

Original Publication

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Elizabeth: Typical or Troubled Teen? A Training Case for Health Professionals to Recognize and Report Child Maltreatment

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Citation: Sonney J, Willgerodt M, Lindhorst T, Brock D. Elizabeth: typical or troubled teen? A training case for health professionals to recognize and report child maltreatment. *MedEdPORTAL*. 2018;14:10712. https://doi.org/10.15766/mep_2374-8265.10712

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Abstract

Introduction: Training on the recognition and reporting of child maltreatment is a critical component of any health professional education program. Unfortunately, it is nationally recognized that health care professional training on recognition and reporting suspected child maltreatment is insufficient. Similarly, recent attention has been given to the need for interprofessional learning opportunities targeting to advanced health profession trainees such as doctor of nursing practice, masters in social work, physician assistant, and family medicine residents. **Methods:** An interprofessional case-writing faculty team convened to develop this case and the affiliated materials, including video vignettes, faculty training, comprehensive faculty guide, evaluations, and trainee resources. Trainees were divided into interprofessional teams and advised to develop a prioritized plan of care for a complex patient case, though it was not revealed that the case involved child maltreatment. An initial video vignette showed an adolescent female and her mother during a provider visit to establish care. Teams developed a prioritized plan of care following the vignette. Additional case details unfold during the second vignette, and teams revised their initial plan based on this new information. Interprofessional faculty facilitators guided discussions using prompts from the faculty guide. **Results:** Postsession surveys revealed that the learning objectives were met, and that both facilitators ($N = 20$) and trainees ($N = 69$) were very satisfied with the overall curriculum. Challenges centered around focusing on care priorities rather than provider critique. **Discussion:** This curriculum is relevant for a variety of trainees and is an important complement to the curricula of many professions.

Keywords

Interprofessional Education, Communication, Abuse, Child Maltreatment, Advanced Health Profession Trainee, Roles, Responsibilities

Educational Objectives

By the end of this session, learners will be able to:

1. Explain the roles and responsibilities of health care professions involved in caring for the patient with suspected maltreatment.
2. Discuss one's knowledge and opinions related to patient care with clarity and respect.
3. Integrate the knowledge and experience of other professions—appropriate to the specific care situation—to inform care decisions.
4. Develop a common understanding of care priorities and develop strategies to meet patient care needs.
5. Utilize active listening to encourage ideas and opinions of other team members who complement one's own professional expertise.
6. Identify local and national resources for child maltreatment recognition and reporting.

Appendices

- A. Faculty Guide.docx
- B. JIT Facilitator Training.pptx
- C. Educational Program Slides .pptx
- D. Case Video Vignette 1.mp4
- E. Case Video Vignette 2.mp4
- F. Trainee Evaluation.docx
- G. Facilitator Evaluation.docx
- H. Resource List for Trainees .docx

All appendices are peer reviewed as integral parts of the Original Publication.

Introduction

Child maltreatment is a widespread problem. In 2015, there were 683,000 child victims of abuse and neglect in the United States.¹ Given their frequent contact with children, health care professionals in nursing, social work, and medicine in all 50 states are considered mandated reporters of suspected child maltreatment.² Reporting possible child maltreatment is dependent upon the recognition of maltreatment as well as knowledge of reporting requirements and procedures. Recognizing maltreatment, though, is challenging and contributes to a high rate of suspected underreporting.¹ Underreporting among health professionals is thought to be related to failure to recognize maltreatment and/or questioning one's suspicion of maltreatment, rather than negligence on the part of the health professional.^{3,4} Training on the recognition and reporting of child maltreatment, therefore, is a critical component of any health professional educational program. Unfortunately, it is nationally recognized that health care professional training on the recognition and reporting of suspected child maltreatment is insufficient.⁵

Recent attention has been given to the need for interprofessional learning opportunities targeted to advanced health profession trainees.^{6,7} Interprofessional education (IPE) efforts at the University of Washington (UW) have largely focused on prelicensure students in acute care settings. However, many advanced health professions trainees go on to practice in community-based settings.⁷ In response, a group of interprofessional faculty assessed the collaborative practice learning needs of advanced health professions trainees and identified the need for cases grounded in community-based primary care settings, and for content focused on identification and reporting of possible child maltreatment.

A review of existing *MedEdPORTAL* educational programs revealed numerous offerings that address child maltreatment, all of which targeted medicine trainees alone. Child maltreatment risk factors and prevention were the most common topic, followed by case-based activities primarily focused on acute care of an abused child.⁸⁻¹² Our faculty group determined that a child maltreatment case that engages an interprofessional team was an opportunity to address a gap in the literature. Furthermore, the group desired a case that was not marketed as an abuse case, but rather an activity in which trainees needed to both recognize and respond to suspected child maltreatment. Supported by funding from the Health Resources and Services Administration, we decided that adapting a real-world scenario would provide a credible learning opportunity for trainees to practice recognizing and reporting suspected child maltreatment.

We used the Interprofessional Curricular Framework (from J. Danielson and M. A. Willgerodt, unpublished material, 2018) to guide the program development (Figure 1). This framework incorporates the Interprofessional Learning Pathway Competency Framework¹³ by aligning it with Interprofessional Education Collaborative (IPEC) competencies¹⁴ and learning activities. Our educational approach was grounded in principles of adult learning theory, experiential learning, reflective practice, and communities of learning which posit that learners need collaborative active learning approaches to crystallize learning. Thus, we chose to design a program that used a case-based format focusing on team roles and communication. Further, due to the sensitive and complex nature of child maltreatment, we elected to implement an in-person session in order to provide face-to-face opportunity for learners to engage in meaningful discussion. We also chose to include trainees that had completed approximately half of their clinical immersive experiences. This curriculum module is designed for trainees in the doctor of nursing practice, social work, physician assistant programs, as well as family medicine residents.

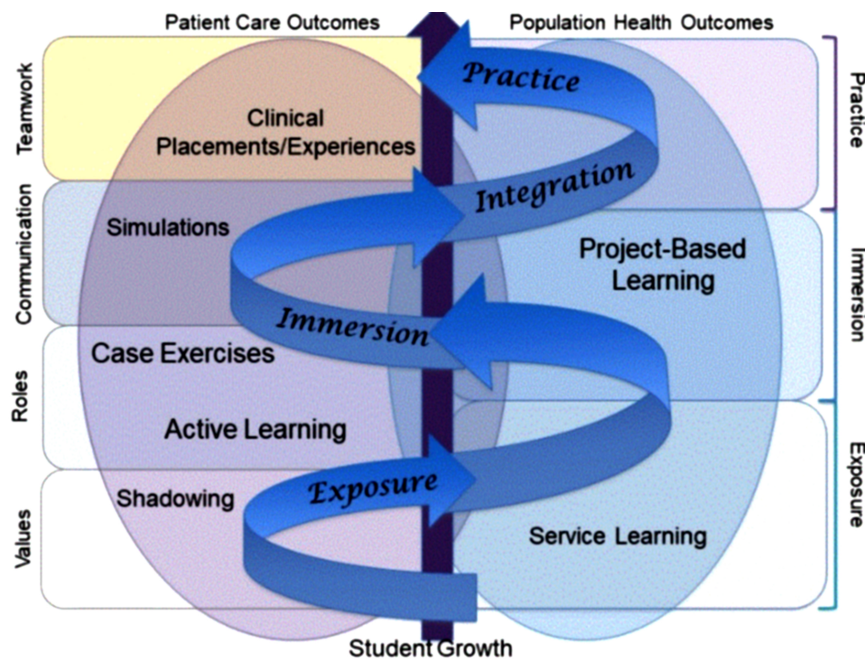


Figure 1. Interprofessional Curricular Framework, (from J. Danielson and M.A. Willgerodt, unpublished material, 2018).

This educational program represents a unique contribution by meeting a known curricular gap in health professions training, identification and reporting of possible child maltreatment. Additionally, this educational program provides a community-based interprofessional collaborative practice training opportunities for advanced health professions trainees, addressing another known gap.

Methods

We sought to create a case that highlighted the complexities inherent in suspected child maltreatment and that also emphasized the importance of team-based care, roles, and communication. Given the emotional nature of this content, a safe and supportive environment was critical for student learning. Our strategies for building a safe learning environment included limiting the size of the learner groups, using interprofessional faculty facilitators, and leveling trainees. Trainee leveling aimed to include learners who are at similar educational preparation levels in order to meaningfully participate, and we included trainees who had completed at least half of their clinical training, given the complex nature of the case. We chose to create interprofessional learner groups of 6-8 trainees to encourage sufficient engagement of all trainees. Finally, an interprofessional faculty facilitation team supported trainees, guided discussions, and incorporated knowledge and expertise as needed.

Faculty facilitators included a mixture of faculty who were experienced in IPE and other health profession faculty. Faculty facilitators were emailed a faculty guide (Appendix A) two weeks before the educational program. The faculty guide included an overview of the case, agenda, materials needed, instructions, and sample questions to facilitate discussion among the learners. Evaluation and debrief instructions are also included. Two just-in-time training sessions for faculty were held immediately prior to the program (Appendix B). We have learned from prior experience that faculty preferred training materials be sent ahead for review, but recognized the need a more focused one-hour in-person training just prior to the program where they could receive an overview of the program, objectives, and have the opportunity to seek clarification.

The educational program lasted approximately two hours. Learners were assigned to interprofessional groups of 6-8, each led by two faculty facilitators. Facilitators used the Educational Program Slides (Appendix C) to guide the session. An opening icebreaker activity involved learners introducing themselves, and then outlining what they know about the educational background, and role of the other health professions in the group. Then learners compared notes and clarified any missing information. Faculty facilitated a discussion about health profession roles, misconceptions, and role overlap.

Following the introductory activity, facilitators introduced the program as one that would involve discussion of an unfolding case where teams would collaborate to develop a patient/family-centered plan of care for a 15-year-old female, Elizabeth, who was establishing care with a new primary care provider. Learners discovered through the unfolding case video vignettes (Appendices D and E) that Elizabeth had a complex medical and psychosocial history. Learners were intentionally not alerted to the presence of abuse, as the intent was for the learners to recognize the possibility of abuse and bring their concern forward to the group for discussion. For this reason, case materials and event titles were purposefully vague. The first vignette (Appendix D) was played, after which learners discussed and documented what needed to be done for the patient, who would do what was needed, and any potential barriers. The second vignette (Appendix E) followed, and learners reflected and individually wrote their perceptions of what was happening with the patient, identified any possible new issues, and prioritized how to approach caring for the patient. The team then reconvened and discussed any new priorities that arose during the second video. Facilitators guided the teams to reach consensus on a revised plan of care together. All teams in the room were then brought together to share their plans of care with the other teams. Faculty then debriefed the session with the trainees with emphasis on exploring how trainees worked together as a team. At the conclusion of the event, trainees and facilitators completed evaluations (Appendices F and G) to measure trainee progress toward the learning objectives. At the end of the session, trainees were also given a child maltreatment resource list (Appendix H).

Results

This program was implemented with a total of 69 trainees from doctor of nursing practice, social work, physician assistant and family medicine residency programs (Table 1). There were a total of 10 interprofessional teams of trainees, each with two faculty co-facilitators ($N = 20$). We used four different meeting rooms for this program, and had 2-3 interprofessional teams grouped around tables in each room. A faculty member from the UW Center for Health Sciences Interprofessional Education, Practice and research functioned as the lead facilitator for each room to guide the sessions and serve as a reference for the other facilitators.

Table 1. Program Participation by Profession and Status

Profession	Trainee (N)	Facilitator (N)
Doctor of nursing practice	29	7
Social work	14	3
Physician assistant	6	3
Family medicine	17	4
Not reported	3	3
Total	69	20

Trainee evaluations were voluntary and confidential. Across all professions, trainees found the program to be worthwhile and valuable ($M = 4.49$ out of 5) (Figure 2). Trainees emerged from the program feeling more confident that working within an interprofessional health care team increased their ability to understand and manage clinical problems. They also reported feeling as though they better understood the roles and scope of practice of their health care colleagues.

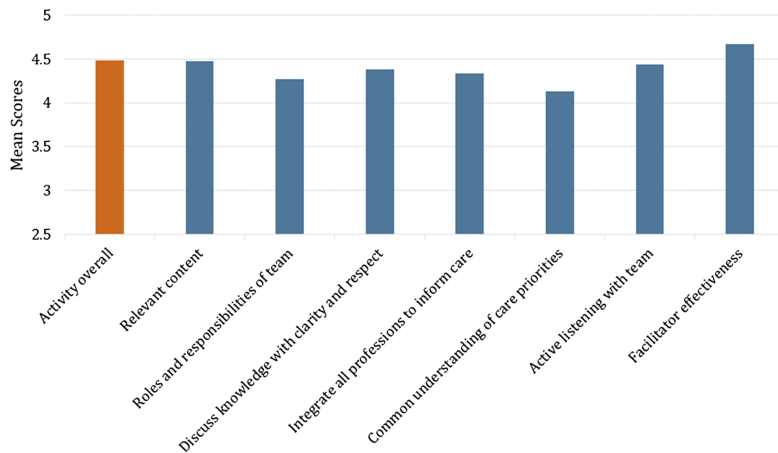


Figure 2. Summary of Trainee Evaluations ($N = 69$). Score response options ranged from 1 = *Poor* to 5 = *Excellent*.

Qualitative comments ($N = 31$) largely centered on developing a better appreciation for the importance of teamwork and communication within the team. For example: “Although we all have different licenses, we share a common desire to act in our patients wellbeing - we all need to work together if this desire is to become reality.” In addition, many trainees asked for more learning opportunities centered focused on collaborative care: “Good event to bring people together BEFORE they are out in the ‘real world’ to learn why it’s important to work in a team.” Finally, learners left the event feeling more prepared to report a suspected case of child maltreatment to Child Protective Services: “I learned about the role of a provider in reporting to CPS. I was aware of the legality required to report, but I did not know steps to take once you do call, how they assess the situation with 48 hrs.”

Faculty facilitators also found the program to be worthwhile and valuable ($M = 4.13$ out of 5; [Figure 3](#)). The facilitators reported that the trainees appeared to enjoy the icebreaker activity and that all were engaged and interested in learning about each other. The largest criticism was feeling unprepared to facilitate the event, though only two of the 17 facilitators attended the just-in-time training session. Despite feeling unprepared, faculty found the Faculty Guide useful and the case to be relevant and important. Several faculty suggested adding guidance that the groups should not focus on criticizing the provider, but rather on care priorities (the Faculty Guide has since been updated to reflect this suggestion). There was also the desire to include additional disciplines in future offerings.

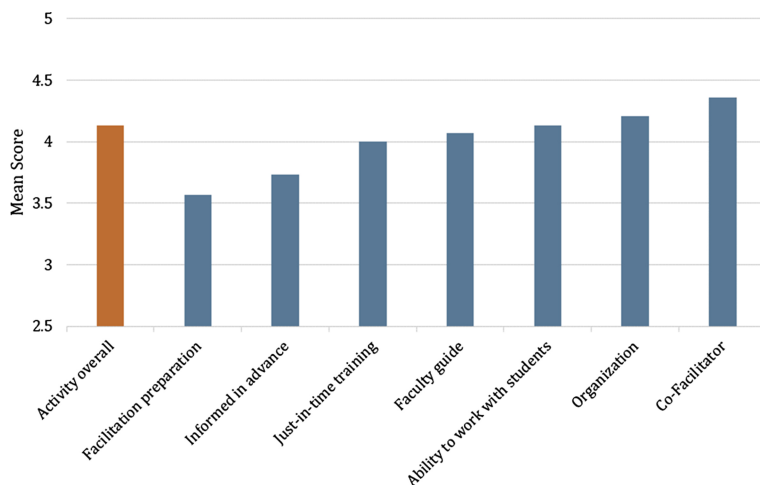


Figure 3. Summary of Faculty Facilitator Evaluations ($N = 20$). Score response options ranged from 1 = *Poor* to 5 = *Excellent*.

Discussion

This program represents a formalized IPE event for advanced health professions trainees. Both faculty facilitator and trainee evaluations indicated that the objectives for this educational event were met. Trainees came away with an appreciation for team-based care, roles, and communication when working with patients with complex psychosocial needs. Given the strong overall evaluation scores, the applicability to a variety of advanced health profession trainees, and the use of national (vs. local) resources, we expect this program to be broadly generalizable to health professions trainees that work in community-based care settings.

Use of the unfolding case format was effective in promoting collaborative approaches to care by providing the opportunity for student discussion as the complexity of the case became apparent. Teams initially focused on the mother-daughter dynamic, and concerned themselves with the tenuous relationship, while also moving to address the teen's high-risk behaviors. However, all teams successfully raised the concern for abuse following the second vignette. Trainees were uncomfortable and sought the opinion of their colleagues to affirm the suspicion of abuse, then quickly transitioned to how to proceed. For most teams, this included determining how to report suspected abuse, who would report, and what the potential consequences might be. We were surprised, though, that not all teams decided to proceed with reporting. We attribute this hesitation to the common misconception that health professionals must report confirmed rather than suspected abuse. The facilitators used this as a teachable moment to affirm that any suspicion of abuse must be reported, and that it is not the responsibility of the health professional to confirm the presence of abuse.

Limitations and Lessons Learned

Limitations of this program primarily included facilitator training and trainee focus on critiquing the provider in the vignettes. The most common criticism of this program was facilitators feeling unprepared, though many did not attend the just-in-time training. We have since decided to offer an online training using lecture-capture technology in addition to the in-person session as a way to ameliorate limited faculty availability. We also learned that the just-in-time training, which focused primarily on explaining the logistics of the event, was insufficient in assisting faculty facilitators in their role. Many of the facilitators were not familiar with the principles of IPE or collaborative practice and as such, there were several missed opportunities when working with the trainees. For example, during the debrief, trainees focused on criticizing the provider's approach to interacting with the adolescent and not necessarily how they functioned as a team. Because faculty were not necessarily versed in the "why" of IPE, trainees did not always understand the rationale for the session. We have addressed this limitation by revising the Faculty Guide and providing sample statements to guide facilitators.

The other main challenge with this program was the logistical planning, including scheduling for trainees and securing commitments from facilitators. To address this common challenge, we are exploring the possibility of quarterly predetermined dates held across all professions for interprofessional learning opportunities. The intent is to have interprofessional faculty assigned to these sessions as part of a teaching assignment, which will address facilitator availability. Curricular revisions have delayed our integration of this program throughout the doctor of nursing practice, social work and physician assistant curricula, through faculty champions are currently assessing how we will implement this program within the new curricula. Nonetheless, trainees consistently appreciate the in-person nature of the event, suggesting that the logistical challenges may be worth enduring.

By using a complex, authentic case-based learning format, learners were able to experience how providers from diverse disciplines have unique and complimentary roles in supporting patients in holistic care. Child maltreatment is an emotional and challenging topic, and trainees emerged feeling more confident in understanding their role in recognizing and reporting any suspected abuse. Furthermore, trainees appreciated the discussion around whether or not to disclose the intent to report to the family as well as how to care for this patient and family moving forward. This program provided a safe environment

to explore the complex, emotional subject of child maltreatment while addressing a known curricular gap, child maltreatment, as well as refine health professional approaches to team-based collaborative care.

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Acknowledgments

Brenda Zierler, PhD, RN, Laurel Barchet, BS, RN, Debra Liner, BA, PMP, University of Washington Center for Health Sciences Interprofessional Education, Practice and Research (CHSIE) Case Development Team and the Learning & Information Technology Video Production Team.

Disclosures

None to report.

Funding/Support

Drs. Sonney, Willgerodt, Lindhorst, and Brock report grants from Health Resources & Services Administration, during the conduct of the study. Additional support for the development of these materials was provided by the Division of Nursing (DN), Bureau of Health Professions (BHP), Department of Health and Human Services (DHHS) under grant number D09HP25029, title "Advanced Nursing Education."

Informed Consent

All identifiable persons in this resource have granted their permission.

Ethical Approval

Reported as not applicable.

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Received: November 9, 2017 | **Accepted:** April 9, 2018 | **Published:** April 27, 2018