A Novel Self-Evaluation Tool to Assess the Team Function of a Child Protection Team

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ABSTRACT

OBJECTIVE: The aim of this study was to develop a reliable and valid self-evaluation tool for use by child protection team (CPT) members.

METHODS: An online survey was administered to members of 10 CPTs. The survey included the following 3 sections: 1) initial conditions (eg, team composition, resources), 2) enabling conditions (eg, team effort, strategy), and 3) team effectiveness (eg, team cohesion, meeting performance standards). Each section contained multiple subscales. Internal consistency was calculated using Cronbach α. To evaluate construct validity, the subscale scores of the most advanced teams who qualified as centers of excellence (n = 3) were compared with the subscale scores of the other teams (n = 7) to determine whether the tool could distinguish between the two.

RESULTS: Of 116 team members, 83 (72%) completed the survey. The subscales exhibited good internal consistency (α = .71–.97). The 3 centers of excellence had significantly higher mean scores than the other 7 CPTs on the following subscales: incentives (in the initial conditions section, 61.46 vs 38.89; $P = .003$), effort (in the enabling conditions section, 79.31 vs 67.70; $P = .003$), and professional growth (in the team effectiveness section, 83.89 vs 80.40; $P = .004$).

CONCLUSIONS: This novel survey demonstrates satisfactory test characteristics and can be used to assess CPT performance and identify areas for improvement.

KEYWORDS: child abuse; child protection team; program evaluation

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WHAT'S NEW

Child protection teams (CPTs) should conduct regular internal performance reviews, but there is no standard tool available. We developed a reliable and valid survey that can be used by CPT members to identify team strengths and weaknesses and promote quality improvement.

HOSPITAL-BASED CPTS WERE first established more than 50 years ago as an approach to the care of abused children.[1–3] These multidisciplinary teams are typically composed of doctors, nurses, social workers, and other professionals with expertise in the field of child abuse and neglect. Nationwide, CPTs vary significantly in their composition, roles, and source of funding, but they share a common goal of improving the coordination and quality of care of children who are suspected victims of maltreatment.[3–19]

In a recent study, experts in the field of child abuse and neglect reached consensus on tasks that CPTs should perform and factors related to the effectiveness of CPTs.[20] The expert panel identified regular program review as a characteristic of high-quality CPTs and concluded that CPT performance should be evaluated both internally by CPT members and externally by professionals who use CPT services. The National Association of Children's Hospitals and Related Institutions (NACHRI) has published guidelines that outline what a CPT should do to be considered either a basic team, an advanced team, or a center of excellence[21] (Table 1), but there is no standard approach to evaluating CPT performance, and no evaluation tools are available.

A reliable and valid self-assessment survey would help CPTs conduct regular internal evaluations, identify team strengths and weaknesses, and monitor progress toward goals of quality improvement. The use of a standardized evaluation would also allow for the comparison of teams to one another and help identify the characteristics of CPTs that are critical to success. The aims of this study, therefore, were to develop a self-evaluation tool for use by CPT members and to evaluate the structure, internal consistency, and construct validity of the instrument.

METHODS

THEORETICAL FRAMEWORK

To develop a model of performance specific to CPTs, we used the theoretical framework of Hackman's model of group effectiveness[22] as well as prior findings on factors related to the effectiveness of CPTs.[20] Although there are many ways

Table 1. Summary of NACHRI Guidelines: Characteristics of CPTs That Are Basic Teams, Advanced Teams, or Centers of Excellence*

CPT Characteristic	Basic Team	Advanced Team	Center of Excellence
Structure/staffing			
Medical leadership	Pediatrician with training in child maltreatment; supervises and reviews cases, provides court testimony as needed, collaborates with others in the community	Mentors other providers, directs improvement of medical services to maltreated children, helps secure funding	Fellowship training in child abuse and neglect, board eligible or certified in child abuse pediatrics; regional leader, educator, researcher
Team administration	Paid position, allocated time for team coordination; helps develop policies/procedures for management of maltreatment, collects and tracks data, cooperates with community investigations, provides appropriate follow-up as needed	Works to secure ongoing administrative support and funding, organizes multidisciplinary team meetings, organizes peer-review systems, identifies gaps in the child abuse response system	Coordinates community advocacy and prevention efforts, facilitates research and educational activities, takes a leadership role in organizations involved in child protection
Social work	Social worker is a permanent team member, has training in child abuse	Social worker available during all regular hours and on call for emergent cases	Social worker is a regional resource, addresses mental health of referring providers
Function/role			
Clinical services	Team provides consultations, medical evaluations of suspected victims, sexual abuse exams, forensic interviews, psychosocial assessments, and mental health referrals	Program, clinic, or center staffed by CPT members; someone is on call every day for consultation	Services performed by a clinician who specializes in child maltreatment, mental health, counseling provided; subspecialists trained in child abuse issues available
Policies	Program has referral policies, clinical practice guidelines, and is in compliance with state laws related to reporting abuse	Protocols for referrals from outlying institutions, policies related to community outreach, protocols with risk management department	Crisis communications plan in place
Prevention/advocacy	Participates in advocacy initiatives to the greatest extent possible	Time, resources allocated to advocacy and public education	Leadership in advocacy programs; hosts conferences, task force meetings
Community collaboration	Works with child protective services and local evaluation and treatment centers	Meets regularly with protective services, police, other hospitals	Serves as a regional medical resource for the community and other organizations
Education	Trains hospital staff in child abuse recognition, referral; staff participate in continuing education activities	Education provided to residents and other trainees as well as to community-based providers and organizations	Gives trainees the opportunity to participate in research, may support a fellowship program, provides national training
Research	Members have knowledge of relevant research, collect data on cases on which team consults	Regular updates on maltreatment literature, team initiates studies	Initiates major research projects, engages other centers
Administrative infrastructure			
Funding/reimbursement	Optimizes reimbursement from third-party payers, tracks expenses, partners with other organizations for grants/funds	Contracts with community organizations and agencies; has grants from local, state, or national organizations	Diversified funding, multiple research grants, state funding, or appropriations
Risk management	Works with hospital on standards for reporting abuse, complying with hospital standards	Provides 24-hour coverage to offer expert assessment as needed; develops plan for accusations of staff	Trains other providers on identification and reporting of abuse; presents information on controversial cases

*NACHRI = National Association of Children's Hospitals and Related Institutions; CPT = child protection team.

to evaluate team performance, we chose to use Hackman's model (Fig. 1) because it has been used in the evaluation of multidisciplinary health care teams in the past.[22,23]

Hackman's model is based upon the premise that a team's effectiveness is related to definable variables that impact team function. The first category of variables, known as *initial conditions,* is composed of structural features that include group structure and composition, task clarity, organizational context, and the physical environment. The second category of variables, known as *enabling conditions,* reflects the actual performance of team members. Variables included in this category are team effort, adequate knowledge and contribution, and task performance strategy. Both initial conditions and enabling conditions impact *team effectiveness,* and Hackman identifies the following 3 specific outcomes that should be included in measuring team effectiveness: 1) the team's production of a high-quality product, 2) the team's cohesion, or desire to continue working together, and 3) the team's contribution to the well-being and growth of members.

To adapt this model to the evaluation of CPTs, we used information on factors related to CPT effectiveness to