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Behavioral Health Integration for India's Pediatric Population for Social Workers

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Abstract : Social work students rarely receive integrated pediatric behavioral health care education in India. Social work students should be knowledgeable about pediatric behavioral healthcare concerns and interventions and evidence-based treatment (EBT) to support their patient population. The Behavioral Health Integration for the Pediatric Population for Social Workers (BHPPS) intervention was a webinar-based, two-and-a-half-hour training session designed for social work students at an international university. BHPPS aimed to increase the knowledge of student social workers on pediatric behavioral health diagnosis and increase their confidence in identifying EBT. This study was quasi-experimental. A pre/post survey was designed to gauge if the BHPPS intervention increased the student social workers' knowledge of pediatric behavioral health and confidence in identifying EBT. Data were analyzed using a one-tail pairedsamples *t*-test assuming unequal variances. The difference was not significant between pre- and posttest; therefore, the null hypothesis was rejected for both hypotheses (Hypothesis 1, $p = 2.58$; Hypothesis 2, $p = 8.10$). The primary implication of this study is that student social workers require more than two and a half hours of training on pediatric behavioral health and EBT to serve the pediatric behavioral health patient population better.

Behavioral Health Integration for India's Pediatric Population for Social Workers Problem Description Globally, there is a lack of trained behavioral health providers (Al-Dmour et al., 2020).

The training that behavioral health providers and students receive does not support brief evidence-based interventions that can impact whole health outcomes for the pediatric behavioral health population (McKerrow et al., 2020). Behavioral health providers and students can improve their pediatric knowledge and skills to significantly impact global health challenges through brief education and training on evidence-based pediatric behavioral health care treatment methods (Flearey et al., 2018). India is one such country that is lacking in pediatric behavioral health knowledge and training for social work students (Hossain & Pirchit, 2019).

Pediatric Behavioral Health

Ten percent of children worldwide have behavioral health diagnoses (World Health Organization, 2021). It is estimated that 80 million children worldwide, ages 10-14 years old, have behavioral health concerns (United Nations International Children's Emergency Fund, 2021). Two in seven children under eight years of age have a behavioral health condition (Tyler et al., 2017). Pediatric behavioral health must be addressed on a global level. Out of the estimated 40% of children who require behavioral health services, only 30% receive services (Aguirre Velasco et al., 2020). The 2016 National Survey of Children's Health found that children with disabilities are more likely to have unmet health care needs. Children with autism spectrum disorders have a rate of four times more unmet health care needs than their neurotypical peers (Karpur et al., 2018). Children whose families have limited financial resources encounter barriers to acquiring the behavioral health services they need to thrive and succeed (Chakawa et al., 2020; Karpur et al., 2018).

Children and their families who come from communities of color, diverse backgrounds and experience significant concerns related to the social determinants of health are more likely to have limited and delayed access to behavioral health treatment, resulting in increased symptomatology (Dickson et al., 2021). Limited access to youth behavioral health services disproportionately affects communities of color (Chakawa et al., Owens et al., 2021). Behavioral health service

implementation is vital in the pediatric setting (Polaha et al., 2018). Many children are not screened for behavioral health diagnoses and are overlooked for necessary services (Polaha et al., 2018). When children are screened early for behavioral health conditions in their primary care office, they can be connected with services that support their behavioral health care needs. (Dickson et al., 2021). When the correct evidence-based treatment (EBT) is implemented early on, the probability of favorable health outcomes is increased (Polaha et al., 2018).

Knowledge and advocacy are crucial to spreading awareness of pediatric behavioral health issues (Arora et al., 2017; Knight et al., 2019). In the past ten years, the identification and evaluation of behavioral health concerns and a focus on preventative medicine in the pediatric population have improved (Herbst et al., 2020; Polaha et al., 2018). Integration of behavioral health into pediatric settings has significantly increased, allowing for early identification of behavioral health concerns, improved access to services, and increased treatment options for children and their families (Owens et al., 2021).

A reported 50 million children in India have symptoms of behavioral health conditions (Hossain & Pirchit, 2019). A consensus among the Academy of Pediatrics on Early Childhood Development members is that children should receive behavioral health interventions before the age of three (Bharadva et al., 2020). India has minimal behavioral health services for the pediatric patient population (Fledderman et al., 2021). Pediatric medical providers acknowledge there is insufficient time or enough specialists to support the pediatric behavioral health population (Fledderman et al., 2021; Hossain & Pirchit, 2019).

Pediatric Behavioral Health Provider Shortage

Limited availability of pediatric behavioral health services presents significant gaps in care for children and their families (Webber, 2016). On a global level, children of all ages are underserved in behavioral health services, and those with access often do not have opportunities for early behavioral interventions (Al-Dmour et al., 2020; Tyler et al., 2017). Due to the high demand for behavioral healthcare those involved in pediatric care must participate in additional training in pediatric behavioral health to meet the demands and better serve their patient population (McMillan et al., 2020; Pidano et al., 2018; Walter et al., 2019). Although India has the Indian Academy of Pediatrics, there is no information listed on the organization's website noting a shortage of pediatric behavioral health providers. However, a recent call was issued by the American Academy of Pediatrics (AAP) for all pediatricians to gain additional certification to meet their patients' behavioral health needs through additional training to address the shortage of pediatric behavioral health professionals (McMillan et al., 2020, Walter et al., 2019).

Shortages in pediatric providers affect the ability to deliver appropriate and timely care to this population. In 2017 the top three pediatric healthcare providers that were in greatest need were developmental pediatricians (11.8%), child and adolescent psychiatrists (10.8%), and pediatric neurologists (9.7%) (Children's Hospital Association, 2017). The provider shortage can lead to an appointment wait time of up to 18.7 weeks which prevents the pediatric population from receiving the care they need in the time frame that would be the most beneficial (Children's Hospital Association, 2017). Pediatric staffing shortages in India are comparable to those in the United States. To provide the number of services required by India's National Rural Health Mission (NRHM), the number of medical providers specializing in the pediatric population needs to increase to meet demand and the NRHM requirements (Hagopian et al., 2012; Nair et al., 2022).

Pediatric Behavioral Healthcare Evidence-Based Treatment Protocols

Evidence-based treatment (EBT) is the cornerstone of ethical and impactful/effective medical and behavioral health care (Slocum et al., 2014). To ensure that patients receive the appropriate treatment and care, medical and behavioral health professionals should utilize EBT. Applied behavior analysis (ABA) is one such EBT. ABA consists of behavior modification using EBT,

such as prompt hierarchy, running trials of behavior modification, and behavior extinction. Cognitive behavior therapy (CBT) focuses on patients while collaborating with a therapist skilled in CBT, identifying negative thinking and adapting their behavior around newly developed positive thoughts (Mayo Clinic, 2019). Acceptance and commitment therapy (ACT) is another form of psychology-based EBT. ACT aims to have patients accept the medical and behavioral health diagnoses they cannot change and focus on the aspects of their lives that they can change to increase their quality of life (Dindo et al., 2017). Evidence-based treatment and training can improve children's quality of health care (Mayo Clinic, 2019).

Pediatric Behavioral Healthcare Intervention Knowledge

Integrated pediatric behavioral health care professionals have a variety of interventions available for use with the pediatric patient population (Ny & Weisz, 2016). Integrated behavioral health care professionals may have access to behavior analysts, therapeutic recreation specialists, or child life specialists. The environment the pediatric patient is being seen in will determine the intervention resources available. Few medical and behavioral health providers do not prescribe to the theory that interventions work (Bershal & Ross, 2019). Including the pediatric patient's family in behavioral interventions creates a team with a consistent approach to care for the child (Zimmerman et al., 2021).

Integrated Pediatric Health Care

Integrated pediatric health care (IPHC) benefits the patient, their family, and the healthcare system. Communication in an IPHC setting leaves less room for error within the patient's care team (Pidano et al., 2020). An additional benefit to IPHC is the inclusion of team-based family systems approaches that include the parents/guardians in the healthcare decisions for the child. Although the child is the patient, in most cases, the decision is up to the discretion of the guardians (Katkin et al., 2017; Pidano et al., 2020). Integrated behavioral health care increases the success of chronic care management and improves the quality of life for children with chronic long-term care needs while significantly reducing the cost of care (Lewis et al., 2021; Wolfe et al., 2020).

Children with disabilities often present with complex medical or behavioral issues that challenge caregivers, guardians, and healthcare providers (Altman et al., 2018). Having a child with a disability, specifically autism spectrum disorder (ASD), increases parental stress (Karpur et al., 2018). Decreased parental stress and anxiety, and increased trust, have been linked to the provider's knowledge of pediatric integrated health care and the provider's ability to address pediatric behavioral health problems with the child and parent. (Balbino et al., 2016; O'Brien et al., 2018). An essential aspect of pediatric integrated care is a focus on the family. Children are dependent on their families when they experience a medical condition. Family involvement is vital to the successful care of children, as well as offering family support and guidance (Pidano et al., 2020).

Limited pediatric medical and behavioral health providers in India leads to inadequate integrated health care opportunities for the pediatric patient population (Hagopian et al., 2012; Nair et al., 2022). With limited access to providers, pediatric patients can often not be seen by more than one provider during a visit, leaving unaddressed behavioral or medical health needs (Fledderman et al., 2021). There is a need for providers to work together to improve the health of the pediatric population through the practice of integrated health care (Fledderman et al., 2021).

Online Education and Training for Professionals

Online education is a considerable step toward spreading pediatric behavioral health knowledge to the professionals who treat children (Price, 2020). Video-based behavioral health lectures increase health care providers' knowledge of medical conditions and effective ways to support children and their families with behavioral health diagnoses (Suryavanshi et al., 2020). Online programs have

been developed to meet the educational needs of physicians who treat children by offering them free web-based training modules to gain information on pediatric behavioral health needs (Arora et al., 2017). There is an increased benefit of web-based lectures when provided on a live and interactive platform, such as Zoom (Jackson et al., 2018). Live web-based lecture participants can ask questions and expand their learning with active engagement and real-world case scenarios (Jeno et al., 2017).

There are fewer access barriers to learning using an online educational platform (Elzainey et al., 2020; He et al., 2019; Kyaw et al., 2019). Technology and online teaching bridge the learning gap for global learners (Narayan et al., 2015; Seymour-Walsh et al., 2020). Due to the Covid-19 pandemic, 83% of college students have reported participating in distance learning (Jackson et al., 2018) and medical graduate school students' online learning has significantly increased (Alsoufi et al., 2020). Distance learning has a significant value, especially during a global crisis like the Covid-19 pandemic (Al-Balas et al., 2020). By utilizing online web-based lectures, we reduce barriers and increase access to learning. However, the increased use of technology for education delivery has impacted seasoned educators may have an aversion to using an online learning platform ((Jackson et al., 2018; Smeraglio et al., 2020). Training educators in online education delivery is essential for improving students' learning experiences and outcomes (Jackson et al., 2018).

Medical doctors in India are not required to hold a certain level of education to practice in their field. Data from the 2001 census showed that 31.4% of practicing physicians achieved education up to the high school level; however, 57.3% held no medical qualification (Anand & Fan, 2016). Online education has filled a gap for the people of India in recent years, especially concerning Covid-19 and continued educational needs (Nimavat et al., 2021). Medical and BH providers are now able to access content and experiences that 10-years ago were not available to them, thereby increasing the skill level of these professionals (Nimavat et al., 2021).

Adult Learning Styles

There are different learning styles for adults that can be applied in different environments. For example, Kolb's Adult learning theory, experiential learning is where knowledge is applied in specific contexts. (Dhital et al., 2015; Long & Grummelt, 2019; Raducu & Stanculescu, 2021). The instructional design theory aims to empower adult learners to look forward to a specific result to be learned and achieved (Khalil & Elkhider, 2016). In contrast, the descriptive theory chains steps together to teach adults to a specific outcome Online learning takes the best of these learning theories to empower adults to take their learning wherever life takes them (Snyder, 2009).

Rationale/Conclusion

Pediatric behavioral healthcare services and providers are imperative to the health of the world's youth. Developing and implementing training programs that address the integration of evidence-based pediatric behavioral health care into post-secondary education is essential. As the access to post-secondary social, behavioral, and medical education improves, webinar-based learning increases the availability of pediatric behavioral health care education to current and future students. Education in integrated pediatric health care and how it impacts the patients, and their families can benefit each person on the child's healthcare team (McMillan et al., 2020).

India has the world's second largest population, with 50 million of their estimated 427 million children being diagnosed or displaying some symptoms of a behavioral health diagnosis (Hossain & Pirchit, 2019; Humanium, 2022). Taking steps toward educating India's future behavioral and medical professionals in pediatric behavioral health can improve the health care outlook for the country's growing pediatric population.

Problem Statement

CSIBER University, India, does not provide education and training on pediatric integrated behavioral healthcare for the Master of Social Work (MSW) students. MSW students have requested training in integrated pediatric care to fill their learning gap on integrated pediatric best practices and evidence-based treatments (EBT). For social workers to provide effective quality treatment, acquiring further education in pediatric behavioral health and EBT is crucial to address children's mental and physical health in India. In doing so, the student's knowledge and confidence in understanding IPHC best practices and EBT will improve, and their patients will experience a better quality of care.

Specific Aims

The MSW students engaged in an educational training webinar addressing integrated pediatric behavioral healthcare, evidence-based treatment protocols, interventions, and ways to communicate and build relationships with healthcare professionals to serve their pediatric behavioral health patients. The training was designed to increase MSW students' knowledge of pediatric behavioral healthcare and their confidence in identifying an evidence-based treatment protocol for pediatric behavioral health patients.

Research Questions

- RQ1:** Will clinical social work students significantly improve their pediatric behavioral healthcare-specific topic and intervention knowledge (DV) after participating in an integrated healthcare webinar series (IV)?
- RQ2:** Will clinical social work students significantly improve their confidence in their ability to identify an evidence-based treatment protocol for pediatric behavioral health patients (DV) after participating in an integrated healthcare webinar series (IV)?

Hypotheses

- H1:** Clinical social work students will significantly increase their pediatric behavioral healthcare-specific topic and intervention knowledge (DV) after completing an integrated healthcare webinar series (IV), as evidenced by pre-/post-test survey scores.
- H2:** Clinical social work students will significantly improve their confidence in their ability to identify an evidence-based treatment protocol for pediatric behavioral health patients (DV) after completing an integrated healthcare webinar series (IV), as evidenced by pre-/post-test survey scores.

Methods

Context

Chhatrapati Shahu Institute of Business Education and Research (CSIBER) University is located in Kohlapur, Maharashtra, India. CSIBER operates as an autonomous higher-learning program under the University Grants Commission (UGC) and Shivaji Universities (CSIBER, 2021). CSIBER is a higher education learning institution that offers in-person and online classes. CSIBER is accredited as a College with Potential for Excellence (CPE), Grade A+ NAAC, and Quality Enhancement and Excellence of Higher Education (CSIBER, 2021). CSIBER offers nine master's programs, with one in a healthcare-related field, the Master of Social Work degree. The CSIBER Department of Social Work supported 112 students (64 males and 48 females) during the intervention.

One module offering healthcare integration training was located within the Masters of Social Work degree. The university was focused on revising the curriculum to support student learning of integrated behavioral health. The addition of pediatric integrated behavioral healthcare to the CSIBER University Department of Social Work curriculum benefits the current students and the future pediatric patients with behavioral health diagnoses they support.

Project Site

This culminating project (CP) occurred at CSIBER University, Department of Social Work in Kohlapur, India. The Department of Social work offered graduate-level course work for students pursuing their Master of social work degree. Due to the Covid-19 pandemic, the Department of Social Work moved students to a hybrid learning model. Department professors instructed students in person at the university while other learning took place online. Students who participated in this intervention were learning from their home environment.

Project Participants

First and second-year CSIBER University social work graduate students were made aware of the additional learning opportunity presented through this project by their current instructors. Each year 60 students are added to the program making the potential number of students for this intervention 120. The CSIBER University stakeholders set intervention exclusion criteria as third and fourth-year social work students and students other than those enrolled in the Department of Social Work at CSIBER University.

Stakeholders

The Doctor of Behavioral Health (DBH) student met with Dr. Ronald O'Donnell, clinical professor in the Arizona State University Doctor of Behavioral Health program, to generate ideas for this CP. Dr. O'Donnell conducted research and training on integrated health care globally and had recently established collaboration with CSIBER University Department of Social Work. He suggested partnering with the CSIBER University Department of Social Work to develop a webinar that addressed the needs of the social work students in acquiring educational content on pediatric behavioral health. The DBH student met with the stakeholders identified on the project charter weekly to discuss the educational support needs of the CSIBER social work students (see Appendix A). The project stakeholders included four CSIBER social work faculty assigned to support this project.

The CSIBER University Department of Social Work benefited from the CP by increasing the educational content provided to their students and collaborating with Arizona State University. The social work students benefited from the CP through exposure to content not currently in the curricula. The pediatric behavioral health patient population benefits through the increased use of evidence-based interventions to support their unique medical and behavioral healthcare needs.

Quality Improvement

CSIBER University Department of Social Work did not offer students educational content to support integrated pediatric healthcare (IPC). By completing training and increasing knowledge on IPC and EBT, social work students may be able to improve patient care. With input from the project stakeholders, the project focus was determined, and the desired outcomes were developed. To increase the knowledge of social work students for the pediatric behavioral health population and EBT for pediatric behavioral health patients, a two-and-a-half-hour-long webinar was developed based on topics requested by CSIBER University stakeholders.

Social workers with increased knowledge to successfully support the pediatric behavioral health population can improve patients' and families' health care experiences by effectively applying EBT

specific to a child's diagnosis. Social workers may improve their experience providing care by learning how to support and treat the pediatric behavioral health population efficiently and effectively.

An A3 report was completed to assist the DBH student in mapping out the process for the intervention. Data collected pre-and post-lecture was displayed in graphical representation for analysis and inclusion in the report. The A3 report allowed the intervention team to view the project from beginning to end and plan for adaptations that may be needed for the project's success (see Appendix B).

Intervention Description

The Behavioral Health Integration for the Pediatric Population for Social Workers (BHIPPS) webinar used the Zoom platform. The webinar was implemented on a Wednesday from 7:30 PM to 9:30 PM Indian Standard time (IST). The lecturer was in the United States, Eastern standard time zone, and the students were in Mumbai, India, which is Indian Standard Time (IST).

The DBH student, who held a master's in educational leadership and administration with an emphasis on early childhood education practiced as an ABA therapist, conducted the webinar. As a subject matter expert (SME), the DBH student consulted with the CP stakeholders in choosing the lecture topics (See Appendix A and Appendix C). The BHIPPS webinar was presented with a PowerPoint.

Study of the Intervention

Pre-/post-surveys were conducted via Google Forms for all project participants. The pre-survey included three demographic questions and 12 subject matter content questions. The post-survey included six 'rate the presenter' questions and the same content questions as the pre-survey. The content-specific questions included one on autism, one on sensory processing disorders, two on EBT, two on asthma, one on stunting, one on medical diagnosis affecting mental health, two on obesity, and two on nutrition. Survey results were collected from Google Forms and compared pre-post BHIPPS intervention. A CSIBER University stakeholder and co-author of the pre-post survey included the requirement for students to list their email addresses for internal tracking purposes. Email addresses were used to match the pre and post-surveys.

Survey data analysis will guide any adaptations of the BHIPPS webinar better to meet the needs of future social work students. Surveys were administered via Google Forms at the end of the webinar. Data was downloaded from the interventionist's Arizona State University Google drive one hour after completing the intervention. One hour was chosen to allow students to complete the survey with adequate time.

Measures

BHIPPS Pre-Post Surveys

The BHIPPS pre-/post-surveys (see appendix D) measured CSIBER social work students' perceived increase in knowledge and confidence after participating in the BHIPPS intervention. Through collaboration with Drs. O'Donnell and Manson, the CSIBER University stakeholders, and the DBH intern, the BHIPPS surveys were developed. The measure was designed for ease in understanding, implementation, and data analysis. Understanding the students existing knowledge and confidence through pre-BHIPPS survey data compared to post BHIPPS survey data informed the interventionist on the success of the BHIPPS project and guided any adaptations to the webinar. A Likert scale ranging from one to four was utilized for data collection (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). Demographic questions included gender, age, and year in the social work program (see Appendix D).

Measure Development

Due to the multiple content areas of BHIPPS, the interventionist could not locate any previous studies that utilized questions appropriate for all BHIPPS subject areas. The BHIPPS surveys were not tested for reliability and validity; however, all questions were sourced from previous studies with reliability and validity. Questions were adapted from studies to match the intervention participants' educational specialization and applicability to the region of the intervention implementation. Adaptation of questions included change in study population educational focus, region of the world, or age. For example, the study conducted by Corsano et al. (2020) utilized nurses as the study population; in the BHIPPS survey, it was changed to social work students; the study by Donini et al. (2016) focused on adults diagnosed with malnutrition, the focus was changed to children diagnosed with malnutrition for the BHIPPS survey (see Appendix E).

Data Security

The Google forms platform was utilized for the collection of survey data. Data was kept on the secure Arizona State University Google drive servers until the interventionist logged on to access the data. Data were accessed post-intervention and transferred to the interventionist's secure laptop for data analysis.

Analysis

The BHIPPS intervention was a quasi-experimental pre-and post-intervention design study. The BHIPPS webinar was the independent variable, and the pre- and post-surveys were the dependent variables. Data were entered into an Excel spreadsheet provided by Arizona State University College of Health Solutions. The data set included a codebook that defined each type of data collected and all data received from the pre- and post-surveys. The pre- and post-surveys were analyzed using paired samples *t*-tests since they are the preferred form of data analysis for pre-/post-survey results (Rangraz et al., 2020; Xu et al., 2017).

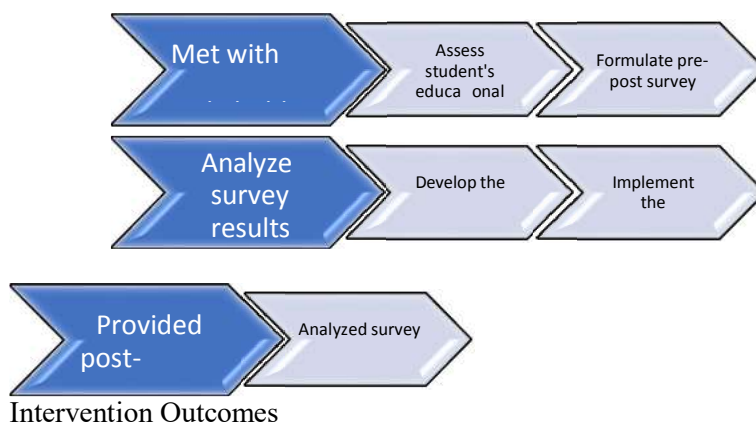
Results

Implementation

The students of the Social Work School at CSIBER University in India were the target of the intervention. The targeted intervention was to fill in the educational gaps about pediatric healthcare and better the knowledge given to the students on this topic to help them better serve the pediatric patients that they will encounter and help. Over time, there were modifications to the intervention because initially, the intervention was supposed to be presented as a three-part lecture series, each lasting an hour. Instead, to increase attendance and make it easier to gain attendance and make it easier to gain student participation, it was decided by the interventionist and the CSIBER University stakeholders to combine the series into one lecture. The dosage was one time for two and a half hours during the students' standard class time (see Figure 1). The rationale for using online webinars instead of another approach is that online lectures have shown impactful results in imparting knowledge to college-level individuals. It was also appropriate to do an online lecture format due to the location of the intervention in India and the interventionist being in the United States. Due to serving those in India and teaching them with the lecture, the implementation had to be done in this manner. The DBH student led meetings each week to learn about the needs and experiences of social workers in India. By gauging the needs of the student learners through learning about gaps in their education directly from them, the training content areas that the students identified included autism, applied behavior analysis interventions, asthma, malnutrition, obesity, and common comorbidities of behavioral health diagnosis. The content areas were researched and used to create the BHIPPS intervention.

The DBH student then created and implemented a Google Forms pre-intervention survey to assess the personal perceived knowledge for each content area students had prior to the intervention. The pre-intervention survey had ten content-specific questions and four demographic questions. A stakeholder from CSIBER University included the requirement that all their students' email addresses; this was later used for pairing pre-and post-survey responses. The DBH student then implemented the intervention. After the webinar lecture, the Google Forms post-intervention electronic survey was emailed to each participant. The post-intervention survey included the same ten content area-specific questions as the pre-intervention survey and an additional five 'rate the presenter' questions. The interventionist then accessed results from the assigned ASU google drive and prepared the data for statistical analysis. The DBH student and CSIBER stakeholders held a post-intervention discussion to review the graphical display of survey results produced by Google Forms.

Figure 1 : BHIPPS Implementation and Development Process Flow Chart



Participant Descriptive Variables

Descriptive variables for all study participants are presented in Table 1. Of the participants ($n=149$), 23 did not complete the pre-BHIPPS survey, while 43 did not complete the post-BHIPPS survey. The majority, 67 (61%) of Behavioral Health Integration for the Pediatric Population participants (BHIPP), were male. Master of Social Work year one students were the most common participants, 96 (64%), with the mean student age being 23.42 years old ($SD = 3.49$). The variable mean was used in place of missing data for further analysis. The pre-BHIPPS survey Cronbach's Alpha showed high internal consistency with a .95, whereas the post-BHIPPS survey had weaker internal consistency with a Cronbach's alpha of .66. The overall mean rose by 21 between the pre-BHIPPS survey and the post-BHIPPS survey.

Table 1 Participant Descriptive Variables

Variable	Frequency	Percentage	
Gender			
- Female	43	39%	
- Male	67	61%	
Participant Education Level Class			
- MSW1	96	64%	
- MSW2	48	32%	
- MSW Awarded	3	2%	
- MPHIL/PhD	2	1%	
	<i>M</i>	<i>SD</i>	Cronbach's α
Age	23.42	3.49	N/A
Pretest BHIPPS Scores	2.34	0.59	.89
Posttest BHIPPS Scores	2.98	0.91	.97

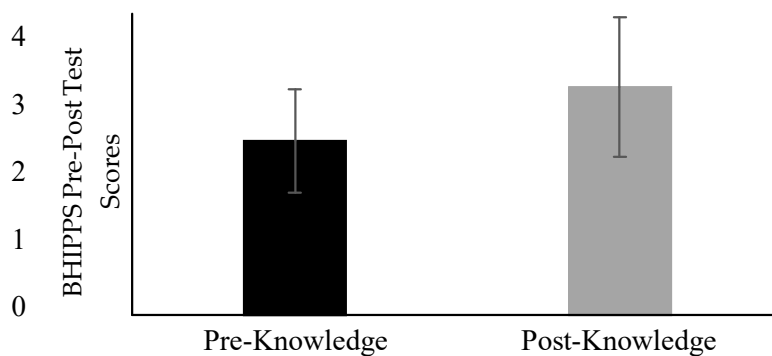
Hypothesis Testing

After completing an integrated healthcare webinar (IV), clinical social work students will significantly increase their pediatric behavioral healthcare-specific topic and intervention knowledge (DV), as evidenced by pre-/post-test survey scores. A one-tail two- sample assuming unequal variances *t*-test was conducted to determine whether clinical social workers increased their knowledge of pediatric behavioral health topics and interventions changed following the Behavioral Health Integration for the Pediatric Population for Social Workers (BHIPPS) intervention. On average, participants scored lower on their knowledge of pediatric behavioral health topics and interventions prior to the intervention ($M = 2.37$, $SD = 0.67$) compared to after the intervention ($M = 2.98$, $SD = 0.92$). This difference is not significant, and the null hypothesis was accepted [$t(179) = -6.14$, $p = 2.58$.] and represented an effect of $d = 0.78$ (see Table 1 and Figure 2).

Table 2 : Results Comparing BHIPPS Pretest vs. Posttest

	<i>t</i>	<i>df</i>	<i>p</i>
Knowledge scores	6.13	181	2.58
Confidence scores	7.14	203	8.10

Figure 2 : Differences in Pre-Intervention Knowledge versus Post-Intervention Knowledge



After completing an integrated healthcare webinar (IV), clinical social work students will significantly improve their confidence in their ability to identify an evidence- based treatment protocol for pediatric behavioral health patients (DV), as evidenced by pre-/post-test survey scores. A one-tail two-sample assuming unequal variances *t*-test was conducted to determine whether clinical social workers improved their confidence in identifying evidence-based treatment protocols for the pediatric behavioral health population following the BHIPP intervention. On average, participants scored lower on their confidence in identifying evidence-based treatment protocols for the pediatric behavioral health population prior to the intervention ($M = 2.19$, $SD = 0.89$) compared to after the intervention ($M = 2.96$, $SD = 0.95$). This difference is not significant, and the null hypothesis was accepted [$t(201) = -7.14$, $p = 8.10$](see Table 2 and Figure3).

Figure 3 : Differences in Pre-Intervention Confidence versus Post-Intervention Confidence



Unintended Consequences

Unexpected Benefits

The unexpected benefit resulting from the implementation of the BHIPPS intervention included participants sharing knowledge with their peers, participants that did not attend the intervention, or that are further along in the program than they are. Another unexpected benefit was the stakeholders' decision to fine-tune this intervention with the next DBH intern and grow the intervention content to meet the educational needs of future students. The addition of content to the curricula will provide the social work students the opportunity to learn about different populations, such as, the pediatric behavioral health population that BHIPPS focused on.

Negative Consequences

Although no negative consequences presented themselves during BHIPPS intervention, there is a possibility that they could occur in future implementations. A potential unintended negative consequence of the intervention may be a student utilizing an ABA technique incorrectly and unintentionally causing harm to the patient. Another potential unintended negative consequence could be the social work students who participated in the intervention using a non-appropriate EBT technique preventing the patient from improving.

Discussion

Summary

This project aimed to increase the pediatric behavioral health knowledge of the social work students at CSIBER University in India. The social work students do not receive training on pediatric behavioral health. Knowledge of pediatric behavioral health is a crucial topic that the CSIBER University social work students should be learning as social workers in training. The interventionist created a lecture on multiple pediatric behavioral health topics to decrease the learning gap in pediatric integrated behavioral health that the students currently face. A pre/ post-survey was used to gain data on the students' pre-BHIPPS intervention knowledge and confidence in the topics and again post-implementation of the BHIPPS intervention. The key findings were that many first-year students felt more knowledgeable than they were on topics presented in the BHIPPS intervention, as evidenced by pre-post survey analysis. Post-analysis survey data also suggested an increase in the students' confidence level in identifying evidence-based treatments.

Interpretation

Studies that have examined the role that social workers' play in the pediatric behavioral health population's treatment were not identified. Pediatric behavioral health knowledge is limited (Arora et al., 2017; Knight et al., 2019). There are 50 million children in India with symptoms of a behavioral health diagnosis (Hossain & Pirchit, 2019). The aim of the first hypothesis was to support the CSIBER University social work students in acquiring pediatric behavioral healthcare-specific topic and intervention knowledge through participation in the BHIPPS intervention. The analysis of the post-BHIPPS intervention survey data did not show a significant increase in the students' acquisition of knowledge of behavioral healthcare specific topics or interventions. The BHIPPS intervention was conducted online, and online education programs help disseminate healthcare knowledge (Price, 2020). The BHIPPS online intervention provided the CSIBER University clinical social work students exposure to novel integrated pediatric behavioral health care content.

Supporting children with a behavioral health diagnosis is challenging. Using EBTs provides the most effective and ethical treatment services (Slocum et al., 2014). The second hypothesis in the BHIPPS intervention was developed to promote the CSIBER University social work students in

increasing their ability to identify EBTs for the pediatric behavioral health patient population. The BHIPPS intervention post-survey data showed that the study participants did increase their ability to identify EBTs. There was not a significant increase in students' knowledge of EBT post-BHIPPS intervention survey analysis. Increasing the CSIBER University social work students' ability to identify evidence-based treatments compared to those not evidence-based prepares them to treat their future pediatric behavioral health patients (Polaha et al., 2018).

Limitations

Although online training has been successfully used for educating medical providers, the BHIPPS intervention was conducted with students in India while the interventionist was in the United States. Therefore, the difference in time zones and students' available times made the implementation of the intervention challenging. The BHIPPS intervention is technology-heavy which may be challenging for some instructors or some areas of the world due to internet availability (Smeraglio et al., 2020). A thorough understanding of current chat and texting applications, online collaboration, and survey instruments are essential for BHIPPS implementation. Yet another limitation was that the BHIPPS intervention was implemented during Covid-19 restrictions, which prevented all CSIBER University social work students from learning in one location; the students participated in BHIPPS from their homes. The learning environment did not allow for engagement with the interventionist on a level where students could learn from each other. The BHIPPS intervention was further limited due to time constraints. Instructing students with no prior experience with the pediatric behavioral health population either in-person or through lecture within two hours left many topics uncovered or not explored fully. The BHIPPS intervention was not designed for generalizability outside of the country of India. Prevalent comorbidities for children in India were extensively discussed during the intervention. Not all participants completed both the pre and post-intervention surveys which created a gap in data. The students were not required to participate in the intervention, which could be related to this incomplete dataset and be considered selection bias. The survey instrument had not been previously used; this pilot study was the first of its kind. Further implementation of the BHIPPS intervention with the accompanying survey tool will be needed to determine validity and reliability.

Conclusions

Pediatric behavioral healthcare services and providers are imperative to the success of the world's youth. Developing and implementing training programs that address the integration of evidence-based pediatric behavioral health care into post-secondary education is essential. As the access to post-secondary social, behavioral, and medical education improves, webinar-based learning increases the availability of pediatric behavioral health care education to current and future students. Education in integrated pediatric health care and how it impacts the patients, and their families can benefit each person on the child's healthcare team (McMillan et al., 2020).

India has the world's 2nd largest population, with 50 million of their estimated 427 million children being diagnosed or displaying some symptoms of a behavioral health diagnosis (Hossain & Pirchit, 2019; Humanium, 2022). Taking steps toward educating India's future behavioral and medical professionals in pediatric behavioral health can improve the health care outlook for the country's growing pediatric population. CSIBER University School of Social Work has taken the initial step by integrating content from the BHIPPS intervention into their curriculum, which places their social work students at an advantage over those that do not attend CSIBER University. The addition of the BHIPPS content to the curriculum improves the confidence and knowledge of the social work students in treating the pediatric behavioral health population.

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