



Healthcare professionals' priorities for child abuse educational programming: A Delphi study[☆]

Yi-Wen Chen^a, Susan Fetzer^b, Chiao-Li Lin^c, Joh-Jong Huang^d, Jui-Ying Feng^{a,c,*}

^a Department of Nursing, National Cheng Kung University Hospital, Tainan, Taiwan

^b Department of Nursing, University of New Hampshire, USA

^c Department of Nursing, National Cheng Kung University, Tainan, Taiwan

^d Department of Family Medicine, Yuan's General Hospital, Kaohsiung, Taiwan

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ABSTRACT

Child abuse reporting and intervening are a complex process. A comprehensive training program with targeted goals and priorities enables professionals to effectively address the needs of abused children and their families. The study purpose was to identify the content and priorities of health professional education in child abuse by integrating expert opinions and achieving consensus. A 3-round Delphi study was conducted with 25 multidisciplinary experts in health care, social welfare, psychology and counseling, and law and jurisdiction. Structured questionnaires collected expert opinion of appropriateness and importance of knowledge, subjective norms, attitudes, skills, team collaboration and teaching strategies. The expert response rates ranged from 96 to 100% for the 3 rounds, and consensus was achieved. Knowledge was regarded as the most important element. Two items on forensic evidence in the skill category received the highest importance score. Results provide a basis to develop educational programs achieving clinical competence in child abuse care.

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1. Introduction

The prevalence and mortality of child abuse exceed that of childhood cancer and other less commonly occurring diseases. The impact of child abuse on victims' development, mental and physical health as well as social function is staggering (Felitti et al., 1998; Walker et al., 2011). Insufficient and inappropriate management of child abuse is catastrophic for victims, families, and involved professionals with the worst consequence that is the loss of a child's life. Frequently, child abuse related health problems are overlooked by health care professionals. Few health care professionals receive formal education in managing child abuse cases. The lack of education focuses attention on the need for ongoing health professional development (Christian, 2008; Krugman & Cohn, 2001).

Health care professionals express discomfort in dealing with violence-related problems (Feng & Levine, 2005; Flaherty et al., 2006; Ward et al., 2004). In a Canadian study, pediatricians felt least competent in the initial evaluation and management of sexual abuse and most competent in treating the failure to thrive. Over 90% of pediatricians felt poorly trained, and stressed the need for further training to enhance their competence in child protection (Ward et al., 2004).

1.1. Clinical competence in child abuse

Knowledge of child abuse and the law is the foundation of clinical competence in child abuse. Many child abuse cases are complicated and hard to diagnose with ambiguous evidence. Professionals often use their own judgment and the legal definition of child abuse to determine the necessity to report (Smith, 2006). However, clinical competence in child abuse is more than general knowledge or skill. Botash et al. (2005) argued that new knowledge health care professionals obtain from continuing medical education in child sexual abuse is not enough to provide competence in the interpretation of clinical findings or the provision of legal advocacy to families. However, pediatric subspecialists in child abuse, established by the American Board of Pediatrics, provide an accurate diagnose of abuse, consult on child safety, provide expertise in law, direct child abuse treatment and prevention programs, and participate on multidisciplinary teams in child abuse (Block & Palusci, 2006). Unfortunately, the number of pediatric subspecialists in child abuse is limited and their services are not readily available or easily accessible.

1.2. Educational and training programs

Education is required before achieving clinical competence. Violence researchers have utilized a variety of educational programs to enhance health care professionals' clinical competence with child abuse. Content has included knowledge, attitudes, perceived capability, screening, identification, and reporting rates of child abuse and domestic violence

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* Corresponding author at: National Cheng Kung University, No.1 University Road, Tainan, 70101 Taiwan. Tel.: +886 6 2353535x5851; fax: +886 6 2377550.

E-mail address: juiying@mail.ncku.edu.tw (J.-Y. Feng).

(Campbell et al., 2001; Davila, 2006; King, Reece, Bendel, & Patel, 1998; Shefet et al., 2007). However, Theodore and Runyan (2006) noted that only one quarter of practicing pediatricians felt adequately prepared even though they had significantly more education in the diagnosis and management of child abuse during their residency than was previously available. Continuing education helps bridge the gap between the need for clinical competence in violence and lack of sufficient violence-related content and skills within medical and nursing curriculums. To enhance patients' health outcomes, clinicians must continually update their knowledge and skills, introduce changes into practice, and improve their performance (Davila, 2006).

Continuing education programs in child abuse have successfully improved professionals' awareness, but have failed to increase clinical performance (Khan, Rubin, & Winnik, 2005). Professionals from different disciplines or specialties often work individually and communicate poorly in reporting and managing child abuse (Anderst & Dowd, 2010; Feng, Fetzer, Chen, Yeh, & Huang, 2010). As healthcare professionals are often the first to encounter abused children and the ones to initiate interdisciplinary collaboration, it is important to examine opinions and suggestions from professionals across disciplines to improve interdisciplinary communication and collaboration.

There has been little discussion and no consensus on the scope and priority of child abuse education for health care professionals in Taiwan. Therefore, the Delphi technique was used to investigate experts' opinions about clinical competence in child abuse and to reach a consensus on the content and priorities for educational programs. The Delphi method provides valuable empirical data on complex topics allowing the identification and integration of experts' opinions about key variables. It has been widely used in policy change (Richardson & McKie, 2008), health advocacy curriculum development (Flynn & Verma, 2008), research priorities (Back-Pettersson, Hermansson, Sernert, & Bjorkelund, 2008) and identifying clinical or leadership competence (Palarca, Johnson, Mangelsdorff, & Finstuen, 2008; Witt & de Almeida, 2008). Applying a Delphi design in this study allowed experts across disciplines to begin a dialogue that identifies and analyzes clinical competencies of child abuse.

2. Method

The purpose of this 3-round Delphi study was to identify the content and priorities for health care professionals' education which has the potential to improve multidisciplinary clinical competence in child abuse care.

2.1. Selection of experts

The selection of experts with experience-rich and specialty knowledge in the topic of interest is important to achieve the goal of a Delphi study (Chiou & Tsai, 1996). Multidisciplinary collaboration is a key to success in the process of child protection. Understanding and communicating expectations and professional roles across different disciplines help resolve conflicts and enhance collaboration, which in turn improves the care quality for victims and their family (Feng et al., 2010). The study purposely chose experts from different disciplines in child protection who are or have been in contact with health care providers.

Sample size for Delphi studies varies depending on the research topic and specific situation (Akins, Tolson, & Cole, 2005). Linstone and Turoff (2002) suggested that an expert panel with 10 to 50 experts was appropriate. An expert is defined as an "informed individual", "specialist in the field" or "someone who has knowledge about a specific subject" (Keeney, Hasson, & McKenna, 2001). Purposive sampling technique was used to identify a multidisciplinary panel of experts in child abuse identification and management. Practicing experts from diverse geographic locations in Taiwan with at least 10 years experience in one or more of the following areas were invited to participate: clinical

experts with the clinical treatment or care of victims of child abuse, research experts with a research area in child abuse, or education experts with a specialty in child abuse. Experts were identified via the author list of the handbook in child abuse and neglect for health care providers by the National Health Research Institutes in Taiwan as well as professional groups and organizations for child protection.

2.2. Procedures

Approval was obtained from the University Institutional Review Board prior to the study. Literature review, contacts with health professionals and snowball sampling were used to identify 30 experts who met at least two inclusion criteria. The experts were personally contacted and the study was explained. Each expert was provided with information including the time commitment required for the study. A Round 1 packet was mailed to 25 experts who agreed to participate. The Round 1 packet contained a cover letter, informed consent, demographic questionnaire, Round 1 Delphi Questionnaire, and two stamped return envelopes. Informed consent was returned in one of the envelopes prior to data submission. Experts had three weeks to complete the questionnaire. Reminders were made by emails and phone calls for each round.

The Round 1 Delphi Questionnaire was developed based on a comprehensive literature review and findings from studies based on the Theory of Planned Behaviors (TPB) (Feng & Wu, 2005; Feng et al., 2010). According to the TPB (Ajzen, 1991), an individual's behavior and behavioral intention are determined by attitude toward behavior, perceived behavioral control, and subjective norms. Subjective norm is the perceived social pressure from significant others to perform or not perform a behavior. Feng and Wu (2005) found that nurses would be more likely to report child abuse if they perceived specific others thought they should report. The questionnaire includes 69 items in 5 categories related to clinical competence in child abuse: knowledge (22 items in 5 subcategories), subjective norms (4 items), attitudes (3 items), skills (33 items in 6 subcategories) and team collaboration (7 items). The knowledge subcategories included general aspects of child abuse, family dynamics, child protective service, policy and law, and ethics. The skill subcategories included clinical manifestations and assessment in child abuse, health care for the abused child, care for the perpetrator, care for the abused family, forensic evidence and medical records, and communication and therapeutic relationship. Eleven items queried experts' opinion on education strategies.

Experts were asked to rate the appropriateness of the item content and the importance of the item content for child abuse education. Each item was rated on a 5-point Likert scale, ranging from 1 = very inappropriate/unimportant to 5 = very appropriate/important. Each item, subcategory and category has a blank space for experts' comments, suggestions or additional information and questions. Experts were instructed to add any essential content elements not on the questionnaire.

The Round 2 Delphi Questionnaire was based on the results of Round 1 responses. Items were revised, added, deleted, combined or re-categorized. Means and standard deviations (*S.D.*) of each item from Round 1 were provided to the experts as score references for Round 2. Experts were encouraged to indicate their agreement with the appropriateness and importance of ratings from Round 1.

The Round 3 Delphi Questionnaire was derived from the results of the Round 2. Any item receiving a mean score of less than 4 in Round 2 was interpreted as failure to reach consensus and deleted. The Round 3 Delphi Questionnaire and the results from Round 2 were returned to experts. They were encouraged to reconsider their Round 2 responses in light of the mean scores. Any item ratings could be revised. In each Round, experts were encouraged to comment on two open-ended questions concerning the barriers to reporting and managing child abuse and clinical competence.

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