provide those services.

A couple of participants emphasized the importance of *educating clients about trauma* and explained that the challenge was not solely in improving organizations' and providers' capacity to be trauma-informed, but that part of the responsibility is with the youth and families ($n = 2$). One social services provider described the normalizing of trauma among youth and families that needs to be unlearned: "They (clients) need to be educated. Most of them have trauma. It's like for them (clients), they don't even live like they've had trauma. They just don't see how that it's trauma—it's like they're normal." Similarly, another professional from the social services sector expanded on the importance of educating clients about trauma since some of their clients' actions can contribute to the re-traumatization of other youth and families:

I think it would be different if clients were required to participate in services. Clients aren't required to attend any services other than attended case management sessions. If I have a client and they live in a single room occupancy building and

because of their trauma and their neighbors' trauma they are always fighting, I can't require them to go get mental health treatment to deal with their trauma and their triggers so we're kind of backed into a corner in that respect.

Other participants reported the need to *expand the availability of TIC training to all personnel who interact with youth that have experienced trauma* (n = 2). One social services participant said, "I just pray that not only people in social work still get the trauma-informed care, I meant everyone on the front line really should have it." Another social services interviewee described the challenge in working with other staff who have not yet been trained in TIC and subsequently, are unable to competently address the needs of youth that have experienced trauma:

Like, we have two new people and they've never been to where the clients reside, but clients come in here but they still don't know—they're making assumptions or putting resources together for them but they don't know how they're living.

4. Discussion

Our study highlights that providers perceived contextual factors as influencing whether agencies and individual providers were better able to support traumatized youth in accessing appropriate trauma treatment and services after participating in TIC training. Very few studies have assessed barriers and facilitators to TIC referrals (Conners-Burrow et al., 2013; Fraser et al., 2014; Lang et al., 2016). Moreover, to our knowledge, there has been no prior evaluation of the SAMHSA TIC training intervention as it relates to these factors. Consistent with prior literature (Anderson, Blitz, & Saastomoinen, 2015; Lang et al., 2016; Perry & Daniels, 2016), our findings suggest that youth-serving organizations and providers may become more trauma-informed as a result of participating in a TIC intervention. Similar to those studies, our research suggests that barriers external to training including lack of coordination across systems, workforce shortage, and funding issues may make it difficult for agencies and individual providers to refer traumatized youth to appropriate services. Moreover, even when referrals are made, additional factors including transportation and insurance coverage may serve as structural barriers for youth and families to be able to access needed trauma treatments and services.

Similar to providers, families of traumatized youth also have competing demands that make it difficult for traumatized youth to access the needed treatment and services. Some participants described the process of re-engaging youth who previously received treatment and services as cumbersome. More specifically, the fragmented structure of the healthcare system poses a challenge for youth with a history of trauma to transition from one provider to another, consequently delaying treatment.

An important point raised during the interviews by a few participants, which was not reported in prior studies on this topic, is the concept of normalizing trauma. Given the high prevalence of poly-trauma, as noted earlier in this paper, some traumatized youth come from families where experiencing traumatic events and their psychological sequelae is not viewed as preventable or addressable but rather is accepted as a part of life. The perceived inevitability of trauma and doubt about the utility of treatment may serve as a barrier to

traumatized youth getting the help that they need in some families. Thus, participants suggested that youth and families should also be educated in TIC and encouraged to seek appropriate treatment and services. Lastly, participants brought up the salient point of the need to educate their colleagues in TIC. The providers who participated in the TIC training comprised a small percentage of all providers who interact with traumatized youth throughout the city on a daily basis, and participant responses indicated that training more staff may be necessary in order to shift agency culture and practice. Thus, it may be beneficial to provide the TIC intervention to more providers at each agency to produce meaningful improvements in agency referral practices.

Findings from this study suggest there is great variation in organizational and provider capacity to provide treatment or make referrals. Some participants reported an increased likelihood of referrals as a result of interacting and networking with providers from other agencies that have the resources to adequately address the needs of traumatized youth. This is consistent with the only two prior quantitative studies to our knowledge that have examined organizational and provider factors associated with referrals, which also found that participants endorsed improved organizational and provider readiness to refer traumatized youth after participating in a TIC training (Kerns et al., 2016; Kramer et al., 2013). Moreover, some participants in this study described how the training improved their agencies' recognition of the importance of linking youth with a history of trauma to appropriate services, thus influencing these organizations and providers to make referrals a higher priority.

Other participants reported no change in their capacity to provide treatment or make referrals. Some participants explained that the training fell short of equipping participants with tangible resources, specifically a directory of treatment and service providers specialized in working with traumatized youth. The fact that only 4 participants reported that they are more likely to refer traumatized youth to services after the intensive TIC training is somewhat discouraging. One hypothesis that could explain this finding is that while some agencies were able to leverage the training as an opportunity to connect with other organizations, other providers were still unaware of the resources that were available in the community. In addition, participants described challenges beyond the scope of the TIC training. For example, some participants noted the shortage of personnel trained in working with traumatized youth, as well as the lack of formal connections between child-serving systems, which made it difficult for participants to implement lessons learned from the TIC training to better support traumatized youth through referrals. The barriers highlighted by these participants are consistent with prior studies (Fraser et al., 2014; Lang et al., 2016), which also found that factors external to the training, specifically workforce shortage and lack of awareness of available specialized treatment and services, were barriers to referring traumatized youth. Implementation science theories (Aarons, Hurlburt, & Horwitz, 2011; Palinkas et al., 2008) have also highlighted the importance of considering the outer and inner contexts (i.e. levels) of public sector service systems in influencing the implementation process of novel practices. Thus, in addition to internal factors including organizational and individual provider characteristics, outer context factors such as inter-organizational networks can also support or hinder successful referral of traumatized youth.

While some participants noted no change in youth referrals due to structural challenges, others explained that referring traumatized youth was already a standard practice at their organization. Although participants who were already familiar with both the importance and process of making referrals to appropriate trauma treatments and services may not have gleaned anything novel from the training with regards to referrals, it is plausible that their participation in the training may have benefitted their less knowledgeable counterparts from other participating agencies in the training who may have learned tips and strategies for making referrals to appropriate trauma treatments and services.

Although recognizing the signs of trauma and responding appropriately to traumatized youth are part of the basic principles of TIC, some participants still reported feeling unprepared to identify situations in which making a referral would be appropriate. Other participants explained that referrals were not consistently made at their agencies because engaging with other service systems was not part of their routine responsibilities, and there were other competing professional priorities that took precedence over referring traumatized youth.

Given that the lack of communications between child-serving systems was reported to be a major barrier to organizations and individual providers making referrals, the development of a structure that formally connects these agencies and providers with specialists would appear to be a logical step toward improving trauma treatment access. Participants pointed out that the healthcare field, in which a given individual may be seen by multiple providers, could serve as a model for linking disparate service systems to more holistically address the needs of youth who have experienced trauma. While a sophisticated infrastructure as used in healthcare may be time- and resource-intensive to develop and implement, participants suggested that in the interim a directory of specialists trained to address the needs of traumatized youth could be a starting point for helping participants be better equipped to respond adequately to traumatized youth. It is also important to acknowledge that the number of specialists with expertise in working with traumatized urban youth is currently limited. Initiatives to increase this pool of specialists are also critical.

4.1. Limitations

This study has several limitations. Although we attempted to recruit providers across all participating sectors of the TIC training for this qualitative study, those who volunteered were primarily from the social services sector, with a few additional individuals from law enforcement and other government agencies. As a result, our sample was not representative of all intervention participants, and we may not have captured all key perspectives on the TIC training. Moreover, the sample size and small proportion of the overall sample that volunteered to be interviewed inserts significant selection bias into our findings. Our approach was exploratory, however, striving for depth of understanding and not representativeness. In addition, although the qualitative approach of this study provided a nuanced understanding of perceived barriers to making referrals, we were not able to assess whether the training had an effect on actual referrals made. Collecting and assessing data on referrals posed a methodological challenge as participants in the training represented a range of sectors, each with different types of referral protocols and practices. Several of the participating organizations, including those from law enforcement and parks and recreation,

do not keep track of the number of traumatized youth they encounter, let alone referrals that are made to trauma treatment and services.

5. Conclusion

5.1. Implications for research

The study has several implications for research. First, given the small sample size included in this study, future studies that include larger sample sizes are warranted. Recruitment efforts that include provision of incentives may help to support the inclusion of a sample that is more representative of training participants. The field would also benefit from additional research on issues raised by this study, including barriers and facilitators to TIC referrals as well as the degree to which participants improve their capacity to provide TIC services or make referrals after participating in the training. Lastly, given that the current study was conducted shortly after the conclusion of the TIC training, future longitudinal studies can explore if any changes related to TIC referrals occur after a longer time period post-intervention.

5.2. Implications for practice and policy

The current study has implications for practice. Findings indicate that there is variation in service providers' knowledge and use of referral systems. Partnering agencies and individual providers more familiar with referral resources and processes can potentially support the transfer of knowledge and best practices to more novice organizations and providers. In addition, although the training focused on helping youth-serving agencies and personnel become more trauma-informed, families can either support, or hinder traumatized youth from accessing services, particularly by normalizing trauma. Thus, there may be a need for additional trainings that focus on educating families of traumatized youth about the value of connecting youth to trauma treatment and services. Moreover, as part of youth- and family-oriented TIC trainings, there is a need for wraparound services that address these population's needs, such as transportation and childcare, to minimize barriers that could hinder youth from getting to their appointments with trauma specialists.

The study also has implications for policy. Although TIC trainings can raise awareness about the importance of responding appropriately to the needs of traumatized youth through referrals, structural challenges must be addressed to create an effective youth referral system. Increasing the workforce specialized in working with traumatized youth is critical in order to address the current lack of mental health providers in this area. There is also a need for funding to support the development of an infrastructure that formally links child-serving agencies with one another. Such a system would not only facilitate the referral of youth to trauma treatment and services but could also provide better monitoring of youth outcomes following referral.

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Abbreviations

BCHD	Baltimore City Health Department
BHSB	Behavioral Health Systems Baltimore
SAMHSA	U.S. Substance Abuse and Mental Health Services Administration
TIC	trauma-informed care

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