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Training

Child protection training for paediatricians

N Shabde

Making a difference

In recent years high profile child abuse cases in the UK have led to paediatricians being censured in the media. This has caused serious concern to paediatricians. On one hand, eminent paediatricians acting as expert witnesses were accused of mistaken "allegations",¹ while on the other hand, there was failure of recognition of child abuse in other cases.^{2,3}

Consequently, the confidence of paediatricians has been undermined leaving them in the position of "damned if you do and damned if you don't" when confronted with potential child abuse cases.⁴ There is a real concern that paediatricians have lost confidence, feeling undervalued and unprotected themselves. This has been made worse by the adverse publicity surrounding some child abuse cases, which encourages society to lose confidence and distrust the ability of paediatricians to deal with child abuse cases. This has also been reflected in an increase in complaints against paediatricians,^{4,5} which the Royal College of Paediatrics and Child Health (RCPCH) survey revealed deterred many of them from undertaking this vital area of work.⁶

Against this background and with the ethos that "child protection is everyone's responsibility" being reinforced by recent legislation⁷ and guidance,⁸ what role can training play in making a difference to health professionals' confidence?

WHY DO WE NEED TRAINING?

Child protection work requires not only a range of clinical competences but also confidence, courage, and development of appropriate attitudes and feelings.⁹

Serious case reviews over the last 30 years have highlighted time and again the need for effective interagency communication and appropriate Child Protection training.¹⁰ However, until recently, Child Protection training has remained a neglected area of undergraduate and postgraduate medical training.¹¹⁻¹⁴

The National Society for Prevention of Cruelty to Children (NSPCC) undertook a survey of training needs in Child Protection of paediatricians (2002). This highlighted a need to give greater priority to the subject and to encourage doctors to take up training early in their careers to prevent them developing an "avoidance" approach to Child Protection, which may be hard to break down.

An unpublished survey of paediatric specialist registrars (SpRs) to look at their confidence and attitudes in Child Protection work in the Northern Deanery (2001) highlighted that 89% felt insecure when dealing with Child Protection cases. Only 11% felt confident being involved in Child Protection work; 78% felt they were inadequately trained in Child Protection; 32% felt Child Protection was essential part of their training; and 95% expressed a desire to be trained, which was encouraging.

It has been shown that Child Protection training can lead to short term improvements in knowledge and skills as well as a greater sense of competence in managing cases of child maltreatment in paediatric residents.¹³

Until now, the availability of Child Protection training for the UK paediatrician has varied enormously across the country and has not been a compulsory component of postgraduate paediatric training.

The RCPCH in 2003 embarked on the project to develop a Child Protection training programme for paediatricians. The initial thinking was influenced by discussions within a multidisciplinary group.

OVERVIEW OF THE RCPCH TRAINING PACKAGE

The Level I programme, "Safeguarding Children: Recognition and Response in Child Protection", an educational programme for paediatricians in training, was launched nationally in the UK in January 2006. We believe this is probably a unique standardised training

programme in Child Protection worldwide, and therefore it is to some extent an experimental venture. This has been developed by the RCPCH in collaboration with the NSPCC and the Advanced Life Support Group (ALSG). The ALSG was chosen to project manage and roll out the training because of the structural and administrative similarities of the Advanced Paediatric Life Support (APLS) and Child Protection training programmes. Both use a standardised intensive day course taught by experienced trainers and can be held in venues throughout the country.

The overall aim of the Child Protection course is to raise awareness and better equip paediatricians in training with the knowledge and skills to enable them to recognise and respond to Child Protection situations competently and confidently at a level appropriate to their stage of training and responsibility. It is intended that all future paediatric trainees will undergo this training.

The broad learning objectives include understanding attitudes and feelings, increasing background knowledge in child abuse and neglect, and understanding outcomes for children, with an emphasis on understanding their duty in safeguarding children. The course addresses the issues that doctors' responses in Child Protection situations may reflect their attitudes, beliefs, and values, and unchallenged they can be an impediment in recognition and response in Child Protection.

The essential component of the training is a one day intensive interactive course run by experienced trainers. In addition, materials are available on an interactive DVD-ROM and in a Reader (written specifically; gives a comprehensive background to the subject) as an integral part of the training. The RCPCH Child Protection Companion (written by an expert group; assists paediatricians in their daily practice in recognition and the process of management of child abuse and neglect) will also be recommended for pre- and post-course reading.

The DVD-ROM contains anonymised real-life case scenarios, a library of images with commentary, expert interviews representing all professionals working in this area, and links to additional resources. It is a valuable resource for pre-course preparation, post-course consolidation, and continued learning.

The one day course is aimed at junior trainees in paediatrics, but aspects of it are relevant for any doctor for whom basic training in Child Protection is appropriate (e.g. GPs, emergency medicine specialists, and child psychiatrists). It has been designed to use a

variety of teaching methods, including lectures, workshops, role-play, and scenarios to enhance the learning experience and obtain the desired outcomes.¹⁵ It will cover the essential aspects necessary to provide candidates with a structured approach to handle possible child abuse and neglect cases. By placing an emphasis on reinforcing the process of "diagnosis" with which they are already familiar from day to day work with children and families, it is hoped that candidates will feel empowered rather than intimidated by the training experience.

The importance of working together in Child Protection has been emphasised. This includes when to refer to senior colleagues, and developing strategies and skill in communicating effectively and sensitively with children and families and with other professionals for effective multi-agency working. All candidates are strongly recommended to avail themselves of locally provided multi-agency training programmes using this course as a foundation.

Particular attention has been given to the importance of developing communication skills in the Child Protection process. This is addressed in both interactive lecture based and role play sessions, which give candidates an opportunity to identify and use appropriate methods of communication to inform families about any concerns and the Child Protection process using the Calgary Cambridge Communication skills framework.¹⁶

Quality assurance (QA) of the package will be managed by the ALSG on behalf of the collaborative group (RCPCH/NSPCC/ALSG). QA mechanisms include structured trainer selection and training; comprehensive and consistent training materials; a detailed course centre registration; and validation, which includes a step by step guide to running the course according to the predefined regulations. Monitoring, audit, and feedback are also an integral part of this aspect of the package.

The one day course was rolled out nationally in March 2006.

Work has begun on the Level II programme, "Safeguarding Children", which is largely funded by the Johnson & Johnson Pediatric Institute (JJPI).¹⁷ The programme seeks to create a philosophy of paediatric practice that places child abuse and Child Protection within a broader context of safeguarding—keeping all children safe and promoting their welfare, including their emotional and psychological wellbeing. The aim is to ensure that specialist registrars (SpRs) and career grade paediatricians reach and demonstrate an acceptable standard in respect of safeguarding

children. It is hoped that the programme will be available by the end of 2007.

Training alone will not be enough to sustain competence and confidence in child protection work. The messages delivered in the training and materials need constant reinforcement and junior staff need ongoing access to empathic senior colleagues for support and supervision.

It is hoped that structured early training will also stimulate paediatricians' interest in research in this field. The Welsh Systematic Review Group in Child Protection provides an example of how the academic base can be developed.¹⁸

PAEDIATRICIANS AND THE COURT PROCESS

Many paediatricians find giving evidence in court very stressful and challenging. Very few paediatricians receive training in this area. High profile cases have made paediatricians reluctant to give evidence in court in straightforward cases and certainly have acted as a disincentive to take on an expert witness role. This will partly be alleviated by the Collins judgement¹⁹ giving immunity to witnesses provided the appeal currently before the courts is dismissed. There is a major drive from the RCPCH in conjunction with the Interdisciplinary Family Law Committee of the Family Justice Council (FJC)²⁰ to promote a "minipupillage" scheme for paediatric trainees. Trainees and consultant paediatricians will be able to familiarise themselves with the court process, and understand the roles of family and criminal courts, and the level of the burden of proof required in different courts. More importantly, they will need to appreciate the importance and requirement of giving an independent and objective opinion, and that their duty is to the court. A minipupillage scheme for child psychiatrists has been in place for a number of years and there is a perception that it works well.

CONCLUSIONS

Paediatricians have always played a key role in safeguarding children directly or indirectly. In the current climate of hostility and complaints culture, paediatricians feel demoralised and vulnerable working in Child Protection. Some paediatricians are reluctant to work as designated or named doctors and furthermore, there is a dearth of paediatricians willing to take on expert witness work. Clearly, this will leave children unprotected.

Training in isolation will not empower paediatricians to feel confident about Child Protection work.

However, training must be seen as an initial step towards improving the current climate and to make Child Protection safer for children and paediatricians. Training must be reinforced by peer review, supervision, and support from designated and named professionals, senior managers, and the RCPCH.

The impact of Child Protection training must be evaluated in both the long and short term. Early outcome measures might include improvements in attitudes, knowledge, and levels of confidence.⁹

Paediatricians play an essential role in Child Protection. Appropriate training will enable them to undertake this important work competently and with confidence.

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Further information regarding the Child Protection Level I course can be obtained by visiting the ALSG website: www.alsg.org under child protection.

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Worldwide cost-effectiveness of infant BCG vaccination

Churchill said there is no finer investment for any community than putting milk into babies; in most of the world putting BCG into babies is also a sound investment. A meta-analysis and cost-effectiveness assessment (Bernadette Bourdin Trunz and colleagues. *Lancet* 2006;**367**:1173–80; see also Comment, *ibid*: 1122–4) has shown that spending about US\$206 (£116) in doing so buys the equivalent of one year of life unblighted by tuberculous meningitis or miliary tuberculosis. For US\$1.8 million (£1 million) you could prevent nearly 300 cases of severe childhood tuberculosis worldwide, or 450 in South East Asia. Calculations were based on UN and WHO data and on information supplied in governmental reports or published in medical journals. The study included 194 countries and territories grouped into nine regions and aimed to show the effect on severe childhood tuberculosis of infant BCG vaccination for children born in 2002. In that year some 100.5 million infants were given BCG and it is estimated that this will have prevented 29 729 (24 063–36 192) cases of tuberculous meningitis and 11 486 (7304–16 280) cases of miliary tuberculosis in children in the first 5 years of life. Thus every 10 000 vaccinations will prevent three cases of tuberculous meningitis (one case for every 3435 vaccinations) and one of miliary tuberculosis (one case for every 9314 vaccinations). Of the 41 215 cases of severe childhood tuberculosis prevented 19 093 (46%) will be in South East Asia, 11 189 (27%) will be in sub-Saharan Africa, 6127 (15%) in the Western Pacific, and only 1185 (3%) in Latin America. In the established market economies, where infant BCG vaccination coverage is limited, an estimated 76 cases will have been prevented.

In 2002 routine infant BCG vaccination was practised in 157 countries and territories. Coverage was greater than 90% in 101 countries and less than 60% in only nine. About 76% of the 132.8 million children born in 2002 were vaccinated. In some countries, including The Netherlands and the USA, BCG vaccination is not performed. In five, including Norway, BCG is not given to children under school age, and in another five, including the UK, Sweden, and Switzerland, it is given only to at-risk groups.

The cost of BCG is US\$2–3 (£1.12–1.70) per dose or around US\$8600 (£4800) per case of tuberculous meningitis, US\$24 000 (£13 500) per case of miliary tuberculosis, or US\$6212 (£3500) per case of either, prevented. The cost per case prevented is lowest where more cases are prevented (US\$5738 (£3226) per case of tuberculous meningitis, and US\$15 563 (£8750) per case of miliary tuberculosis prevented in South East Asia) and highest in the established market economies (US\$101 628 (£57 146) and US\$275 646 (£155 000) respectively). The average cost per disability-adjusted life-year gained was US\$300 (£168) for tuberculous meningitis, US\$800 (£450) for miliary tuberculosis) and US\$206 (£116) for either. For tuberculous meningitis the cost per DALY gained was US\$190 (£107) in South East Asia, US\$368 (£207) in the Western Pacific, and US\$3365 (£1890) in established market economies.

A commonly accepted guideline is that health interventions are good value if the cost per DALY gained is up to twice the average annual income. The cost per DALY gained from infant BCG vaccination (US\$206, £116) is well below that figure (gross national income in low income countries is around US\$735 (£413) per person). The cost of short course chemotherapy for active tuberculosis is less than US\$50 (£28) per DALY gained in low- and middle-income countries. Infant BCG vaccination should therefore continue in countries with a high incidence of tuberculosis.