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

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A B S T R A C T

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

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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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