SPECIAL CONTRIBUTIONS

KNOWLEDGE AND ATTITUDE ASSESSMENT AND EDUCATION OF PREHOSPITAL PERSONNEL IN CHILD ABUSE AND NEGLECT:

REPORT OF A NATIONAL BLUE RIBBON PANEL*

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Violence against children, specifically in the area of child maltreatment, is a public health concern that has reached epidemic proportions. Prehospital providers, who often witness scenes of child abuse and neglect, can fill an essential role in identifying neglect and abuse in the home, at school, and in other locations.

In October 2001, a blue ribbon panel of national experts in emergency medical services (EMS), emergency medical services for children (EMSC), and child protection services (CPS) convened to discuss the prehospital provider's role in identifying and reporting suspected child abuse and neglect. Significantly, this marked the first time national experts from the worlds of child protection and EMSC met face-to-face to address this issue. With expertise in EMS education, pediatric emergency medicine, pediatric surgery, psychiatry and psychology, social work, legal practice, law enforcement, and fire and rescue services, the participants represented the entire continuum of care for at-risk children. When all available services are used and integrated, children are kept from falling through the cracks, and the highest quality of care possible is provided for them.

Guided by research findings from a national survey conducted by the Center for Pediatric Emergency Medicine (CPEM), the panel's goals were to:

- Recommend content areas in child protection that will form the basis for future educational resources for prehospital providers
- Develop recommendations regarding advocacy and policy issues important to EMS and CPS
- Discuss plans for continued collaboration between the EMS and CPS worlds

This article presents a summary of their findings.

BACKGROUND

In 2000, CPEM received federal funding from the EMSC Program to launch a National Child Protection Education Project. To begin the project, CPEM established an advisory board representing major national organizations in EMS, EMSC, and child protection, as well as a review panel composed of individuals with expertise in these areas. Working with the advisory board and review experts, the National EMSC Data Resource Center (NEDARC), and the National Registry of Emergency Medical Technicians (NREMT), CPEM staff developed a questionnaire targeting EMTs and paramedics nationwide. The survey instrument queried prehospital providers regarding 1) knowl-

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*Blue Ribbon Panel participants, Center for Pediatric Emergency Medicine staff, and local conference staff are listed in the appendix.

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edge of signs and symptoms associated with child abuse or neglect, 2) self-efficacy and attitudes toward recognition and management of child abuse or neglect, and 3) knowledge of identification, documentation, and reporting procedures for suspected child abuse and neglect.

The questionnaire was pilot-tested and revised, and then 10,000 copies were distributed to a representative cross-section of prehospital providers throughout the United States. Two mechanisms were used for distribution: one was a sampling system previously developed for the NREMT's Longitudinal EMT Attributes and Demographic Study (LEADS) project, and the other involved direct distribution to EMS offices in 15 states and territories, where the surveys were subsequently administered at regional training sites during certification courses and continuing medical education conferences. The overall return rate, independent of method, averaged 44%. The results were tabulated and analyzed in collaboration with the NREMT and NEDARC. Following data analysis, the blue ribbon panel convened to review and discuss the results.

THE CONTINUUM OF CARE FOR THE ABUSED OR NEGLECTED CHILD

Prehospital Phase

Emergency medical services providers are trained and either certified or licensed. Levels are defined by the state and region and are based partially on the Department of Transportation's *National Standard Curricula*. In their original forms, these curricula provided limited information on pediatric care and even less on child protection. In addition to the time constraints in these curricula, a review of their outlines indicates that material focuses on recognition of severe physical abuse, with little discussion of documentation and almost no discussion of other manifestations of child maltreatment, interaction with families, and issues of cultural diversity. Representatives from EMS and EMSC discussed the roles and responsibilities of prehospital providers as well as training for the different certification levels.

The Certified First Responder curriculum touches only briefly on pediatrics in a description of resuscitation techniques. No information on child abuse is given at this level. The EMT-basic program provides for 6 hours of pediatric education, half of which is didactic material. This level of training accounts for the education of the majority of EMS providers. Child abuse is a required component of the didactic material without specifying the exact time for this topic; traditionally, however, only 5 to 10 minutes is spent on this subject. The EMT-intermediate learns additional skills in adult care together with a brief mention of pediatric airway issues, but no additional information on child protection issues is provided. The EMT-paramedic program provides for expanded pediatric information and skills. Child abuse is a required component in this curriculum, but there is no set time for the didactic material and no opportunity for applied education using scenarios or role-playing; typically, it is no more than 15 to 20 minutes.

Each of these curricula includes practical components that could be applied to child abuse, such as the scene survey, during which EMS providers could gain valuable information for CPS. However, the components are not taught within the framework of child abuse, so this opportunity is missed. Other topic areas that could include child abuse information are patient assessment, mechanism of injury, focused history, documentation, and communication with other health care professionals.

Because EMS providers are often called to the home of the child, they can have an important role in identifying and recording information that many medical and child protection professionals do not have an opportunity to see.

It is imperative that prehospital providers and their leadership, as well as child protection advocates, understand each other's roles. For example, without an understanding of the variety of child protection interventions possible, prehospital providers who report their suspicions may see that the child was not removed from the home and conclude that nothing came of their report. However, CPS professionals are encouraged to keep families together when the child's safety and well-being are not compromised. CPS is a complex system; prehospital personnel would benefit by understanding how it is designed to work and how cases move through it.

Child Protection Phase

The child protection phase begins after a prehospital provider has reported a suspicion of abuse or neglect. This phase encompasses interventions performed by hospital personnel and the local child protection agency. CPS professionals presented key issues in child protection as they relate to EMS.

All states have laws, policies, and guidelines for child protection, which are based on federal statutes. The CPS agency in each state or region provides support services to families. CPS workers may remove children from unsafe homes; try to reunite children with their parents or other primary caregivers when appropriate; and develop alternative permanency plans, including adoption, when the latter is not possible. They also help children develop independent living skills as they near the age of emancipation. Depending on local statutes, the family court may be involved alongside CPS.

Regional variations in child protection practices

indicate that more uniform guidelines are needed. For example, states do not universally consider prehospital personnel mandated reporters of suspected child abuse or neglect. *Mandated reporters* are generally defined as individuals who, in the course of their employment, their occupation, the practice of their profession, or any capacity as required by state jurisdiction, come into contact with children and report or cause a report to be made to CPS when they have reason to believe, on the basis of their medical or professional capacity, that the child they observe is a maltreated or abused child. The definition of an *abuser* also varies by state. It could be the parent or paramour of the parent, other relatives, other caregivers (e.g., foster parents, facility staff, and child care providers), or any other person with ongoing responsibility for the care of a child.

Reporting is necessary so that further injury can be prevented and the safety of the child ensured. For an incident to be considered child maltreatment, the following must be true:

- The alleged victim is younger than 18 years.
- The alleged perpetrator has temporary or ongoing responsibility for the child.
- There is harm or substantial risk of harm to the child.
- A specific incident or set of circumstances is evident or manifest (as defined by individual state law).

The first step in reporting suspected abuse and neglect is to communicate with a hotline or another reporting mechanism.

The child protection worker who initially responds to the complaint will determine whether the information meets the state's criteria for abuse or neglect and whether an investigation is warranted. If so, the Child Protection Agency will initiate an investigation. This often begins with interviews of the child, the caregiver, the alleged perpetrator, and, in some instances, the person who reported the information. The investigation will determine whether there is sufficient evidence to substantiate a finding of abuse or neglect. Possible investigative outcomes include "founded" or "indicated," "unfounded" or "ruled out," and "unsubstantiated."

An outcome of "founded" or "indicated" means that enough evidence is present to indicate that physical abuse or neglect occurred. Depending on the circumstances, the child may be allowed to remain in the home while various interventions are provided, such as home visits by a social worker, counseling, parenting classes, or drug testing. Alternatively, if there is a high risk for further abuse or neglect, the child may be removed from the home. Planning must begin immediately, because federal law mandates that a permanent plan for a child's living arrangements be made within 18 months from the time the child enters the child welfare system.

A ruling of "unfounded" or "ruled out" means that there is insufficient evidence to indicate abuse or neglect. The case is closed unless additional information supports a finding of abuse or neglect. Some states may elect to enter a finding of "unsubstantiated." This means that the court believes that abuse or neglect occurred, but evidence to support such a finding is lacking.

Multidisciplinary child protection teams in local hospitals and in some communities review all cases reported from their hospital or geographic areas. These teams often include a representative from CPS to help facilitate the flow of information, but the EMS community is rarely represented. This lack of representation hinders the efforts of EMS providers and child protection workers to develop a mutual understanding of each other's roles; as a result, child protection workers often have little knowledge of the information prehospital providers can furnish regarding the cases they examine.

Legal Issues Affecting the Continuum

A final presentation and discussion focused on legal issues of concern to EMS and CPS professionals.

Mandatory Reporting

All of the states and the District of Columbia have enacted a mandatory reporting statute. These statutes vary greatly from jurisdiction to jurisdiction, but all include a list of persons who qualify as mandated reporters. Typically, all persons who are employed in occupations in which they deal with children or who come into contact with children are mandatory reporters. This may include school personnel, doctors, medical examiners, daycare providers, social workers, mental health professionals, law enforcement officials, EMTs, and others in similar professions. Some jurisdictions even include photo developers who may discover photographs depicting pornographic images of underage children. In approximately 18 states, anyone who suspects child abuse is required to report it, regardless of profession. It is vital for prehospital providers to be familiar with their jurisdiction's definition of a mandated reporter.

Standard of Proof for Reporting

The standard to determine whether a mandated reporter must notify authorities of suspected child abuse varies from state to state. Typically, a report is required whenever the reporter suspects or has reason to suspect child abuse or neglect. Suspicion can be based on physical observation, statements made by

TABLE 1. List of Words and Phrases to Be Defined

Maltreatment
Abuse
Neglect (e.g., optimal care vs adequate care vs minimal care)
Reasonable cause to believe/suspect
Suspicion
High-risk behavior
Assessment/history (physical vs psychosocial)
Caretaker and caregiver (legal, local definitions)
Treatment
Documentation
Report
Mandated reporter
Consent
Sudden infant death syndrome (SIDS)

the child, statements overheard, or transfer of knowledge from another person.

Liability Issues

For a state to receive funding under the Child Abuse Prevention and Treatment Act, it must provide immunity from prosecution to all good faith reports of suspected or known child abuse or neglect. Most states extend this immunity protection to include all criminal and civil actions as well as all judicial proceedings arising from the report.

In 45 jurisdictions and the District of Columbia, penalties are imposed if a mandated reporter fails to make a report. Most states impose one of the following standards: "knowingly," "knows or should have known," or "willfully." A minority of states imposes the standard of "intentionally or purposefully." Penalties may include forfeiture of license or certification, fines, or criminal prosecution.

Confidentiality

To receive grant funding under the Child Abuse Prevention and Treatment Act, records must be kept confidential to protect the identity of the parent or guardian. Mandatory reporters do not have a legal right to know the results of their report. They may be entitled to information, however, if they have subsequent involvement with the child.

RESEARCH FINDINGS

The research findings of the CPEM National Child Protection Education Project were presented. The assessment instrument previously described included demographic information; case scenarios; and questions covering attitude, opinion, and knowledge of child abuse and neglect.

The responses showed the following trends: prehospital providers were more comfortable managing physical abuse than neglect; they were uncomfortable managing sexual abuse and interacting with families of abused and neglected children; and their confidence in these areas tended to exceed their knowledge. There were significant knowledge gaps in the respondents' understanding of pediatric developmental stages and abilities, interaction with families, and the type of evidence that is needed in order to report suspicions of abuse or neglect. Prehospital providers perceived a need for additional training in a multitude of areas; the most frequent requests involved cultural competency, interaction with families, and documentation.

Differences in overall trends were noted according to sex, type of provider, and years of service. The detailed results have been submitted for publication.

GENERAL RECOMMENDATIONS

The panel participants defined several overall issues of importance for EMS and child protection and made the following recommendations.

Mandated Reporters

In many states, EMS providers are not mandated providers, and in places where they are mandated reporters, EMS providers, physicians, and child protection workers may be unaware of this fact. Prehospital providers, as health care professionals responsible for the care of children, should be considered mandated reporters in all states and territories. Prehospital providers and child protection personnel should be educated on this point.

Cross-disciplinary Cooperation

Emergency medical services providers and CPS experts, albeit knowledgeable in their own disciplines, do not possess comprehensive knowledge of each other's areas of expertise and function, and coordination and collaboration between EMS and CPS are virtually nonexistent. As such, further cooperation, coordination, and collaboration between EMS and CPS are needed.

Education

Prehospital providers should be better educated in the following areas: their role in the child protection system, assessment of children in different developmental stages, documentation, and reporting. Furthermore, child protection workers and physicians should receive training on the role of prehospital providers, the assessments they perform, and how they may identify abuse and neglect.

The panels made additional recommendations to:

- Increase focus on similarities between EMS and child protection roles
- Develop educational materials in child protection for EMS providers

- Develop support systems for prehospital providers who report child abuse and neglect
- Ensure that mandated reporting laws are implemented effectively
- Emphasize that the EMS system encompasses prehospital providers, hospital-based physicians, and hospital systems in a single continuum of care (i.e., avoid compartmentalizing prehospital care)
- Create opportunities for internships in which prehospital providers observe child protection workers, police officers, etc.
- Encourage increased focus on child abuse and neglect at state and national EMS conferences
- Encourage increased focus on the role of EMS in child abuse and neglect at local and national child protection conferences
- Communicate with national organizations to promote the value of EMS in child protection investigations

TASK GROUPS AND SPECIFIC RECOMMENDATIONS

The Blue Ribbon Panel focused on the following major issues in child protection to be considered a foundation for the involvement of EMS in child protection. These issues will help in the development of educational resources and address policy, advocacy, and future actions regarding EMS and child abuse and neglect. The issues included:

- Definition of terms
- Role of the prehospital provider
- Challenges to the role of prehospital providers in child protection
- Legal and legislative issues for the prehospital provider
- Problems faced by prehospital providers
- Prevention and identification of high-risk situations
- Patient and family interaction
- Recognition, assessment, and treatment
- Documentation and reporting procedures
- Children with special health care needs
- Cultural competency
- General recommendations regarding policy, advocacy, and future direction

Definition of Terms

Currently, there is no cross-disciplinary consensus regarding definitions of terms in the field of child abuse and neglect. During the meeting, the panel reviewed glossaries taken from EMS and child protection resources, identified differences in definitions, and selected key words and phrases to define in common (Table 1). Nationally recognized experts who have completed work in child protection and EMS will form definitions.

TABLE 2. Roles and Responsibilities of the Emergency Medical Services (EMS) Provider in Child Abuse and Neglect

Role	Responsibility
Gather information	Scene survey Observation of patient/family interaction Assessment of mechanism of injury
Provide appropriate medical care	Based on local protocols Includes emotional support
Recognize suspected child abuse and neglect	Obtain education in recognition (e.g., of child development, cultural practices in the community) Actively look for and be open to the possibility of abuse and neglect Involvement with curriculum development and standardization Keeping current on child abuse and neglect recognition practices
Provide interventions	Communicate with family and other health care providers
Document and report	Evidence preservation Understanding barriers and limitations Training in legal issues (e.g., what to report and how to document)
Integrate with child protection services/teams	Participate in fatality review teams (legal, medical, social work) Multilevel information exchange Obtain feedback and results of official investigative reports Develop follow-up mechanisms Share "best practice" models Undertake internships in other areas (e.g., medical, legal) Include child abuse and neglect presentations at EMS conferences
Engage in prevention activities	Participate in community programs

TABLE 3. Challenges to the Role of Prehospital Providers in Child Protection

Challenges
After EMS* providers develop a suspicion of child abuse or neglect, what is their next step?
If EMS providers should report the incident, to whom do they report it? Extent of report?
Limited time and process for prehospital providers to report
How to report if child is not transported
Possible solutions
Develop a mechanism to make prehospital provider reporting effective
Develop resources for prehospital providers to treat severely ill/injured patient at scene and still be able report suspicion of child abuse and neglect
Work toward a system in which prehospital providers are uni versally accepted as mandated reporters
Promote awareness of child abuse and neglect within EMS system
Promote awareness of EMS within the child protection system

*EMS = emergency medical services.

The basic vocabularies used by prehospital providers and child protection experts may differ, leading to inconsistency and confusion. For example, a prehospital provider considers *assessment* to mean a physical assessment conducted at the scene, whereas the child protection professional considers it to mean a comprehensive physical and psychosocial evaluation to determine whether there are grounds for suspecting abuse and neglect. The EMS prehospital provider should use the term *suspected child abuse*. Many do not know that suspicion is the only requirement for initial reporting; thereafter, local authorities will investigate to determine whether definitive proof of child abuse or neglect exists. The definitions of *suspected child abuse and neglect* versus *child abuse and neglect* are key for prehospital providers in understanding their roles.

Role of the EMS Provider in Child Abuse and Neglect

The prehospital provider's role in child abuse and neglect was discussed, and associated responsibilities were outlined (Table 2).

It was discussed that the role of prehospital providers is to care for children, including providing emotional support, and to adequately document their findings. It was recommended that prehospital providers be educated in the areas of abuse and neglect, including recognition, treatment, documentation, and reporting.

Recognition of child abuse depends partly on knowledge of child development stages; for example, in order to decide whether a child is malnourished, the provider must be aware of what the normal weight should be for the child. To assess whether a mechanism of injury reported by the parent is plausible, the provider must know the average capabilities of a child at that age (e.g., "Is this infant capable of rolling off a couch?"). Prehospital providers also require knowledge of cultural practices and special-needs children in the community. They need to understand proper reporting requirements and proper objective documentation methods that will hold up in court, when necessary. Most importantly, they need to know how to get their report to someone who has the authority to activate the system on the child's behalf.

Challenges to the Role of Prehospital Providers in Child Protection

The panel discussed the challenges prehospital providers face in their role in child abuse and neglect (Table 3). For example, there is no universal concept regarding where prehospital providers should deliver their report. The assessment survey indicated that

TABLE 4. Legal and Legislative Issues for Emergency Medical Services (EMS) Providers

Problem	Possible Solution
Differences in states regarding who is a mandated reporter	Recommendation to make everyone a mandated reporter
Ambiguity in language	Standardize language
Are EMS providers mandated reporters when they are off duty?	Include clarification in law or regulation as has been done for other mandated reporters
Contents of reports: how easy are they to write? Are they formulated for EMS?	Require documentation that reflects prehospital terminology and available information
Multidisciplinary teams within CPS* do not include EMS	Provide for prehospital inclusion where these teams are mandated
Parental consent: what to do when parents want to accompany their child on transport or when parents refuse transport for their child	Provide legal mechanism for transport of the possibly abused or neglected child without parental consent
Legalities regarding cultural and religious attitudes toward medicine and treatment	Educate prehospital providers in the legal issues regarding cultural and religious beliefs
Lack of training in legal aspects of documentation	Education in objective documentation, including noting child's emotions and objectively recording what is said

*CPS = child protection services.

TABLE 5. Problems Faced by Prehospital Providers

Limited clinical exposure to child abuse/neglect because of the low percentage of pediatric calls
Limited opportunity for on-scene assessments beyond those essential to direct patient care
Lack of a clear, consistent role in reporting child abuse/neglect from state to state and region to region
Lack of familiarity with mechanisms for reporting directly to the child protection agency
Failure of child protection agency to include providers in the investigation/evaluation process
Child protection services have traditionally not been educated about the importance of emergency medical services (EMS) in child maltreatment detection, evaluation, and, if needed, prosecution
Lack of inclusion in interdisciplinary teams dealing with child abuse and neglect (e.g., child fatality reviews, child protection teams in hospitals)
Limited experience and education in recognizing subtle findings that, when put together, might lead to the suspicion of child abuse and neglect

some providers report suspicions to the emergency department (ED) physician; in most cases, a social worker subsequently reports on behalf of the ED physician. However, professionals in CPS prefer to receive information "early and up front," rather than second- or thirdhand. Should the prehospital provider report directly to CPS?

How can the reporting process be made easier? If another EMS call comes through before the EMTs and paramedics leave the ED, they may not be able to deliver a full report at that time. Emergency departments also need an effective system of reporting that includes the prehospital provider and accounts for the problem that ED staff, such as social workers, may not make reports on behalf of the prehospital providers, who are not considered part of the ED staff.

Legal and Legislative Issues

The Panel defined several legal issues and recommends further study to find definite solutions (Table 4). Prehospital providers need to understand suspicion, scope of authority, jurisdictional lines, kidnapping, and consent. Prehospital providers lack adequate training in documentation of child abuse and neglect, particularly in the legal context.

Some of the questions raised included:

- What do EMTs know about proper collection of evidence or items relevant to diagnosis and treatment and transfer of that evidence?
- What rights do parents and children have regarding consent for examination and transport?
- What is the definition of an emancipated minor? How does that affect the prehospital provider's actions?
- What is the prehospital provider's liability when a superior does not want to make a report? What alternatives are available in such situations? What is the prehospital provider's civil liability?
- Are providers mandated to report when they are off duty?
- What if providers suspect abuse of someone in the household other than the patient they were called to treat? Would they be liable if they did not report it?

Legal aspects of cultural competency must also be considered, including the use of folk medicine in the community versus abuse or neglect, refusal of treatment for religious reasons, care for undocumented aliens, and consideration of cultural and religious beliefs.

Problems Faced by Prehospital Providers

Although much of the discussion focused on key issues related to the role of prehospital providers in child protection, one discussion centered on specific possible problems faced by prehospital providers (Table 5).

Prehospital providers respond to a high volume of adult calls but few calls involving children; of these, even fewer will involve child abuse and neglect. Providers must be vigilant for signs of abuse or neglect during all pediatric calls, but they must also remember that abused or neglected children may be present during adult calls. Under the intense pressure of the acute care environment, providers perceive that they do not have time to perform assessments beyond direct patient care. To address this dilemma, it is important to develop generic guidelines that providers can follow at all scenes. These should include an assessment for possible child abuse and neglect during the scene survey any time children are present, with the goal of heightening awareness of child abuse and neglect in any situation. This assessment need not interrupt patient care and may not require immediate documentation. It is sufficient for providers to mentally note elements that may help in a later investigation, documenting these findings when the crisis is over.

There is some agreement that the essential role of the EMS provider includes identifying, recognizing, and reporting child abuse and neglect, but the manner in which this translates into practice, procedures, and guidelines varies among communities and EMS systems. The unclear role presents a problem for the provider in knowing his or her course of action. Some possible solutions are to encourage states to clarify

TABLE 6. Key Knowledge Points in Identifying High-risk Situations

Criteria CPS* uses to determine safety/lack of safety for child and definition of safe/unsafe
Circumstances that indicate high risk
When talking about safety in regard to child protection, refer to risk for harm and risk for maltreatment
Determinants of accidental versus nonaccidental injuries
Threat-to-harm versus harm, at-risk versus high-risk
Normal growth and development
Clinical presentations of child abuse (e.g., findings that indicate accident vs inflicted and common symptoms)
Recognizing a hazardous environment (i.e., not just a dirty or untidy home)
Caregiver disabilities and characteristics that create a high-risk situation (e.g., mental and physical health, alcohol or other substance abuse)
Criteria for rapid assessment for high-risk situations
Documentation of observations
Resources and referrals for at-risk families that do not need immediate CPS
Effective ways to pass information and communicate concern to hospital staff, referral agencies, or child protection workers

*CPS = child protection services.

language defining the prehospital provider's role as a mandated reporter of child abuse and neglect, and to decide whether providers are expected to report directly to the CPS agency or integrate reporting with other reporting mechanisms

Problems are also caused by most prehospital providers' lack of familiarity with systems for reporting child abuse and neglect in their state. Suggested solutions were to:

- Educate prehospital providers on state and local reporting requirements
- Establish protocols and systems to facilitate the reporting process for prehospital providers (e.g., add a check box to the run sheet of suspicions and to whom/where did/do they report [ED, physician, hotline])
- Teach providers to document the scene with photographs
- Educate providers about what should be included when reporting
- Determine how reports should be coordinated and by whom

Recognizing child abuse often involves fitting together many subtle clues. By themselves, these clues may seem innocuous, but together they reveal a more suspicious picture. Prehospital providers have limited experience recognizing the findings that create this picture, but their observations may be additive to others findings leading to suspicion. A problem is that prehospital providers do not often know that, even without reaching the level of suspicion, documenting their findings may be helpful to others involved in child protection.

Child protection workers generally do not contact the prehospital provider during the investigation of alleged child abuse or neglect. Providers have few interactions with CPS. In many cases, CPS professionals do not even know that they can contact prehospital providers for information. As more prehospital providers objectively document significant observations during emergency calls, thereby conveying valuable information to investigative staff, the current gap between EMS and CPS will begin to close. Better linkages and communication between CPS and EMS will help to promote this cooperation locally and nationally.

Currently, prehospital providers are not included in interdisciplinary teams dealing with child abuse and neglect, such as child fatality reviews and child protection teams in hospitals. EMS representation would give prehospital providers an opportunity to hear about the outcome of child abuse cases. Knowing that something has been done to help the child will provide a strong incentive to report future findings.

High-risk Situations and Prevention

Prevention is a complex challenge for CPS professionals and is even more so for the prehospital provider. Because of the low volume of pediatric calls, there is scant evidence to suggest whether EMS personnel can carry out prevention and identification of at-risk children, but panel members agreed that it is within their purview.

Child protection professionals view risk as the potential for maltreatment or harm. Their assessment in these cases focuses on whether the child is safe in the current environment. Terms such as *at risk* or *high risk* do not necessarily mean that maltreatment has occurred, but, rather, that the family requires interventions to prevent maltreatment from occurring. These situations may not yield reportable evidence of child abuse or neglect, yet a timely referral to social services may serve as a method of prevention. At-risk children could benefit if prehospital providers had the knowledge and skills to identify these situations (Table 6).

It may be useful to place a check box on the patient care record so that providers could request a social work referral when transporting an at-risk child to the hospital. If the child is not transported, providers could give the family a brochure with referral information and telephone numbers. This would give prehospital providers an opportunity to contribute to pre-

vention efforts. Finding time for prevention-related activities is a challenge for CPS professionals and prehospital providers alike.

Patient and Family Interaction

Prehospital providers receive limited training in family and patient interaction, so they are not well equipped to cope with the volatile family situation that may accompany potential child abuse or neglect. CPEM research showed that EMTs and paramedics reported the least confidence in this area. Most respondents indicated a need for additional education in techniques for interviewing and interacting with the family in such situations. The Panel established key knowledge and skills issues in this area (Table 7).

Role-playing and scenarios are the best methods for training and educating providers in these techniques. Scripted questions may be helpful as well. Future technology may bring additional tools to this arena, such as interactive video presentations.

TABLE 7. Knowledge and Skills in Patient and Family Interaction

General approach
Listen
Ask
Keep in mind you don't know! (i.e., do not assume)
Cultural variations
Don't make assumptions based on stereotypes
Be realistically supportive
Be respectful
Scripted questioning
Medically relevant
Forensically informed
Intervention strategies for the hostile patient and family (i.e., unsafe situations that pose danger to the patient or provider)
How to spot red flags
Documentation of interactions and statements; passing along information

Recognition, Assessment, and Treatment

The results of CPEM's survey demonstrated that prehospital providers need to broaden their view of assessment and open their eyes wider if they are to recognize potential child abuse and neglect or children who are at risk. The relative scarcity of pediatric calls contributes to this problem. Child protection professionals use a basic assessment framework, which assesses the questions of who, what, where, when, and how, when investigating a suspicion of child abuse; this could be readily adapted for prehospital providers. Prehospital providers should be reminded that they already acquire most of this information when they perform the scene survey and determine the mechanism of injury. Because most prehospital providers have only been taught about severe physical abuse and traumatic presentations in their certification courses, it is clear that child abuse and neglect issues need to be incorporated into medical presentations (e.g., apnea, lethargy, seizures) going from the general to the specific in child abuse and neglect.

Prehospital providers must be assured that they are not expected to employ the specialized skills or fill the role of a social worker. Their role is not to fix the problem at the scene, but, rather, to identify the problem and pass along the information. This is how they can actually fix it.

Given that prehospital providers are afforded few opportunities to practice their recognition, assessment, and treatment skills, the Panel agreed that frequent educational opportunities are needed. Various teaching methods were suggested; for example, experienced providers could act as mentors to help less seasoned providers enhance their skills and knowledge. Additional questions about child abuse and neglect could be added to examinations for the national registry and state certification. Helpful pocket resources that address child abuse and neglect could be developed.

The Panel suggested the following scenarios for role-playing to help with training in the areas of recognition, assessment, and treatment:

- What does one do when child abuse or neglect is suspected, and the family refuses treatment or transport?
- Can a child be transported without obvious medical necessity?
- What does one do if abuse or neglect is suspected, but there is no medical need for transport?
- What does one do when the abused child is not the patient for whom the ambulance was called?

Documentation and Reporting Procedures

The Panel agreed that the importance of proper documentation cannot be overemphasized. Documentation reinforces memory, provides a vehicle for conveying information to others, and increases the accuracy of testimony, if required. During every emergency call, prehospital providers should attune all of their senses to their surroundings so that they can precisely describe the environment and, if appropriate, the mechanism of injury, even if there is no time to document them at the scene. It is imperative to use clear, objective language for all documentation and to avoid opinions and judgments.

All providers, regardless of whether they are mandated reporters, must gain the requisite knowledge and skills for reporting (Table 8). Education efforts should cover the definition of reporting, who is man-

TABLE 8. Knowledge and Skills for Documentation

Importance of proper documentation
Methods for proper documentation, including phrasing and terminology
Identify the mechanism of injury and child development issues
Scene documentation, including environment and mechanism of injury
Documentation checklist for efficiency, improved patient call reports, and better identification of suspicious cases
Details checklist (e.g., accuracy, mechanism of injury; hygiene, prior medical care, use of proper legal documentation)
Awareness of inappropriate terminology
Recording statements of bystanders

TABLE 9. Knowledge of Children with Special Health Care Needs (CSHCN)

CSHCN are at high risk for child abuse and neglect
Parents of CSHCN are at high risk for wrongful accusation of abuse
Interviewing and interaction skills (use role-playing in training an resource)
Address CSHCN in case studies and scenarios for practice

dated to report, to whom the report is made, the mechanism for reporting, and reporting criteria, such as reasonable suspicion.

Children with Special Health Care Needs

The Panel agreed that knowledge about children with special health care needs should be integrated with information on child abuse and neglect, because statistics have shown that these children are at high risk for abuse and neglect. Prehospital providers should be made aware of this so that they can watch for signs of child maltreatment. Specific knowledge and skills can help them assess children with special health care needs for abuse and neglect (Table 9).

TABLE 10. Cultural Competency Knowledge and Skills for Child Abuse and Neglect

Child-specific cultural competency issues (most key points of curricula in cultural competency are not specific to children but, rather, discuss normative cultural values and practices)
Knowledge of ethnic variations in the local neighborhood
Identification of community leaders
Differentiating folk practices from child abuse and neglect for referral purposes
Provider practices and biases
Psychosocial issues
Interviewing techniques that account for cultural practices and norms
Interviewing across language barriers (e.g., identifying an appropriate translator, such as a child or relative)
Awareness of nonverbal cues by translator when another is translating for the patient

Cultural Competency

Prehospital providers require knowledge and skills in cultural competency so that they can appropriately assess children from different cultural backgrounds for child abuse and neglect (Table 10). Without this knowledge, provider bias may emerge, greatly affecting the accuracy of the evaluation. To that end, EMS should include members of culturally diverse communities in such areas as protocol development, multidisciplinary teams, and general outreach. EMS participation in community activities should be encouraged. EMS personnel need resources that expand their knowledge of cultural diversity within their communities. EMS agencies should be encouraged to teach existing courses that include cultural competency training.

Advocacy and Future Meetings

The final portion of the meeting focused on future needs for advocacy and subsequent meetings (Table 11). The Panel resolved that prevailing attitudes toward education in child abuse and neglect must be changed in order to advance the role of EMS in this arena. It would be helpful to produce a joint position paper on this issue with EMS and CPS.

The Panel called for cross-disciplinary presentations at EMS and child protection conferences so that each discipline will understand the other's role. EMS representatives should be included in hospital-based and other child protection interdisciplinary teams. In addition, it was agreed that the EMSC National Resource Center would create, with the help of participants from the Blue Ribbon Panel, a fact sheet on the topicof child abuse and neglect for national distribution to the EMS world, promoting awareness of advocacy needs.

With regard to advocacy activities to improve existing policy, most discussions focused on issues of mandated reporting. Many states have statutes that make prehospital providers mandated reporters but do not require mandated education. How can providers be expected to report if they have no knowledge of the law? The Panel agreed that both education and reporting must become mandatory. It was suggested that the reporting process be facilitated through a checklist or form that prehospital providers could incorporate in their patient call record. It may be helpful to establish an outline for the form that could be used nationally, but each state will need to adapt this outline to its own requirements.

The Panel resolved to publish this summary of the consensus conference simultaneously in EMS and child protection journals, with the hope that it will

TABLE 11. Recommendations for Advocacy and Collaboration

Produce a joint position paper with EMS* and child protection organizations
Deliver presentations on child abuse and neglect at EMS conferences
Deliver presentations on EMS at child protection conferences
Add EMS representatives to hospital-based and other child protection teams
Create a fact sheet for national distribution to the EMS world
Make education and reporting mandatory in all states
Create a checklist or form that EMS can incorporate into its record and use for reporting
Publish meeting summary simultaneously in EMS and child protection journals
Incorporate cross-disciplinary material into EMS and CPS* training to delineate roles

CPS = child protection services; EMS = emergency medical services.

help personnel in EMS and CPS understand and remember the importance of each other's roles. Panel participants will facilitate presentations on this topic at EMS and child protection meetings. The Panel suggested that educational materials in EMS and child protection arenas incorporate cross-disciplinary information on each profession's roles. Finally, the Panel recommended that data continue to be collected in the area of child protection and EMS.

CONCLUSIONS

This conference provided an important first step in bridging the gap between the child protection and EMS worlds. The Blue Ribbon Panel recognized the importance of the identification, recognition, documentation, and reporting in child protection that prehospital personnel can provide. Although prehospital providers are not mandated reporters in all states, it was felt that this should be advocated, and that providers must be educated to fulfill this role.

Prehospital providers are in the unique position of visiting the home unannounced and seeing the actual mechanisms of injury. They may observe child protection issues whether the child is the patient or a bystander. Mechanisms should be established to help providers recognize situations that do not fit the criteria for mandated reporting, so that they can help the families of at-risk children obtain social services that may protect these children from future harm.

Child protection experts must be educated as well, so that they will better understand the prehospital provider's important role in identifying and reporting child maltreatment. The continued cooperation of these two disciplines is essential if we are to help children who suffer from maltreatment. Continued cooperation can be fostered through mutual understanding, increased presence and participation at each other's conferences, and publication of research data from this field.

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APPENDIX

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Although these individuals were appointed to represent their organizations, and the comments contained in this document represent the participants' input, formal approval of this summary was not obtained from the boards of these organizations.

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