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A MESSAGE FROM THE ASSOCIATE DEAN FOR RESEARCH

This issue of *Research Bytes* features faculty publications that are focused on systems and organizations. These macro-level investigations include sociodemographic factors impacting access to care, structural racism in schools, implementing large-scale change in child welfare systems, effectiveness of suicide attempt surveillance, and institutional capacity to deliver quality cancer care. Read about these and more in this edition of *Research Bytes*.

Assessing the Healthy People 2020 Objective to Expand Early Treatment Receipt Among a National Sample of Children with Autism Spectrum Disorder

M.E. Yingling, L.M. Creel, & B.A. Bell

Journal of Developmental & Behavioral Pediatrics | DOI: 10.1097/DBP.0000000000000786



National objectives to get children with *Autism Spectrum Disorder* into treatment before age 4 have been successful in younger children. The authors recommend targeting outreach efforts to children and families at high risk for delayed treatment to continue the improved treatment rates.

This study investigated outcomes related to a national objective (*Healthy People 2020, HP2020*) to get children with autism spectrum disorder (ASD) into treatment at earlier ages. The study aimed to compare the proportion of children who received treatment by 48 months old in a national sample with the target proportion of 57.6% and to explore the relationships between individual and contextual factors and age of treatment among a national sample of children with ASD. The results of the study indicate that the objective to enroll 57.6% of 8-year-old children with ASD in treatment by 48 months old was not met in this sample, of which 40.9% received treatment by 48 months. In contrast, 88.3% of 3-5-year-old children with ASD received treatment by 48 months old, indicating the initiatives set forth for early identification and treatment of ASD within young children may have been successful. This study's findings corroborate other literature and reiterate the need for targeting outreach efforts to children and families that belong to groups known to be at risk for delayed treatment: families in which English is a second language, with lower educational attainment, and in which children are at risk for adverse childhood experiences. Barriers to receiving specialist care and diagnosis of ASD include PCP referrals, limited provider networks, and availability of specialists and mental health providers in the area.

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Institutional Capacity to Provide Psychosocial Care in Cancer Programs: Addressing Barriers to Delivering Quality Cancer Care

K. Kayser, D.M. Brydon, H. Moon, & B. Zebrack

Psycho-Oncology, 29 | DOI: 10.1002/pon.5488

This study investigates barriers and promoters to delivering quality psychosocial services in 58 cancer programs across North America. Oncology care providers (n = 2008) participated in a survey in which they identified barriers and promoters for delivering psychosocial care at their respective institutions. Multilevel modeling was used to examine (a) the extent to which provider and institutional characteristics were associated with the most common barriers, and (b) associations between perceived barriers and institutional capacity to deliver psychosocial services as measured by the Cancer Psychosocial Care Matrix. Across 58 Commission on Cancer-accredited programs in North America, the most frequently reported barriers were inadequate number of psychosocial care personnel, lack of funding, inadequate amount of time, lack of systematic procedures, and inadequate training for oncology



Providers reported significant institutional barriers to delivering quality cancer care.

A major barrier was the lack of a systematic process for psychosocial care delivery.



providers. Overall, there were few significant differences in reported barriers by type of institution or type of provider. In general, the most frequently reported barriers were significantly associated with the institution's capacity to deliver quality psychosocial care. In particular, the lack of a systematic process for psychosocial care delivery significantly predicted lower levels of institutional capacity to deliver quality psychosocial care. When identifying barriers, respondents reported a greater number of institutional barriers than barriers related to individual provider or patient characteristics.

A Cost Analysis of Trauma and Well-being Screening for Children in Custody

J. Strolin-Goltzman, B.F. Antle, C. Collins-Camargo, & V. Wood

Human Service Organizations: Management, Leadership, & Governance | DOI: 10.1080/23303131.2021.1946454

According to SAMHSA (2014), 1 of the 10 domains of a trauma-informed approach to child welfare relates to universal screening; however, costs of installation and implementation models are often unclear. This paper provides administrators of human service organizations with a fiscal example of the estimated cost of implementing screening with children in the custody of a public child welfare system. Findings show that the cost of installation and start-up are estimated at 208 USD per child while ongoing implementation/sustainability costs are 130 USD per child when implementation is universal to all children in custody. These costs are manageable within many care organizations and may be crucial for long-term benefits. Closer collaboration between child welfare and mental health agencies can improve the identification of children in need of mental health services. Further, this collaboration may help prevent children from languishing in the child welfare system and reduce racial inequities.



Costs associated with trauma and well-being screening for children in custody are manageable within many organizations and can improve the identification of and referral to treatment for children in need of mental health services.

Impact of County Sociodemographic Factors and State Policy on Geographic Access to Behavior Analysts Among Children with Autism Spectrum Disorder

M.E. Yingling, M.H. Ruther, E.M. Dubuque, & B.A. Bell

Administration and Policy in Mental Health and Mental Health Services Research

DOI: 10.1007/s10488-021-01120-y

To examine the relationship between geographic access to Board Certified Behavior Analysts (BCBAs) among children with autism spectrum disorder (ASD) and county sociodemographic factors and state policy, we integrated publicly available data from the U.S. Department of Education's Civil Rights Data Collection, Behavior Analyst Certification Board's certificant registry, and U.S. Census. The study sample included U.S. counties and county equivalents (e.g., parishes, independent cities) in 49 states and D.C. (N = 3040). Highly affluent and urban counties had the highest access to BCBAs with odds ratio estimates for affluence ranging from 2.26 to 5.26. County-level poverty was positively associated with access, yet this relationship was moderated by urbanicity. Race-ethnicity and healthcare insurance coverage were negatively related to access. Other variables were not significant. Targeting non-urban and less affluent counties for provider recruitment and maintenance could most improve access to BCBAs. In addition to strategies specific to BCBAs for improving geographic access, traditional strategies used for other healthcare providers could be useful.

Children diagnosed with *Autism Spectrum Disorder* from wealthy, urban counties had the highest access to Board Certified Behavior Analysts (BCBAs). Race/ethnicity and healthcare insurance coverage were associated with less access to BCBAs.

Targeting non-urban and less affluent counties for provider recruitment and retention can help improve access.



Public Health Surveillance of Youth Suicide Attempts: Challenges and Opportunities

M.D. Singleton, L.M. Frey, & A. Webb

Suicide and Life-Threatening Behavior | DOI: 10.1111/sltb.12572

Surveillance of youth suicide attempts presents many challenges. To assess common data sources that capture information about youth suicidal behavior, we compared counts of high school students who reported (a) a suicide attempt and (b) an injurious suicide attempt, requiring medical treatment in the previous twelve months, with counts of suicide deaths and intentional self-injuries obtained from administrative data sources. Youth Risk Behavior Surveillance System (YRBSS), high school enrollments, and vital statistics were used to estimate the ratio of suicide attempts to suicide deaths among Kentucky high school students. YRBSS and enrollment data were used to estimate the number of Kentucky high school

Comparisons of high school students' self-reported suicide attempts with administrative data sources revealed *much higher rates of suicide attempt in self-reports versus official data.*

This data suggests an average 943 suicide attempts for every suicide death, which is much higher than expected.



students who received medical treatment following a suicide attempt, which was compared with hospital and emergency department (ED) discharges for intentional self-injury from administrative claim records. We estimated 943 students reporting a suicide attempt for every suicide death, a result that is higher than previous estimates for youth. Self-reported suicide attempts resulting in medical treatment were 7.5 times higher than self-injuries reported in claims records. Future research should address concerns about undocumented cases of intentional self-injury in administrative claims systems; patient encounters in nonhospital settings for injuries resulting from a suicide attempt; and validity of Youth Risk Behavior Survey questions on suicidal behavior.

Self-reported suicide attempts were
7.5 times higher
than what was included in claims records.

Implementation of System-Wide Change in Child Welfare and Behavioral Health: The Role of Capacity, Collaboration, and Readiness for Change

A.M. Winters, C. Collins-Camargo, B.F. Antle, & A.N. Verbist

Children and Youth Services Review, 108 | DOI: 10.1016/j.childyouth.2019.104580

Children who enter out-of-home care are at risk for trauma and behavioral problems, however the child welfare and behavioral health systems do not effectively communicate to provide evidenced-based treatment. This case study describes the implementation of Project SAFESPACE to address these concerns. The project was driven by shared recognition in child welfare, behavioral health and their stakeholders that the system was not adequately identifying and responding to the behavioral health needs of children in out-of-home care. Utilizing survey research, we present findings from four cohorts of child welfare and behavioral health staff as they began implementation of the intervention (N = 1370). Guided by the implementation stages framework, this five-year project was required to examine capacity, collaboration, and readiness in the needs assessment phase, and chose to identify these constructs as outcomes in themselves. As such, we were able to trend data in our implementation teams and other periodic dissemination efforts to show progress and support recommendations for course correction as needed. This study revealed statistically significant differences in the perceptions of workers from each system in capacity for trauma-informed knowledge, collaboration (in the interaction between cohort and provider type), and organizational readiness for change. While our study found differences between cohorts and providers in the perception of these factors, it is certain that implementation in real world child welfare and behavioral health settings present a vast array of contextual factors that may influence them, both related to and totally external to the project being implemented. Leadership and policy change can facilitate growth in these implementation drivers throughout stages to full implementation and ultimately sustainability.

This study identified various factors driving implementation:

- Coaching and consultation
- Substantial effort required during installation phase
- Maintaining buy-in and momentum



Leadership and policy change can facilitate growth in implementation drivers through the following mechanisms:

- Data system and technology supports
- Resource investment and organizational commitment
- Collaborative implementation team structures
- Periodic measurement of capacity and readiness

A school social work practice model informed approach to structural racism in schools involves not only individualized intervention on behalf of students of color, but also attention to the school and surrounding milieu that engages both people and policy.

The model encourages school social workers to

1. Provide *evidence-based* education and services
2. Promote a *school climate and culture* conducive to student learning and teaching excellence
3. *Maximize access* to school- and community-based resources.



Structural Racism in Schools: A View through the Lens of the National School Social Work Practice Model

J. Crutchfield, K.L. Phillippo, & A. Frey

Children & Schools, 42(3) | DOI: 10.1093/cs/cdaa015

Structural racism—implicitly discriminatory practices and policies that have negative consequences for individuals and groups of color—is a powerful force in contemporary American society, including in our public education system. This article explores the potential for school social workers (SSWers) to address structural racism through the use of the national school social work (SSW) practice model as a tool to guide systemic, ecologically oriented intervention within schools and educational policy spaces. In this article, the authors review data on racial disparities in educational attainment, placement, opportunity, and discipline practices that have led to increased attention to structural racism in schools. They then discuss and describe the national SSW practice model and its suitability for the structural interventions in response to structural racism in schools. Finally, they provide recommendations for how SSWers can respond effectively to this pressing social problem. These recommendations include a list of resources for addressing structural racism.

