DEFENSE HEALTH BOARD

HEALTHY MILITARY FAMILY SYSTEMS:

EXAMINING CHILD ABUSE AND NEGLECT

AUGUST 6, 2019

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OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VA 22042-5101

DEFENSE HEALTH BOARD

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

SUBJECT: Healthy Military Family Systems: Examining Child Abuse and Neglect

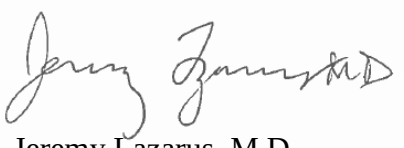
The Defense Health Board (DHB) is pleased to submit its report summarizing the findings and recommendations from its independent review of Healthy Military Family Systems: Examining Child Abuse and Neglect.

On June 15, 2018, the Acting Assistant Secretary of Defense for Health Affairs (ASD(HA)) requested that the DHB review the policies and practices in place to prevent, detect, assess, and treat abusive behavior and the resulting injuries that occur in military families. The DHB was charged to examine the unique factors that contribute to child abuse and neglect within military families and provide recommendations to reduce the stigma and improve the prevention and management of abuse and neglect towards children in the health care setting. Specifically, the Acting ASD(HA) requested the DHB:

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children;
- Review existing support programs for victims of child abuse and neglect in the Military Health System (MHS);
- Determine mechanisms to advocate treatment options in military health care settings; and
- Evaluate the training and educational opportunities available to military health providers to ensure that they are aware of and utilize the best available practices and resources.

The Work Group conducted literature reviews on key topics, received briefings from subject matter experts, analyzed and interpreted data, and reviewed current policies and practices related to child abuse and neglect within both the MHS and civilian healthcare systems. The Work Group presented to the DHB on August 6, 2019, and following public deliberation of the findings and recommendations, the attached report was approved and finalized.

On behalf of the Board, I appreciate the opportunity to provide the Department with this independent review and hope that it provides useful information to promote and improve child abuse and neglect prevention, intervention, and quality of care across the MHS.



Jeremy Lazarus, M.D.
President, Defense Health Board

Attachment:
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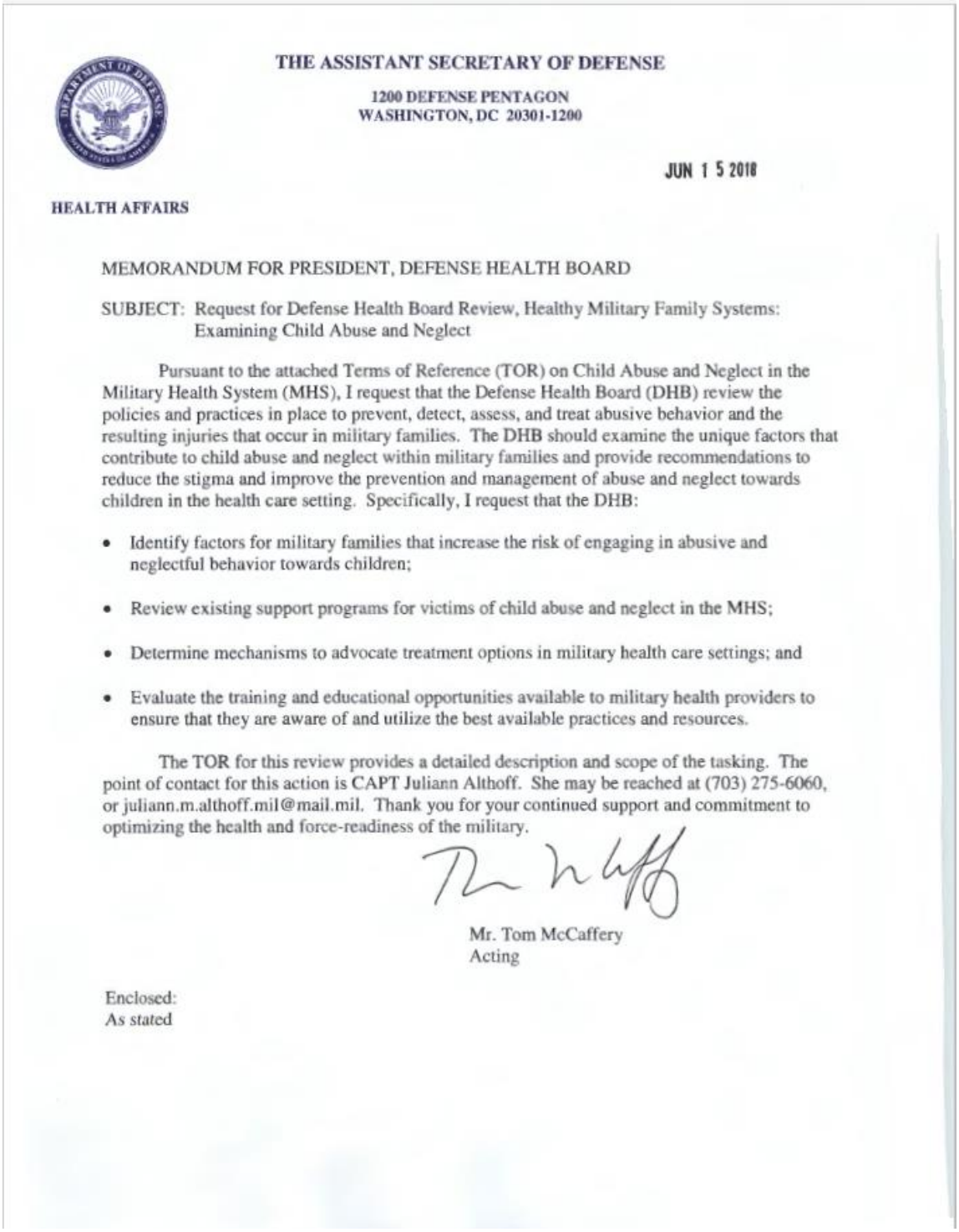
CHARGE TO THE DEFENSE HEALTH BOARD



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JUN 15 2018

HEALTH AFFAIRS

MEMORANDUM FOR PRESIDENT, DEFENSE HEALTH BOARD

SUBJECT: Request for Defense Health Board Review, Healthy Military Family Systems: Examining Child Abuse and Neglect

Pursuant to the attached Terms of Reference (TOR) on Child Abuse and Neglect in the Military Health System (MHS), I request that the Defense Health Board (DHB) review the policies and practices in place to prevent, detect, assess, and treat abusive behavior and the resulting injuries that occur in military families. The DHB should examine the unique factors that contribute to child abuse and neglect within military families and provide recommendations to reduce the stigma and improve the prevention and management of abuse and neglect towards children in the health care setting. Specifically, I request that the DHB:

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children;
- Review existing support programs for victims of child abuse and neglect in the MHS;
- Determine mechanisms to advocate treatment options in military health care settings; and
- Evaluate the training and educational opportunities available to military health providers to ensure that they are aware of and utilize the best available practices and resources.

The TOR for this review provides a detailed description and scope of the tasking. The point of contact for this action is CAPT Juliann Althoff. She may be reached at (703) 275-6060, or juliann.m.althoff.mil@mail.mil. Thank you for your continued support and commitment to optimizing the health and force-readiness of the military.

Mr. Tom McCaffery
Acting

Enclosed:
As stated

ABSTRACT. HEALTHY MILITARY FAMILY SYSTEMS: EXAMINING CHILD ABUSE AND NEGLECT

> "If our families are not ready, our Service members are not ready."
> *—Dr. Terry Adirim*
> *Deputy Assistant Secretary of Defense*
> *(Health Services Policy and Oversight)*

The military family occupies a unique position in the fabric of our Nation's defense, contributing to the readiness of the Armed Forces. Threats to the health and integrity of families create threats to the warfighter's preparedness to execute the national security mission. Child abuse and neglect (CAN) is a significant threat to family integrity and readiness and must be addressed as a command and leadership issue in the Department of Defense (DoD).

CAN and other forms of violence thrive on secrecy. Secrecy is tied to stigma and fear of repercussions, among other factors. The DoD is engaged in ongoing efforts to change the perception that help-seeking is a sign of weakness, particularly in the area of suicide prevention. Similar efforts must be made to change the stigma around seeking help for struggles that lead to child maltreatment* and other forms of violence. This approach must include a strong messaging and public awareness campaign.

The issue of career repercussions stemming from CAN has been raised as a barrier to help-seeking. While sometimes indicated and necessary, particularly in light of the unique military occupational requirements, the potential loss of one's livelihood can also serve as a formidable obstacle to seeking help in challenging and escalating circumstances. The DoD can and must do more to intervene before family issues and risk factors culminate in circumstances that warrant separation.

The role of barriers to help-seeking in perpetuating problem behaviors is widely acknowledged. Barriers to help *provision* – which can also act to sustain maladaptive behaviors – are less understood. The phenomenon of "gaze aversion" may be one such barrier to help provision. Runyan defines gaze aversion as "turning our heads away from unpleasant topics.[2]" Gaze aversion within the context of CAN may contribute to the failure to identify child maltreatment, particularly in equivocal cases, when another more palatable – but less likely – cause could be cited. Gaze aversion may occur on a systematic basis, as well, curtailing the allocation of time, attention, resources, and effort to issues of significance like CAN. Krugman and Leventhal hold that "[to] look directly means tackling the problem head on and that requires an effective child protection system and a clear governmental approach to research, services for victims and families, and prevention with funding commensurate with the extent of the problem.[3]"

Addressing CAN from a public health perspective offers significant promise in the quest to eradicate it. A public health approach frames a problem as a health issue with risk factors that can be addressed through intervention and outcomes that can be tracked. Prevention is

* The term "child maltreatment" is used in this report to capture the entire scope of CAN.

prioritized and risk factors and symptoms are treated rather than stigmatized and punished. In the DoD, support must also be offered for families with elevated risk profiles and in times of increased stress through a combination of indicated supports and interventions. CAN in the military is driven by factors both similar to and distinct from CAN in the civilian sector; these factors must be attended to in plans to address child maltreatment.

The Military Health System (MHS)[†] is an essential and powerful partner in a public health approach to CAN in the DoD. Health care providers[‡] are typically the first point of contact outside the family and have historically been the most frequent identifiers of CAN within the most vulnerable population: children ages zero to three. Regularly scheduled well child visits provide a routine opportunity to assess risk factors and suspected maltreatment in families. To take maximum advantage of this opportunity, the MHS must standardize CAN training, policies and procedures across outpatient and inpatient facilities and must institutionalize existing CAN specialty expertise at the Enterprise level. Consideration must be given to the role of health care providers in the Purchased Care (TRICARE) network, who see up to two-thirds of beneficiaries for medical care. Gaps between requirements, policies and procedures in the Direct and Purchased Care networks currently limit the DoD's ability to identify and address CAN early on; these gaps limit the DoD's ability to protect children, strengthen families, support positive career trajectories, and preserve the soundness of the Armed Forces.

An effective approach to CAN in the DoD requires strong coordination among important partners, including but not limited to the MHS and the Family Advocacy Program (FAP). Given links between various types of violence across the lifespan, partnerships with offices that address different aspects of violence in the DoD (e.g., Sexual Assault Prevention and Response Office (SAPR) and the Defense Suicide Prevention Office (DSPO)) should be considered.

While a number of excellent DoD programs are available to families with suspected cases of CAN, greater interaction between and coordination of these programs is needed. Stronger coordination must also be ensured between military and civilian agencies in order to avoid fragmentation and ensure the safety and well-being of military children and families. Memorandums of Understanding (MOUs) to ensure consistent reporting and information sharing between Child Protective Service (CPS) agencies, FAP, referring health care providers, and other DoD agencies active in the life of at-risk military families are essential. Leveraging existing expertise within the civilian sector to augment DoD resources is recommended.

CAN-related surveillance and outcomes tracking must be improved and optimized. Optimized data collection will allow a better understanding of the scope of child maltreatment.

[†] The MHS is comprised of the Direct Care and the Purchased Care Networks. The Direct Care Network includes all inpatient and outpatient Military Treatment Facilities across the globe. The Purchased Care Network, also referred to as TRICARE, includes providers within the civilian sector who care for DoD beneficiaries. These providers may either be authorized (non-network) or network providers.

[‡] Throughout this report, "health care provider" and "provider" is used broadly to include any person who interacts with beneficiaries in the health care system, and includes yet is not limited to nurses, physicians, allied health professionals, nurse practitioners, physician assistants, social workers, counselors, psychologists, and medics. The term "child/adolescent health care provider" is used to specify health care providers whose primary duties require regular and recurring contact with children under the age of 18 years, and is aligned with the definition in the DHA draft administrative instruction "Child Care Background Check Program." The term "comprehensive pediatric medical care provider" refers to a child/adolescent health care providers with training, credentials, and privileges to evaluate, diagnose, and manage the full spectrum of general physical care conditions in patients less than 18 years of age.

Additionally, the collection of outcome measures will allow resources to be applied to prevention and intervention initiatives that work.

During the Defense Health Board's yearlong investigation into child maltreatment in the military, many pockets of excellence emerged. However, system fragmentation, both within the DoD and the civilian sector, emerged as a limiting factor in how well at-risk families are served. These fragmented elements, if woven together, could form the basis of a world-class approach to child maltreatment within the DoD.

A condensed summary of the Board's key recommendations, by theme, appears below. More detail is provided in the full report and appendices.

A Public Health Approach is essential to Combatting CAN

The DoD should adopt a systems approach to CAN that acknowledges the interrelationship among multiple forms of interpersonal violence.

The DoD should name CAN as a public health priority with resources and awareness campaigns equivalent to those allocated to other DoD public health priorities.

The Defense Health Agency (DHA) should enact a universal awareness and prevention approach to CAN, which includes an education component.

An opt-out home visiting program should be provided to all families with young children and/or expecting mothers.

The MHS is Integral to the DoD's Anti-CAN Efforts

The role of MHS health care providers in identifying and referring CAN cases must be optimized by developing training and outreach programs targeted to those providers most likely to see cases.

The DHA should ensure that the forthcoming procedural instruction (DHA-PI) on CAN reporting policies and procedures for health care providers includes a requirement to report to FAP as well as Child Protective Services (CPS), and is complemented by local standard operating procedures (SOPs) for reporting. Local reporting SOPs should be tailored to the needs of the individual military medical treatment facilities (MTFs), including specifications that account for the special circumstances of CAN cases that occur overseas. The DHA should charge the Pediatric Clinical Community or Pediatric Specialty Community, or other appropriate body, with ensuring CAN procedural information is disseminated across the Military Health System. Additional policies and procedures will be necessary to standardize CAN care across the Enterprise.

The DoD should fund a centralized expert CAN capability at the DHA level to provide evaluation, consultation, training, and testimony. This capability should incorporate the Armed

Forces Center for Child Protection and allow for decentralized execution of standardized expert functions.

The MHS should establish a dedicated CAN specialty training pipeline at the Joint Service Graduate Medical Education (GME) Selection Board.

The DHA should develop and incorporate a standardized CAN assessment and management tool into the electronic health record (EHR) workflow of child/adolescent health care providers. This should be informed by current best practices in the civilian sector.

Coordination within the DoD and between the DoD and Civilian Partners is Essential

The DHA should have a centralized point of oversight and contact for CAN. This office would lead DHA policy development in CAN, maintain a comprehensive list of internal and external services and help with the coordination of services. The latter would include the establishment of Memoranda of Understanding/Memoranda of Agreements (MOUs/MOAs) with external entities.

The MHS should require the establishment of a multidisciplinary team to address CAN cases at each MTF/installation. These teams should include personnel with medical knowledge of CAN, including conditions that may mimic child maltreatment; an understanding of Child Protective Services (CPS) protocols; 24/7 accessibility; and an ability to enter CAN related reports into the EHR.

The DoD should ensure all MTFs and military installations, as appropriate, have MOUs/MOAs in place with state or local CPS agencies for bilateral information sharing on cases of CAN within DoD families. Compliance with required reporting should be tracked.

The DoD should reconsider requiring at least one comprehensive pediatric medical health care provider to be a member of all Incident Determination Committees (IDCs).

Surveillance and Outcome Metrics Provide Crucial Information

The DHA should conduct a formal epidemiologic survey to more accurately determine the scope of CAN in the DoD and establish an initial baseline to measure changes.

The DoD should require and standardize documentation of all substantiated FAP cases in the beneficiary's EHR.

The MHS should systematically track TRICARE health care providers' notification of CAN to military medical treatment facilities (MTFs)/military providers.

The DoD should support ongoing efforts, such as The Millennium Cohort Program, to track health outcomes including CAN. These efforts should receive proper funding and appropriate action should be taken when significant findings emerge.

Military Unique Factors Must be Considered in the DoD's Anti-CAN Efforts

Efforts should be made to increase awareness of CAN within the DoD and its potential impact on readiness.

The DoD should develop systems for mandatory pre-deployment and re-deployment briefings on CAN and include family violence screening in Post-deployment Health Assessments.

The DoD should develop a strategy for ensuring tighter coordination between losing and receiving Family Advocacy Programs (FAPs) and Commands during deployment or permanent change of station (PCS) of Service members in families with open FAP cases.

The DoD should promote a non-punitive culture that encourages help seeking for CAN and addresses the perception that CAN related struggles, if discovered, will result in career derailment.

REPORT. HEALTHY MILITARY FAMILY SYSTEMS: EXAMINING CHILD ABUSE AND NEGLECT

Child abuse and neglect (CAN) is antithetical to military readiness and to military values. As such, it must be viewed as a command and leadership issue in the Department of Defense (DoD). CAN and other forms of violence thrive on secrecy. Secrecy is tied to stigma and fear of repercussions, among other factors. Efforts must be made within the DoD to change the stigma around seeking help for struggles that lead to child maltreatment and other forms of violence. Barriers to help *provision*–which can also act to sustain maladaptive behaviors, must be proactively addressed. The phenomenon of "gaze aversion," which may manifest as the failure to see child maltreatment[§] when it has likely occurred, or to devote the necessary and appropriate resources to the problem at the systems level, is one such barrier.

The Military Health System (MHS)[**] is an essential and powerful partner in a public health approach to CAN in the DoD. In fact, health care providers[††] are the most frequent identifiers of CAN within the most vulnerable population: children ages zero to three. Medical care, both routine and specialized, offers a powerful means of accessing families who may struggle with risk factors for violence. Health care providers are also integral in care coordination, working with other agencies and offices such as the DoD Family Advocacy Program (FAP), to ensure timely responses and resources.

The MHS is a joint system of uniformed, civilian, and contract personnel overseen by the Defense Health Agency (DHA). Its mission is to provide a medically ready force and ready medical force to Combatant Commands during both peacetime and wartime.[4] Ensuring optimal health for military members and their families is an essential part of this mission.[4] The assurance of family well-being is a critical component of military readiness, enabling Service members to focus on warfighting objectives downrange.[4]

As part of its charge, the Board identified factors for military families that increase the risk of engaging in abusive and neglectful behavior toward children; reviewed existing support programs for victims of CAN in the MHS; determined mechanisms to advocate treatment options in the MHS; and evaluated the training and educational opportunities available to military health care providers to ensure that they are aware of and utilize the best available practices and resources.

[§] The term "child maltreatment" is used in this report to capture the entire scope of CAN.

[**] The MHS is comprised of the Direct Care and the Purchased Care Networks. The Direct Care Network includes all inpatient and outpatient Military Treatment Facilities across the globe. The Purchased Care Network, also referred to as TRICARE, includes providers within the civilian sector who see DoD beneficiaries. These providers may either be authorized (non-network) or network providers.

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CHILD ABUSE AND NEGLECT DEGRADE MILITARY READINESS

All forms of interpersonal violence degrade military readiness. The DoD is committed to combatting various aspects of violence, including intimate partner violence (IPV), sexual assault, and CAN. Experts contend that various types of violence tend to co-occur within the lives of individuals;[5] those that experience one type of violence are more likely to experience other types of violence. For example, CAN has been found to occur in approximately 34% of IPV cases, overall.[6] Moreover, mothers who experience abuse during pregnancy are found to be more detached from their children, leading to other variables of neglect such as missing wellness visits and decreasing the likelihood of vaccination.[6-8] More information about the relationship among different forms of violence across the lifespan can be found in the Centers for Disease Control and Prevention publication, "*Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence."*[9]

Military Life Can Put Children at Risk of Abuse and Neglect… or Build Resilience

Military life is comprised of a unique combination of stressors and potentially fortifying elements. Military families must contend with frequent and recurrent moves away from extended family or from established support networks of friends and colleagues, and with deployments leading to temporary single parenting. Moves may also hinder the ability of spouses to work, preventing the family's ability to supplement the Service member's basic pay and potentially compounding financial stress. Of note, temporary separations due to deployment have been noted by Air Force FAP as a "change in family composition" risk factor for CAN related child fatality.[10]

The deployment cycle is a unique risk factor in military families that can increase the likelihood of maltreatment.[11] Studies suggest gender-specific considerations regarding this potential maladaptive response to deployment. Female soldiers are at greater risk of engaging in child maltreatment in the six months prior to deployment, while male soldiers are at greater risk in the six months post-deployment.[12,13] Deployment periods are also associated with higher odds of physical neglect, lack of supervision, and educational neglect.[14] These findings are compelling and warrant further exploration.

The challenges of military life may have a compounding effect on already vulnerable families– particularly those in which parents are young and/or facing financial stress, two known risk factors for CAN. Indeed, CAN in the DoD is most frequently reported in the junior to mid-career enlisted paygrades of E4-E6; the highest rate of offenders for CAN are Service members in the E1-E3 pay grade who are 3.75 times more likely to have met criteria for a CAN incident.[7,15]

Military life confers benefits as well as challenges. Military families may flourish within the context of a stable, defined occupational structure and social network. An emphasis on honor, integrity, and accountability, and the camaraderie of sharing those values with others, can be unifying. Finally, the benefits that accrue to Service members, including access to an integrated system of military health care, are a substantial resource.

It is important to note that much of the research on the association of child maltreatment is retrospective. There are studies underway to engage this topic prospectively and to begin evaluating interventions. The Uniformed Services University is conducting an in-depth study on deployment and child maltreatment. The Millennium Cohort Study, an initiative that leverages the full force of the DoD integrated health care and organizational systems to evaluate specific health issues affecting the military population, is another example. Also, the Millennium Cohort Study has the capability to study issues related to child abuse and neglect within its parameters. However, such studies would require funding across multiple years.

Statistics are Variable and Must be Viewed in Context

Interestingly, available reports suggest that rates of CAN in the military are lower overall than those in the civilian sector (Table 1).[15,16] However, there are concerns about reporting accuracy in both civilian and military settings.[11] As seen in Table 2, civilian rates of maltreatment vary substantially across data sources, reflecting varied definitions, inclusion criteria, and methods of data collection. The Child Maltreatment Report, a Department of Health and Human Services compilation of cases substantiated by state Child Protective Service (CPS) agencies, is often considered a benchmark. However, findings of reports such as the National Incidence Study of Child Abuse and Neglect (NIS-4) and the National Survey of Children's Exposure to Violence (NatSCEV II) suggest that CPS rates capture only a portion of the burden of child maltreatment in the United States.

Table 1. 2017 Civilian and Military Child Maltreatment Statistics Demonstrating Likely Underreporting in the Military Population

	Civilian Sector[17]	Military Population[15]
Number of Reports of Child Maltreatment (Rate per 1,000 Children)	55.7	13.7
Victim Rate (per 1,000)	9.1	5.0
Percent Change from Prior Year	-2.4%	-5.0%
Fatalities	1,720	17
Fatality Rate (per 1,000 Children)	0.02	0.02‡‡
Fatalities Under Three Years of Age (percent)	71.8%	70.5%
Fatalities Under One Year of Age (percent)	49.6%	64.7%

‡‡ The population number used to calculate the DoD fatality rate is not reflective of the entire population of child beneficiaries within the military. Therefore, this rate may not be accurate.

Table 2. Comparative Child Maltreatment Rates per 1,000 Children Aged 0-17 Years, Department of Health and Human Services

	Child Maltreatment Report 2011[17]	NIS-4 2004-2009[18]	NatSCEV II 2011[19]
Neglect	7.9	30.6	47.0
Physical Abuse	1.8	6.5	40.0
Emotional Abuse	0.9	4.1	56.0
Sexual Abuse	0.9	2.5	22.0[§§]

Concerns have emerged regarding the accuracy of reported rates of child maltreatment in the military, as well. Two independent peer-reviewed studies from the past decade note a low linkage rate between medically diagnosed maltreatment cases among DoD beneficiaries and child maltreatment rates substantiated by the DoD's CAN program lead, FAP, relative to the civilian sector.[11,20] Linkage rates of medical cases to FAP-substantiated cases varied from 20.3% to 24.6% across the two studies. In contrast, the civilian linkage rate between medically diagnosed child maltreatment cases and CPS reports is 44%.[12] In both studies, the linkage rate for maltreatment episodes diagnosed in the Purchased Care Sector (TRICARE) of the MHS was less than half the rate for the Direct Care system (2004-2007: 9.8% vs 24.2%; 2014-2015: 16.1% vs 42.9%). These findings suggest a modest increase in FAP reporting over the past decade, with the medical treatment/FAP reporting gap most significant in TRICARE.

Reported patterns displayed in Table 3 suggest variations in the distribution of maltreatment across maltreatment types within the military and civilian sectors. While neglect is the most frequent type of CAN across both sectors, emotional abuse appears more prevalent in the military.[15,21] The prevalence of physical abuse is similar between the two sectors, while there is almost a twofold difference between sexual abuse rates, though both rates are comparatively low.[15,21,16]

Table 3. 2017 Distribution of Maltreatment across Maltreatment Categories

	Civilian Distribution[16]	Military Distribution[15]
Neglect	74.9%	57.4%
Physical Abuse	18.3%	19.7%
Emotional Abuse	5.7%	18.5%
Sexual Abuse	8.6%	4.4%

DoD's Anti-CAN Efforts Start with Family Advocacy

The FAP, comprised of an Office in the Secretary of Defense (OSD) FAP and Service-level FAP programs, is the lead for the DoD in its mission to prevent, treat, and respond to family violence in the military.[15,22] FAP is a congressionally mandated and OSD funded[21] program available on

[§§] Based on fewer than 10 cases.

every installation. It is missioned to provide policy, procedures, prevention, advocacy, training, education, and treatments for family violence throughout military communities.[15,22]

The OSD FAP provides guidance and establishes requirements for the Service FAPs, to include tracking and reporting activities,[15] through the *Department of Defense Instruction (DoDI) 6400.01*. These guidelines include an algorithm to determine met cases, which all Services have implemented. However, the guidelines were written to allow Service FAPs to enact modifications based on Service needs.[23] For example, Service FAPs use different needs assessment tools. The Air Force FAP uses the Family Needs Screener, a validated instrument, for intake of families they serve and to identify many of the co-existing issues associated with CAN.[24] The other Services use varied intake forms.

Service adoption of the recommended Incident Determination Committee (IDC) has also been variable. The IDC, an interdisciplinary committee responsible for determining which cases of suspected maltreatment 'meet criteria' for abuse and neglect, is currently used by the Navy, Marine Corps (USMC), Air Force, and the United States Coast Guard (USCG). Army currently utilizes a Case Review Committee (CRC)[25] to determine met cases. The IDC and CRC differ in the extent of comprehensive pediatric medical care provider involvement. A comprehensive pediatric medical care provider is not included as a standing member of the IDC, though they may be consulted when FAP personnel determine that medical information is needed for decision making purposes.[10,26,27] In contrast, comprehensive pediatric medical care providers are standing members of CRCs. Although the CRC model appears favorable to MHS integration into DoD CAN efforts, Army representatives report that Army FAP is moving to the IDC model.

Opportunity for medical–FAP collaboration appears to differ across the Services as a function of how FAP is designed. In the Air Force, FAP is entirely co-located within the MTF and falls under administrative control of the MTF commander. This organizational placement provides the maximum opportunity for medical collaboration. In the Army, Navy, and Marine Corps, FAP resources are partially or fully managed by the line command. Army FAP is organized in a bifurcated fashion with FAP treatment located within the behavioral health service line. Navy FAP is located in the community yet is the only FAP that provides MHS health professionals with visibility of CAN cases through documentation in the EHR.

The Marine Corps (USMC) and Coast Guard (USCG) are unique in different ways with respect to child maltreatment. The USMC does not have a medical component and is serviced by the Navy.[28] Thus, alterations in standard operating procedures (SOPs) to report or refer CAN cases are tailored and mimic the Navy FAP referral process.[28] The USCG FAP abides by the *DoDI 6400.01* but does not receive fenced funding like the other Services. Additionally, access to Family Advocacy Specialists (FAS) are only available by region instead of by installation.[29]

FAP access is a concern across all Services. FAP offices are open Monday-Friday during regular business hours.[30] Incidents that occur during nights or weekends and are known to non-FAP DoD personnel, including health care providers, are addressed by those DoD personnel and local Child Protective Services (CPS).[30] It is important to note that CPS–not FAP–makes decisions regarding removal and alternate placement of children in CAN cases, no matter what time of day

or night they occur. However, strong, timely communication and coordination between FAPs and civilian CPS agencies is vital to the safety and health of victims of abuse.

Talia's Law, passed in 2016, clarified that mandated reporters in the Armed Services must report to the appropriate CPS agency in addition to their chain of command or designated DoD point of contact.[31] However, reciprocal information sharing with the DoD by CPS was not mandated. A majority of FAPs maintain memorandums of agreement or understanding (MOAs/MOUs) with CPS agencies to promote and encourage strong coordination.[10,25,26,28] The DoD is working with the Department of Health and Human Services to increase the number of these agreements.[26] In addition, the Defense State Liaison Office has been working with states to revise their child welfare laws to require sharing of military-family relevant information with the FAP Office[10]; to date, 23 states have done so. This process could be expedited by leveraging federal authority, such as tying changes in state child welfare laws to grant funding.[32] Information related to military child maltreatment reported to civilian authorities should be routinely available to MHS health care providers, as well.

Finally, current policies do not address the impact of an open case on Service member readiness. Specifically, Service members with an open case are not prohibited from deploying, or from making a more routine Permanent Change of Station (PCS), despite implications for readiness and the potential for cases to be lost to follow up with moves across states or countries.[10,26] All Service FAPs are attempting to make the relationship of CAN offender status to deployability more explicit and to strengthen its relationship with commanding officers.

The MHS Serves an Important Role in the CAN Response, and can Do More

The DoD's medical response to CAN spans the Direct Care and Purchased Care Networks. Currently, there are variable policies and training in place for health care providers across the MHS. Gaps between requirements, policies, and procedures in the Direct and Purchased Care networks currently limit the DoD's ability to identify and address CAN early on; these gaps limit the DoD's ability to protect children, strengthen families, support positive career trajectories, and preserve the soundness of the Armed Forces.

Direct Care System: Variability in Policies, Procedures, and Execution

Health care providers in various parts of the MHS may be called upon to address CAN, such as outpatient health care providers at the MTFs, Emergency Room (ER) personnel, inpatient pediatric services, and others. While some MTFs have developed CAN instructions for outpatient providers, no standardized template is available for use across the Enterprise. Inpatient practice with respect to CAN also appears to be variable. Walter Reed National Military Medical Center (WRNMMC) developed a draft instruction for managing cases of suspected CAN, which relies heavily on social workers to provide crucial coordination.[30] Other MTFs, such as Brooke Army Medical Center (BAMC) at Fort Sam Houston, TX, are considering adopting aspects of this draft instruction.[30] Efforts to create a unified management plan to address child maltreatment may be complicated for MTFs with beneficiary pools that span

multiple jurisdictions. The same may be true for overseas MTFs due to host nation variability in CAN related beliefs, laws, and related factors.

Standardized screening and assessment tools and processes are also needed for CAN. Challenges include a lack of CAN-specific screening tools, competition with many other screening mandates, and broad, non-specific symptoms and signs which have many mimics of abuse.[12,33] Additionally, health care providers are not trained to a standardized level of competence on how to recognize and make differential diagnoses concerning CAN.[34-36]

The changing climate surrounding DHA's transition to managing all MTFs raises a number of issues related to CAN. MTFs have often had the flexibility to execute social admissions for the purposes of performing a CAN evaluation. However, closure of some smaller hospitals has led outpatient child/adolescent health care providers to send children out to Network hospitals, where there is less flexibility for this type of practice. There is concern among health care providers that this may put children at increased risk.[27] Additionally, potential reduction in health provider billets, particularly among pediatric sub-specialties, could significantly impact the availability of CAN related expertise across the Enterprise.[27]

TRICARE Health Care Providers Need Stronger Ties to the DoD to Combat CAN

TRICARE includes coverage for most CAN treatments, including mental health, hospital stays, and ER visits.[37] TRICARE will not send an explanation of benefits related to CAN to the alleged offender when there is an allegation of CAN, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).[37] In the event of a CAN-related Service member separation, the family may maintain access to TRICARE benefits for a period of time after separation.[37]

TRICARE participation agreements require providers to notify the referring MTF or military provider of any suspicion of serious harm to a beneficiary; this requirement applies to cases of child maltreatment.[37] However, TRICARE providers are not required to report CAN to FAP.[37] Finally, TRICARE does not currently mandate CAN-specific training for Purchased Care providers.[37] Standardized CAN training requirements could be included within the contracts; however, such requirements may have more impact on TRICARE network providers than TRICARE authorized (non-network) providers.[37]

MHS CAN Expertise: A Valuable Asset in Need of a Stronger Footing

Child Abuse Pediatrics (CAP) is a relatively new area of Board certification. Requirements include an additional three years of full-time fellowship in child abuse pediatrics after pediatric residency training.[36] There are 339 Board-certified CAPs in the U.S., including five in the DoD (4 uniformed and one civilian),[34] two of which are not dedicated full time to CAN. In 2019, there are two CAPs at WRNMMC, one CAP at San Antonio Military Medical Center (SAMMC), one CAP at Naval Medical Center San Diego (NMCSD) and one CAP outside the continental United States (OCONUS) at Landstuhl Regional Medical Center (LRMC).[34] Two of the five CAPs manage the Armed Forces Center for Child Protection (AFCCP), a centralized capability for expert CAN evaluation, consultation, training, and testimony for the Enterprise.

The AFCCP is an important source of expert consultation and capability for CAN response in the DoD and the MHS. In addition to the two board-certified CAPS, the staff at AFCCP includes a forensic nurse practitioner, a social worker/forensic interviewer, and administrative support. The CAPs at the AFCCP are available to MHS providers world-wide to provide consultation, evaluation, case review, training, and testimony.[34] Structural features of how the AFCCP is funded and manned limit its potential. The AFCCP, an Enterprise-wide resource, is organizationally a division under the Department of Pediatrics at WRNMMC, and competes with other priorities within that Department of Pediatrics.[27]

The majority of CAPs are senior officers and retirement-eligible. Forecasting the ability to replenish the ranks of MHS CAPs is not currently possible, as training of CAPs competes with other pediatric training needs. Proposed reductions in the available training billets for pediatric subspecialists, the category in which CAPs fall, put the sustainability of DoD CAN expertise at further risk. To help sustain these professionals, a dedicated pipeline for CAN training would allow for the maintenance and availability of this specialty.[36]

The Role of Screening for Adverse Childhood Adverse Experiences in the MHS

Adverse Childhood Events (ACEs) are stressful or traumatic childhood events that have been linked to the likelihood of future violence, including victimization and perpetration, as well as decrements to lifelong health and lack of social opportunity.[38] In the late 1990's, the original ACE study began investigating obesity but instead found a link between childhood trauma and the physical and emotional well-being of adults.[39]

The military population has a higher prevalence of ACEs than the civilian population. Findings indicate a higher prevalence of 4 or more ACEs in the military (27.3%) vs. the civilian population (12.9%).[6] These findings could suggest that some Service members join the military to escape personal problems related to ACEs, such as household dysfunction or abuse;[40] the military environment may offer greater structure and predictability than what was previously available.[38]

The Millennium Cohort Study collected information on ACEs in military personnel and determined the prevalence and impact of ACEs among 201,000 participants. In this study, neglect was the least reported (10.3%), followed by sexual abuse (11.5%), verbal abuse (26.0%), and physical abuse (33.7%).[41] In total, half of women reported childhood trauma with the largest difference reported in sexual abuse.[41] Among the conditions associated with ACEs were problems with sexual functioning, homelessness, comorbid mental disorders, poor marital quality, work-family conflict, and family dissatisfaction.[42] Several other DoD projects are also incorporating ACE screening. These include a pilot program at the Pediatric Patient-Centered Medical Home at WRNMMC, HealthySteps (described below), and site-specific screening at several other MTFs.

Universal screening for ACEs is met with some resistance. Health care providers already have mandates to screen for multiple conditions and exposures, including lead exposure, tuberculosis exposure, post-partum depression, developmental delay, autism, and others. Additional

screening mandates, without personnel support and sufficient time to administer the screening instrument, risk not being implemented. Additionally, it is important that screening for ACEs in the medical clinic is linked with services to address the results. Finally, some are concerned that reporting the results of ACE screening in the EHR may adversely affect a child's future accession to the Armed Forces, a significant concern given the increased likelihood–eight to ten-fold–that a military child will enlist in the military as an adult, compared to children from non-military families. On the other hand, ACE screening may add value to understanding military families and might merit a more comprehensive, albeit focused, implementation in the DoD. Military-specific stressors, such as long-term separations from a parent during deployment or living with the risk of parental death, may be surrogates for traditional ACEs or new and military-specific ones altogether.

Although longitudinal studies like The Millennium Cohort Study[43] demonstrate promise in identification of CAN-related risk and protective factors in the military population, more outcomes-based research is needed. According to the World Health Organization's (WHO) Global Campaign for Violence Prevention, a sound public health approach should leverage evidence-based research to answer two fundamental questions: 1) "Why does violence occur?" and 2) "Who does it affect?" After a review of the limited body of military-related CAN research, it is difficult to answer these two questions due to complex, interacting variables.[44] In 2014, the National Council's report, *New Directions in Child Abuse and Neglect*, also identified a need to develop a robust national CAN research agenda, through the use of longitudinal studies, 1) to identify the relationship between CAN causal pathways and outcomes; and 2) to monitor CAN-related program implementation.[45] For the MHS, an improved focus on rigorous, outcomes-based research studies and effective program monitoring, including the tracking of outcomes, could help inform a way ahead.

Treatment for Offenders

Each Service FAP provides treatment programs for alleged abusers, which include evidence-based counseling and rehabilitative services.[28] Each Service uses or has developed their own evidence-based prevention programs and universal curricula, yet they are similar and address similar themes such as addressing anger management, parenting skills, work stress, and family stress management. The majority of the curriculum is designed for groups but often only one or two Service members are enrolled in treatment at a time.[10] Additionally, a Service member's mission requirements or temporary duty assignments can conflict with scheduled treatments, making attendance difficult.[10] However, the greatest challenge for FAP is how Service members generally associate FAP with mandatory domestic violence treatment.[10] This stigma impacts effective large scale community prevention efforts.

More rigorous treatment programs are provided for Service members who are incarcerated for child abuse. The majority of inmates at Naval Consolidated Brig (NAVCONBRIG) Miramar are child sex offenders, and there are a large number at the U.S. Disciplinary Barracks (USDB) Leavenworth.[46] Approximately 80% of offenders at Naval Consolidated Brig Miramar have a history of trauma themselves; this finding supports the intergenerational nature and impact of CAN.[46] Those assessed to potentially be at higher risk of re-offending, based on higher ACE scores, are referred for more intense treatment or may "double-up" on treatments.[26] Since 2004,

17% of offenders on parole and 14.5% of offenders on mandatory supervised release have re-offended.[47] In comparison, the recidivism rate in the first year after release from a civilian prison is 44%.[48]

DoD Offers Many Resources That Should Be Integrated Across the Enterprise

Multiple CAN-related resources are available across the DoD, within both Military Community and Family Policy (MC&FP) (such as FAP and Military OneSource) and within the MHS. However, there does not appear to be a clear, overarching strategy to integrate these activities or coordinate their use across the Department.

Military OneSource, established in 2004, is a 24/7 call center and website that serves as a connection to information and support within the military community. Health care providers have the potential to play a larger role in raising awareness of Military OneSource. Team-based care, focused on providing Military OneSource resources, is not systematically built into military clinics where children are seen.[38] Integrating this process into providers' daily routine still poses a challenge due to time constraints.[38] The DoD also has non-medical counselors available to support those at risk for CAN. The Military and Family Life Counseling (MFLC) Program offers in-person counseling for the military community.[49] Counselors provide up to 12 sessions of free services to the community and are available both on and off the installation.[49] An October 2017 RAND report noted the positive outcomes associated with the non-medical counseling programs offered through Military OneSource and Military Family Life Counseling. This report stated that 90% of participants reported positive experiences using these programs; there was a significant decrease in problems regarding work or daily routines after receiving non-medical counseling, and over 90% of participants reported satisfaction with their counselors.[50] The military chaplain corps is another resource available throughout the DoD. Chaplains provide confidential counseling on topics such as grief, substance abuse, combat stress, and relationships.[51] Typically, chaplains are not licensed counselors or social workers; however, sessions are confidential and aim to help Service members and families.

The HealthySteps Program, initiated in 1994 by the Commonwealth Fund, is an evidence-based, interdisciplinary pediatric primary care program designed to support positive parenting and healthy development of babies and toddlers.[38] A key intervention of the HealthySteps program is inclusion of a HealthySteps Specialist, a professional with training in early childhood development, nursing, or social work, into the primary care team. The DoD is piloting the HealthySteps program in several MTFs and is currently evaluating the effectiveness of integrating the program into its services for military families. Two MTFs (Madigan Army Medical Center and NMCSD) are piloting HealthySteps; Womack Military Medical Center at Fort Bragg, NC, will be joining the pilot soon.[38] In these pilots, Child and Youth Behavioral Counselors have been trained as HealthySteps specialists and work within the MTFs.[38]

The New Parent Support Program (NPSP) is a research-supported preventive program designed to proactively address parenting concerns.[52] A 1990 Government Accountability Office (GAO) report and civilian research suggest that providing parents with education and support when a child is first born is the most effective strategy for preventing child abuse.[53] Congress initiated

funding for NPSP in DoD in 1995.[53] While NPSP has many benefits, services may not reach the most vulnerable groups because the program is voluntary. Moving to an opt-out model might extend its reach. In addition, across-the-board integration of the NPSP and FAP, under which NPSP is housed, into MTFs-either administratively, physically, or both-may provide an opportunity to extend the programs' reach.

Several other parent education initiatives have been developed by the DoD, in partnership with civilian organizations, or adopted from the civilian sector for DoD use. These have been partially integrated into a preventive CAN system by FAP, the MHS, or both. The Clearinghouse for Military Family Readiness at Penn State, in partnership with the DoD's Office of MC&FP, are developing the THRIVE Initiative to empower parents as they nurture their children from the prenatal period until 18 years of age.[54] The THRIVE Initiative includes face-to-face and online parenting programs as well as several free online resources and interactive learning modules.[54] The Period of PURPLE Crying® is an evidence-based program of the National Center on Shaken Baby Syndrome designed to educate parents about one of the major provocations for child abuse: normal infant crying.[55] The DoD has a contract allowing use of these materials. At least several MTFs offer this training to new parents in the MTF while the mother is recovering from childbirth.

The National Guard and Reserves have also developed parenting and CAN-prevention programs applicable to the entire DoD. The After Deployment: Adaptive Parenting Tools (ADAPT) intervention is a 14-week web-enhanced parenting program delivered in two-hour sessions to groups of six to 15 parents per group.[56] ADAPT was developed with the Minnesota National Guard and Reserves "to help families as they cope with the stress of deployment and reintegration."[57] The Families OverComing Under Stress (FOCUS) program is a family-centered, evidence- and trauma-informed resilience training program for military families with school-aged children.[58,59] It is now available at over 30 military installations worldwide, and is experimenting with virtual delivery of its intervention and providing targeted services to Wounded Warriors and their families.

Surveillance and Outcome Metrics Provide Essential Information

Apples and Oranges and Plums: Data and Policy Differences Hamper the Math

Tools to enable CAN surveillance in the MHS are limited. Provider-patient interactions such as interviews are supported by the EHR Tri-Service Workflow (TSWF) forms; details can be captured within free text.[33] Within this form, one question exists in order to capture family violence.[33] Using this field, the DHA data analytics team was able to sample 122,932 patients over one week and determine that providers documented asking this question to 63% of women patients[33] There is further potential to mine this data and capture other trends. Standardizing TSWF forms with CAN questions, making these forms available to other specialties outside of primary care, and enhancing the TSWF template for MHS GENESIS are possible improvements that can be made to better capture data.

It is difficult to ascertain the true prevalence of CAN in the DoD due to data gaps, including coding errors, a difference in populations served by FAP and the MHS, and related factors. FAP

serves Active duty families, while the MHS includes retirees and their beneficiaries, as well. However, MHS data is limited for beneficiaries who use the TRICARE network.

Standardization of surveillance methods and tools across the DoD is essential to fully capture the burden of the condition and to identify gaps in care across FAP and the Direct and Purchased Care networks. It is important to establish metrics and track identified variables, such as reporting compliance and health outcomes, to maintain readiness and identify areas in need of prevention efforts. Coordination of surveillance and tracking activities across the DoD is also essential.

Greater coordination is also required between the DoD and its civilian partners. Talia's Law took the first step in requiring military officials, including military health care providers, to notify CPS of suspected child maltreatment. However, the promise of increased civilian-military cooperation inherent in Talia's Law only works one way; civilian health care providers and CPS agencies are not required to report family violence or neglect cases involving military-connected children to DoD or MHS personnel. This blind spot not only can deprive families of the robust services that the MHS and the DoD can offer, but also allows issues to be lost to follow-up with PCS moves. Many military bases and their states and counties of location have developed MOUs/MOAs to ensure tight cooperation and joint tracking and support for military families affected by CAN.

CONCLUSION

The MHS is critical to the overall DoD response to CAN. The MHS and the DoD can and should standardize and tighten the ways they work together. Examples include the tracking and monitoring of data related to CAN, referring families and children to the appropriate resources when they are recognized as CAN cases through any of the DoD components, consolidating and leveraging the significant medical and Service expertise available within the system, and engaging civilian and community partners to provide the best available prevention and treatment for military connected children and families. A public health approach, including a preventive, evidence-based approach, provides an essential framework for this effort.

System-wide coordination with specialists, social workers, law enforcement, and community resources is vital in the public health approach to CAN. A successful health systems plan for CAN includes validated quality measures that are both quantitative and qualitative, and the ability to scale the plan, while still allowing for tailored approaches based on local risk factor prevalence. A coordinated, multi-sector approach to prevention is essential to changing social norms, providing quality education, including parenting skills, and intervening early. While recent U.S. Preventative Services Task Force (USPSTF) findings note inadequate evidence for primary care CAN prevention efforts in children without signs of abuse,[60] experts suggest that a preventive, universal approach may yield a greater reduction in CAN than an indicated intervention for families in which CAN has already occurred.

It is important to note that although the Board conducted a rigorous year-long investigation, it does have some limitations. A comprehensive evaluation of foreign child protection systems

around military bases OCONUS was outside the scope of the current study. In light of time limitations, the Board did not pursue a comprehensive TRICARE data set to ascertain CAN prevalence among all MHS beneficiaries. Likewise, the Board was only able to review a subset of available CAN processes and procedures at a subset of Military Treatment Facilities, rather than reviewing all MTFs and obtaining all available instructions. Importantly, the Board was not able to review the pending Defense Health Agency Procedural Instruction on Child Abuse and Neglect and does not have visibility on any planned Instructions that may address some of the challenges highlighted in this report.

After reviewing all findings and limitations, the Board concluded that it is in the best interest of the DoD to approach CAN as a public health priority. The Board holds that the DoD must embrace the health and integrity of military families as a key contributor to mission success. Existing military and civilian family support systems must be leveraged, and new initiatives that proactively engage military families developed, to prevent CAN before it happens. Replicating prevention efforts, such as home visitation programs for new parents–particularly in families with young children who are PCS'ing, or have a deployed parent–have promise in this regard.

The next section details the Board's findings and recommendations regarding Healthy Military Family Systems: Examining Child Abuse and Neglect.

FINDINGS AND RECOMMENDATIONS

The Board conducted a comprehensive evaluation to respond to its charge to recommend policies and protocols for identifying, preventing, and treating child abuse and neglect (CAN) within the Military Health System (MHS). The findings and recommendations presented below were informed by:

- A robust literature review;
- Briefings from representatives from the MHS, the Service components, and the civilian sector, including Subject Matter Experts (SMEs) focused on family violence, child maltreatment, prevention efforts, treatment options, and family readiness;
- An Assessment of current MHS and Service policies and practices related to CAN training, referrals, and reporting protocols; and
- Commentary from a session open to the general public.

The following foundational themes emerged over the course of the investigation to guide the Board's findings and recommendations:

- **A public health approach, with universal awareness and prevention as well as education, community supports, and a robust research agenda**, based on rigorous methods and comprehensive data are essential to combatting CAN.
- The **MHS is an essential and powerful partner** in a public health approach to CAN in DoD. Health care providers are typically the first point of contact outside the family and have historically been the most frequent identifiers of CAN within the most vulnerable population: children ages zero to three. Regularly scheduled well child visits provide a routine opportunity to assess risk factors and suspected maltreatment in families.
- **Coordination within DoD and between DoD and civilian partners** is essential to ensuring the safety and well-being of military children and families. This is true both in CONUS and OCONUS; the complexities of addressing CAN in overseas environments are significant.
- **Surveillance and outcome metrics provide crucial information** and must be optimized to better ascertain the scope of CAN and be more responsive to it.
- **Military unique factors** must be considered in DoD's anti-CAN efforts.

A PUBLIC HEALTH APPROACH IS ESSENTIAL TO COMBATTING CAN

Finding 1: Interpersonal violence occurs across the lifespan in varied forms. Different types of violence tend to co-occur within the lives of individuals and families. Those that experience one type of violence are more likely to experience other types of violence.

Recommendation 1: The DoD should establish CAN as a system-wide priority with a clear point of leadership. The DoD should adopt a health systems approach to combatting CAN; the Family Violence Prevention Model by Kaiser Permanente Northern California is one relevant model that could be adapted for use in the DoD. Coordination between Department efforts to

address intimate partner violence (IPV), sexual assault, CAN, and other forms of violence is recommended.

Finding 2: Stigma and system-level "gaze aversion" may contribute to the perpetuation of child maltreatment. A public health approach to CAN, including universal awareness and prevention, as well as education, is essential to combatting these and other factors that sustain CAN in DoD.

Recommendation 2:

A. The DoD should name CAN as a public health priority with resources equivalent to those allocated to other DoD public health priorities. The DHA should enact a universal awareness and prevention approach to CAN, as well as an education component.

B. An opt-out home visiting program should be provided to all families with young children and/or expecting mothers. The program could be an expanded New Parent Support Program and should use best practices as evaluated by the Department of Health and Human Services (HHS) (e.g., Nurse Family Partnership).

THE MHS IS INTEGRAL TO DOD ANTI-CAN EFFORTS

Finding 3: Health care providers play a crucial role in combatting CAN. However, they have differing levels of knowledge about CAN, depending on chosen training pathways and state requirements. Certain specialties (e.g. pediatrics, family medicine, orthopedics, ophthalmology, dermatology, emergency medicine, radiology, neurosurgery, general surgery) are more likely to encounter CAN cases first.

Recommendation 3:

A. The role of MHS providers in identifying and referring CAN cases must be optimized by developing training and outreach programs targeted to those providers most likely to see cases. The DHA should establish and conduct a regularly occurring CAN awareness campaign for all health care providers, initiate mandatory onboarding and annual training, and highlight the importance of the providers' role in anti-CAN efforts.

B. Health care education and training programs within the DoD, including undergraduate and graduate medical, nursing, dental, and medic training programs, should include instruction on the epidemiology, presentation, diagnosis, and management of CAN. The MHS should ensure specialty-specific continuing professional education and training in CAN.

Finding 4: The Family Advocacy Program (FAP) is charged with CAN-related prevention, data capture, and intervention efforts within DoD. The relationship between FAP and the MHS is variable across Services. Health care related CAN policies and procedures vary across the Services. A Defense Health Agency Procedural Instruction (DHA-PI) on CAN reporting requirements and consultation information for health care providers is forthcoming and may clarify the process.

Recommendation 4: The DHA should ensure that the forthcoming DHA-PI on CAN reporting policies and procedures for health care providers includes a requirement to report to FAP as well as Child Protective Services (CPS), and is complemented by local standard operating procedures (SOPs) for reporting. Local reporting SOPs should be tailored to the needs of the individual military medical treatment facilities (MTFs), including specifications that account for the special circumstances of CAN cases that occur overseas. The DHA should charge the Pediatric Clinical Community or Pediatric Specialty Community, or other appropriate body, with ensuring CAN procedural information is disseminated across the Military Health System. Additional policies and procedures will be necessary to standardize CAN care across the Enterprise.

Finding 5: Access to high-level CAN expertise is variable and at risk in the MHS.

A. There are currently only five Child Abuse Pediatricians (CAPs) in the MHS. They are called upon to provide services worldwide, including in remote, hard to reach areas. Telehealth/telemedicine has been utilized to extend the reach of this limited expert pool to some degree. The long-term commitment to this readiness-crucial subspecialty is uncertain and is threatened amid the MHS transformation.

B. The Armed Forces Center for Child Protection (AFCCP) provides a centralized and critical capability for expert CAN evaluation, consultation, training, forensic assessment, and testimony for the MHS. The AFCCP consists of two CAPs, a forensic nurse practitioner, a social worker/forensic interviewer, and administrative support. Funding for the AFCCP is provided by the WRNMMC Department of Pediatrics. There are consistent and long-term concerns about the sustainability of the AFCCP given the current funding model.

Recommendation 5:

A. The DoD should fund a centralized expert CAN capability at the DHA level to provide evaluation, consultation, training, forensic assessment, and testimony. This capability should incorporate the AFCCP and allow for decentralized execution of standardized expert functions.

B. The DHA must ensure that telehealth/telemedicine is readily available to all health care providers to consult with CAPs.

C. The MHS should establish a dedicated CAN specialty training pipeline at the Joint Service Graduate Medical Education (GME) Selection Board. This should not compete with other pediatric subspecialty needs for training billets.

Finding 6: There are no requirements or standardized ways to screen for CAN in the Direct or Purchased Care networks of the MHS. The electronic health record (EHR) in the MHS prompts primary care providers to ask one non-required question related to CAN and intimate partner violence (IPV). Health care providers express concern about adding another screener to the list of screening tools that are currently required.

Recommendation 6: The MHS must require evolving best practice screening for CAN in high-risk populations (e.g., children under 3; confirmed IPV).

Finding 7: The Adverse Childhood Experiences (ACEs) Family Health History and Health Appraisal Questionnaire is not a screening tool specific for CAN but could have some utility. There is concern about the impact that recording ACEs for military-connected children could have on future military accession.

Recommendation 7: The DoD should continue to evaluate the utility of ACEs in the MHS by more formally overseeing and evaluating the primary care initiatives underway at some MTFs. Input from ongoing longitudinal studies of ACEs in the DoD and civilian sector should complement this evaluation.

Finding 8: There is not a standardized systematic way to evaluate and manage suspected or confirmed cases of CAN in the MHS.

Recommendation 8: The DHA should develop and incorporate a standardized CAN assessment and management tool into the EHR workflow of pediatric and family medicine providers. Examples include the American Academy of Pediatrics (AAP) Clinical Guidelines, CAN clinical pathways of the Children's Hospital of Philadelphia, and the Child Protector App of Children's Mercy of Kansas City and University of Texas San Antonio.

Coordination within DoD and between DoD and Civilian Partners is Essential

Finding 9: Coordination between Service-level FAPs and health care providers is variable across Services and installations, due in part to differences in Service FAP models. Navigating the reporting and services required for CAN is complex. A multidisciplinary team approach with someone dedicated as the lead for CAN is essential. This model is present at some MTFs.

Recommendation 9: The MHS should require the establishment of a multidisciplinary team to address CAN cases at each MTF/installation. These teams should include personnel with medical knowledge of CAN, including conditions that may mimic child maltreatment; an understanding of Child Protective Services (CPS) protocols; 24/7 accessibility; and an ability to enter CAN related reports into the EHR.

Finding 10: The current FAP Incident Determination Committee (IDC) model has eliminated the requirement for a comprehensive pediatric medical care provider to be a member.

Recommendation 10: The DoD should reconsider requiring at least one comprehensive pediatric medical care provider to be a member of all Incident Determination Committees (IDCs).

Finding 11: Talia's Law addressed the need for CAN in the military to be reported to CPS. There is no mandated reciprocity for civilian entities such as CPS or TRICARE network providers to report CAN in military families to FAP. A growing number of states and localities have Memoranda of Understanding/Agreements (MOU/MOA) between CPS and FAP. Universal reciprocity may improve the MHS approach to CAN.

Recommendation 11: The DoD should ensure that all MTFs/installations, as appropriate, have MOUs/MOAs in place with state or local CPS agencies for bilateral information sharing on cases of CAN that occur within DoD families. Compliance with required reporting should be tracked.

Finding 12: There are internal and external prevention, treatment, and programming resources for CAN that are not well integrated and may be underutilized by military families. Resources internal to the military include but are not limited to Military OneSource, the New Parent Support Program (NPSP), and HealthySteps. Resources external to the DoD include but are not limited to accredited Child Advocacy Centers (CACs), EndCAN, and Futures without Violence.

Recommendation 12: The DHA should designate a centralized point of oversight and contact for CAN charged with (1) providing a comprehensive list of internal and external services and resources and (2) assisting with the coordination of services. The latter would include establishment of MOUs/MOAs with external entities such as CPS and the National Children's Alliance, the accrediting body for CACs. This centralized point could be the AFCCP.

Surveillance and Outcome Metrics Provide Crucial Information

Finding 13: It is difficult to establish the true incidence of CAN due to the challenges of underreporting of cases and unreliable capture of data. In the absence of adequate data, it is difficult to measure and monitor the scope of the problem.

Recommendation 13:

A. The DHA should conduct a formal epidemiologic survey to more accurately determine the scope of CAN in the DoD and establish an initial baseline against which to measure change.

B. The DoD should require and standardize documentation of all substantiated FAP cases in the beneficiary's electronic health record (EHR).

Finding 14: There are very few requirements of Purchased Care providers for how CAN cases involving military beneficiaries are detected, assessed, managed, and treated. According to the TRICARE participation agreement and the TRICARE Policy Manual, the provider must notify the referring MTF or military provider if there is any suspicion of serious harm to self or others, including cases of CAN. However, there is no tracking mechanism to ensure this occurs. TRICARE covers most CAN treatment, including mental health, hospital stays, and emergency room visits. Currently, Purchased Care (TRICARE) claims provide the only data available for identifying possible CAN cases in the Purchased Care sector.

Recommendation 14:

A. The MHS should systematically track TRICARE providers' notification of CAN to MTFs/military providers to ensure they are adhering to the language in their contracts.

B. The MHS should consider adding language to the TRICARE contract requiring TRICARE providers who suspect or treat CAN in active duty families to share information on cases with FAP, and systematically track compliance.

Finding 15: There are limited studies on CAN in the MHS from which meaningful conclusions can be drawn on short or long-term outcomes.

Recommendation 15:

A. The DoD should study CAN outcomes as a function of service branch, deployment status, gender, interventions, and other relevant variables, which may include the MHS "arm" through which services are provided, i.e., Direct or Purchased Care.

B. The DoD should support ongoing efforts, such as The Millennium Cohort Study, to track health outcomes including CAN. These efforts should receive proper funding and appropriate action should be taken when significant findings emerge.

Military Unique Factors Must be Considered in DoD's Anti-CAN Efforts

Finding 16: Military family readiness is crucial to operational readiness. CAN is antithetical to readiness. CAN is an important issue to the DoD.

A. Healthy, thriving families are critical to sustained Service member readiness and retention. CAN significantly compromises family and Service member health and well-being. Cultural and community supports for families struggling with or at-risk for CAN are essential to mission success. Many of these supports, such as Military OneSource, are available within the MHS. However, the degree to which they are utilized, and when utilized coordinated, is not consistent.

B. Aspects of military culture may influence the likelihood of CAN and reporting CAN when it occurs. Although the structure and support inherent in military service may serve as a resilience/protective factor, the focus on strength and self-sufficiency can stigmatize help seeking in the face of family challenges.

Recommendation 16: Efforts should be made to increase awareness of CAN and the services, such as Military OneSource, available in the DoD to deal with CAN. Education of Service members, including commanding officers, should be a priority within the DoD.

Finding 17: There are unique military-related risk factors.

A. Challenges inherent in military life can exacerbate the likelihood of CAN in at-risk families. Permanent Change of Station (PCS) moves can result in known identified risk factors for CAN, such as financial stressors due to underemployment of active duty spouses, loss of proximity to established support networks, and lack of continuity of care. Deployment periods may be associated with higher rates of neglect of physical needs, lack of supervision, and educational neglect. There is an association between the stages of the deployment cycle and CAN. For example, female Service members are at greater risk for child maltreatment in the six months before deployment, while male Service members are at greater risk in the six months following deployment.

B. Prevalence of CAN differs across military populations. Junior enlisted families have a higher risk profile for CAN. This may reflect their status as young parents of young children who are new to parenting. Financial stress may also play a role.

Recommendation 17:

A. The DoD should develop systems for mandatory pre-deployment and re-deployment briefings on CAN and include family violence screening in Post-deployment Health Assessments.

B. The DoD should strengthen and develop new opportunities to assist with financial stability for military families, including, but not limited to: reimbursing spouses for vocational licensures, ensuring access to high-quality licensed daycares, and increasing the value of basic-needs pay for families with children.

C. The DoD should develop a strategy for continuity of care for families with CAN and ensure tighter coordination between losing and receiving FAPs and commands during deployment or PCS of families with open FAP cases.

Finding 18: The fear of adverse career repercussions emerged as a theme when discussing the potential impact of a finding of CAN. These fears include the impact of lost military status on the family. This may compound the tendency to secrecy and lead to underreporting.

Recommendation 18: The DoD should continue to promote a culture that encourages and supports help seeking for CAN and addresses the perception that CAN related struggles, if discovered, will result in career derailment. Providing early access to programs and supports for Service members and their families, and raising awareness about the positive impact accessing such programs can have on career trajectory, is essential to the goal of reducing family violence and underreporting of CAN cases.

APPENDIX A. CROSSWALK BETWEEN TERMS OF REFERENCE OBJECTIVES AND REPORT RECOMMENDATIONS

Terms of Reference		Board Recommendations
I	Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children, as well as demographic and socioeconomic factors that affect the risk of being abused, and evaluate/identify effective interventions and metrics such as Healthy Steps and Adverse Childhood Experiences (ACEs), intended to proactively prevent abuse and aggressive behavior, and promote healthy development.	**2A.** The DoD should name CAN as a public health priority with resources equivalent to those allocated to other DoD public health priorities. The DHA should enact a universal awareness and prevention approach to CAN, as well as an education component. **7.** The DoD should continue to evaluate the utility of ACEs in the MHS by more formally overseeing and evaluating the primary care initiatives underway at some MTFs. Input from ongoing longitudinal studies of ACEs in the DoD and civilian sector should complement this evaluation. **17A.** The DoD should develop systems for mandatory pre-deployment and re-deployment briefings on CAN and include family violence screening in Post-deployment Health Assessments**.** **18.** The DoD should continue to promote a culture that encourages and supports help seeking for CAN and addresses the perception that CAN related struggles, if discovered, will result in career derailment. Providing early access to programs and supports for Service members and their families, and raising awareness about the positive impact accessing such programs can have on career trajectory, is essential to the goal of reducing family violence and underreporting of CAN cases.
II	Determine mechanisms to advocate treatment options in health care settings that address potential factors for increased risk of child abuse and neglect (i.e., mental health or relationship counseling, nonclinical counseling such as provided by Military OneSource, referral to programs focusing on socioeconomic factors	**1.** The DoD should establish CAN as a system-wide priority with a clear point of leadership. The DoD should adopt a health systems approach to combatting CAN; the Family Violence Prevention Model by Kaiser Permanente Northern California is one relevant model that could be adapted for use in the DoD. Coordination between Department efforts to address intimate partner violence (IPV), sexual assault, CAN, and other forms of violence is recommended. **16.** Efforts should be made to increase awareness of CAN and the services, such as Military OneSource, available in the DoD to deal with CAN. Education of Service members, including commanding officers, should be a priority within the DoD. **17B.** The DoD should strengthen and develop new opportunities to assist with financial stability for military

	such as food insecurity, etc.).	families, including, but not limited to: reimbursing spouses for vocational licensures, ensuring access to high-quality licensed daycares, and increasing the value of basic-needs pay for families with children.
III	Review the policies, protocols, and methods used by health providers and health care teams caring for military families to screen for child abuse and neglect, including recognizing symptoms of physical, emotional, and sexual abuse; identifying patterns indicative of child abuse and neglect; discussing child abuse and neglect; and reporting suspected child abuse and neglect to appropriate programs and authorities.	**3A.** The role of MHS providers in identifying and referring CAN cases must be optimized by developing training and outreach programs targeted to those providers most likely to see cases. The DHA should establish and conduct a regularly occurring CAN awareness campaign for all health care providers, initiate mandatory onboarding and annual training, and highlight the importance of the providers' role in anti-CAN efforts. **5A.** The DoD should fund a centralized expert CAN capability at the DHA level to provide evaluation, consultation, training, forensic assessment, and testimony. This capability should incorporate the AFCCP and allow for decentralized execution of standardized expert functions. **5B.** The DHA must ensure that telehealth/telemedicine is readily available to all health care providers to consult with CAPs. **6.** The MHS must require evolving best practice screening for CAN in high-risk populations (e.g., children under 3; confirmed IPV). **13B.** The DoD should require and standardize documentation of all substantiated FAP cases in the beneficiary's electronic health record (EHR).
IV	Review the policies related to TRICARE Network healthcare providers regarding identification of and appropriate intervention in cases of child abuse and neglect in Purchased Care. Assess how Network providers can be incentivized to work with military resources—clinical and nonclinical—to support victims of child abuse.	**14A.** The MHS should systematically track TRICARE providers' notification of CAN to MTFs/military providers to ensure they are adhering to the language in their contracts. **14B**. The MHS should consider adding language to the TRICARE contract requiring TRICARE providers who suspect or treat CAN in active duty families to share information on cases with FAP, and systematically track compliance.
V	Examine current reporting procedures outlined in Talia's Law and current military health providers'	**11.** The DoD should ensure that all MTFs/installations, as appropriate, have MOUs/MOAs in place with state or local CPS agencies for bilateral information sharing on cases of

	practices for reporting suspected child abuse and neglect to the appropriate authorities including Family Advocacy Program Offices and state child welfare services agencies[6], by noting and eliminating barriers and developing recommendations to track reporting compliance.	CAN that occur within DoD families. Compliance with required reporting should be tracked.
VI	Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.	**4.** The DHA should ensure that the forthcoming DHA-PI on CAN reporting policies and procedures for health care providers includes a requirement to report to FAP as well as Child Protective Services (CPS), and is complemented by local standard operating procedures (SOPs) for reporting. Local reporting SOPs should be tailored to the needs of the individual military medical treatment facilities (MTFs), including specifications that account for the special circumstances of CAN cases that occur overseas. The DHA should charge the Pediatric Clinical Community or Pediatric Specialty Community, or other appropriate body, with ensuring CAN procedural information is disseminated across the Military Health System. Additional policies and procedures will be necessary to standardize CAN care across the Enterprise. **8.** The DHA should develop and incorporate a standardized CAN assessment and management tool into the EHR workflow of pediatric and family medicine providers. Examples include the American Academy of Pediatrics (AAP) Clinical Guidelines, CAN clinical pathways of the Children's Hospital of Philadelphia, and the Child Protector App of Children's Mercy of Kansas City and University of Texas San Antonio.
VII	Review existing support programs for victims of child abuse and neglect in the MHS, as well as the continuity of care coordination with medical and social services to strengthen the interface between medical and non-medical communities (military and civilian).	**9.** The MHS should require the establishment of a multidisciplinary team to address CAN cases at each MTF/installation. These teams should include personnel with medical knowledge of CAN, including conditions that may mimic child maltreatment; an understanding of Child Protective Services (CPS) protocols; 24/7 accessibility; and an ability to enter CAN related reports into the EHR. **10.** The DoD should reconsider requiring at least one comprehensive pediatric medical care provider to be a member of all Incident Determination Committees (IDCs).

		12. The DHA should designate a centralized point of oversight and contact for CAN charged with (1) providing a comprehensive list of internal and external services and resources and (2) assisting with the coordination of services. The latter would include establishment of MOUs/MOAs with external entities such as CPS and the National Children's Alliance, the accrediting body for CACs. This centralized point could be the AFCCP. **17C.** The DoD should develop a strategy for continuity of care for families with CAN and ensure tighter coordination between losing and receiving FAPs and commands during deployment or PCS of families with open FAP cases.
VIII	Evaluate the training and educational opportunities available to military health providers to ensure that they are aware of and utilize the best available practices and resources, both before and after an event, and both inside and outside the MHS, to provide care to victims of child abuse and neglect.	**3A.** The role of MHS providers in identifying and referring CAN cases must be optimized by developing training and outreach programs targeted to those providers most likely to see cases. The DHA should establish and conduct a regularly occurring CAN awareness campaign for all health care providers, initiate mandatory onboarding and annual training, and highlight the importance of the providers' role in anti-CAN efforts. **3B.** Health care education and training programs within the DoD, including undergraduate and graduate medical, nursing, dental, and medic training programs, should include instruction on the epidemiology, presentation, diagnosis, and management of CAN. The MHS should ensure specialty-specific continuing professional education and training in CAN. **5C.** The MHS should establish a dedicated CAN specialty training pipeline at the Joint Service Graduate Medical Education (GME) Selection Board. This should not compete with other pediatric subspecialty needs for training billets.
IX	Assess the role and management of rehabilitative treatments/programs and wellness initiatives in place for abusers, including examining the accessibility of programs that provide support, such as mental health treatment programs, home visiting programs, social services such as family and parenting programs, and	**2B.** An opt-out home visiting program should be provided to all families with young children and/or expecting mothers. The program could be an expanded New Parent Support Program and should use best practices as evaluated by the Department of Health and Human Services (HHS) (e.g., Nurse Family Partnership).

	counseling. This review should include programs provided to military personnel incarcerated for child abuse/neglect crimes in military disciplinary facilities.	
X	Note opportunities to track health outcomes of children who were abused or neglected, including parents' ACEs, within the Millennium Cohort Family Study to determine the full impact on the MHS.	**13A.** The DHA should conduct a formal epidemiologic survey to more accurately determine the scope of CAN in the DoD and establish an initial baseline against which to measure change. **15A.** The DoD should study CAN outcomes as a function of service branch, deployment status, gender, interventions, and other relevant variables, which may include the MHS "arm" through which services are provided, i.e., Direct or Purchased Care. **15B.** The DoD should support ongoing efforts, such as The Millennium Cohort Study, to track health outcomes including CAN. These efforts should receive proper funding and appropriate action should be taken when significant findings emerge.

APPENDIX B. INTRODUCTION AND BACKGROUND

B1. INTRODUCTION

REQUEST TO THE DEFENSE HEALTH BOARD

On June 15, 2018, the Acting Assistant Secretary of Defense for Health Affairs requested that the Defense Health Board (the Board) provide recommendations to reduce the stigma and improve the prevention and management of abuse and neglect towards children in the health care setting.

Specifically, the Board was asked to address and develop findings and recommendations on the policies and practices in place to:

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children;
- Review existing support programs for victims of child abuse and neglect in the military health system (MHS);
- Determine mechanisms to advocate treatment options in military health care settings; and
- Evaluate the training and educational opportunities available to military health care providers to ensure that they are aware of and utilize the best available practices and resources.

To accomplish the objectives above, a subset of the Board was specifically tasked to:

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children, as well as demographic and socioeconomic factors that affect the risk of being abused, and evaluate/identify effective interventions and metrics such as HealthySteps and Adverse Childhood Experiences (ACEs), intended to proactively prevent abuse and aggressive behavior, and promote healthy development.
- Determine mechanisms to advocate treatment options in health care settings that address potential factors for increased risk of child abuse and neglect (i.e., mental health or relationship counseling, nonclinical counseling such as provided by Military OneSource, and referral to programs focusing on socioeconomic factors such as food insecurity, etc.).[61]
- Review the policies, protocols, and methods used by health care providers and health care teams caring for military families to screen for child abuse and neglect, including recognizing symptoms of physical, emotional, and sexual abuse; identifying patterns indicative of child abuse and neglect; discussing child abuse and neglect; and reporting suspected child abuse and neglect to appropriate programs and authorities.[61]
- Review the policies related to TRICARE Network health care providers regarding identification of and appropriate intervention in cases of child abuse and neglect in Purchased Care. Assess how Network providers can be incentivized to work with military resources—clinical and nonclinical—to support victims of child abuse.
- Examine current reporting procedures outlined in Talia's Law and current military health care providers' practices for reporting suspected child abuse and neglect to the appropriate authorities including Family Advocacy Program Offices and state child welfare services

agencies,[58] by noting and eliminating barriers and developing recommendations to track reporting compliance.

- Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.
- Review existing support programs for victims of child abuse and neglect in the MHS, as well as the continuity of care coordination with medical and social services to strengthen the interface between medical and non-medical communities (military and civilian).
- Evaluate the training and educational opportunities available to military health care providers to ensure that they are aware of and utilize the best available practices and resources, both before and after an event, and both inside and outside the MHS, to provide care to victims of child abuse and neglect.
- Assess the role and management of rehabilitative treatments/programs and wellness initiatives in place for abusers, including examining the accessibility of programs that provide support, such as mental health treatment programs, home visiting programs, social services such as family and parenting programs, and counseling.[58,62] This review should include programs provided to military personnel incarcerated for child abuse/neglect crimes in military disciplinary facilities.
- Note opportunities to track health outcomes of children who were abused or neglected, including parents' ACEs within the Millennium Cohort Family Study, to determine the full impact on the MHS.

GUIDING PRINCIPLES

The Board adopted the following guiding principles as a foundation for its review (Figure 1).

Figure 1. Guiding Principles

Overarching Principle: Military family well-being and welfare is essential to force readiness and resilience. A culture that fosters healthy and thriving families is therefore a priority for the Department of Defense (DoD). A culture of family health does not tolerate, condone, ignore, or underreport child abuse or neglect and does not stigmatize victims. It supports and enables healthy family development through advocacy efforts; community supports; mitigation of military specific exacerbating factors; diligent screening, identification, and reporting of maltreatment of any military child, anywhere; and sensitive, effective and timely treatment of child victims of abuse and neglect. The Military Health System (MHS) is an essential partner in combating child maltreatment in the DoD. Mission success depends on a coordinated system of policies, protocols, and institutional supports that foster healthy families. An effective and robust military health care system should integrate prevention, screening, identification, reporting, and treatment of maltreatment into routine care.

Guiding Principles:

1. Optimum mental health among Service members is crucial to resilience and readiness, thus to national security.
2. Victims of child abuse and neglect should not be stigmatized; an environment of support across all levels of leadership is essential.
3. Effective social and health care services for child abuse and neglect, including prevention, intervention and treatment, are reliant upon coordinated policies, protocols, and institutional resourcing that create a climate of support.
4. Institutionalized collaborations and clear referral pathways among military entities and between military and relevant civilian entities are essential to combating child abuse and neglect in military families.
5. Creating social support for families throughout the deployment cycle is necessary.
6. System-wide standardization of best practices for screening, identification, reporting, and treatment of child abuse and neglect–across both the Direct and Purchased Care Networks–is essential to enabling high quality care wherever care is received.
7. Integration of and tracking adherence to child maltreatment protocols in clinical and electronic health record (EHR) workflows, availability of high quality training, certified providers, availability and accessibility to experts, and clear data reporting elements and channels are critical strategies for addressing child abuse and neglect within routine care.

METHODOLOGY

The findings and recommendations in this report stem from a systematic review of information from the following sources:

- A robust literature review;
- Briefings from representatives from the MHS, the Service components, and the civilian sector, including Subject Matter Experts (SMEs) focused on family violence, child maltreatment, prevention efforts, treatment options, and family readiness;
- An assessment of current MHS and Service policies and practices related to CAN training, referrals, and reporting protocols; and
- Commentary from a session open to the general public.

LEGISLATIVE AND POLICY GUIDANCE

National Defense Authorization Act (NDAA) for Fiscal Years (FY) 2017 and 2019; Talia's Law

Table 4 provides a summary of legislation relevant to CAN in the DoD. This includes sections of the *NDAA FY 2017*, *NDAA FY 2019*, and *Talia's Law*. Individual state requirements for CAN protocols can be found in Appendix F.

Table 4. Legislative Provisions Regarding Child Abuse and Neglect (CAN) in the DoD

Legislation	Description
Talia's Law,[31] December 2016	Requires mandated military and civilian reporters within the DoD to promptly notify the appropriate State Child Protective Services (CPS) agency of suspected instances of CAN.
NDAA FY 17 Section 575. Reporting on Allegations of Child Abuse in Military Families and Homes[61]	The following information shall be reported immediately to the FAP office at the military installation to which the Service member is assigned: • Credible information that a child in the family or home of the member has suffered an incident of child abuse. • Information learned by a member of the Armed Forces engaged in an allegation that gives reason to suspect that a child in the family or home of the member has suffered an incident of child abuse. Reports are required to the appropriate child welfare services agency or agencies of the State in which the child resides. The Attorney General, The Secretary of Defense, and the Secretary of Homeland Security (with respect to the Coast Guard when not operating as a service of the Navy) shall jointly, in consultation with the chief executive officers of the State, designate the child welfare service agencies of the State that are appropriate recipients of reports pursuant to this subsection.

	Mandated reporters for suspected child abuse include all service members of the Armed Forces and civilian professionals working within schools, child development centers, chaplains, and/or performing duties and engaging in activities for the Armed Forces and their dependents.
NDAA FY 2019 Section 578. Pilot Program for Military Families: Prevention of Child Abuse and Training on Safe Childcare Practices[63]	A pilot program shall be conducted outside of FAP to assess the benefits of universal home visits that provide training to military families on safe childcare practices and links to community resources. Program goals include assessment of risk factors for, and reduction of fatalities due to, child abuse and neglect.

Policy Guidance

The DoD and the Defense Health Agency (DHA) have issued instructions that address family violence, including CAN and domestic violence, across the Services; these are detailed in Table 5.

Table 5. The DoD/DHA Instructions Regarding Child Abuse and Neglect (CAN)

The DoD Instructions	Description
The DoD Instruction 6400.01, "Family Advocacy Program," February 13, 2015. Amended April 5, 2017[23]	The DoD Instruction 6400.01, FAP reissues the DoD Directive (DoDD) 6400.01 as an instruction and establishes policy and responsibilities for child and domestic abuse through the FAP. These include CAN awareness, prevention and intervention, reporting procedures, treatment, and collection/entry of data into a central child abuse and domestic abuse registry.
The DoD Instruction 6400.07, "Standards for Victim Assistance Services in the Military Community," November 25, 2013[64]	The DoD Instruction 6400.07, "Standards for Victim Assistance Services in the Military Community" establishes the Under Secretary of Defense Personnel and Readiness (USD[P&R]) responsibilities with respect to, and outlines policy, responsibilities, and standards for, victim assistance within the military community. This instruction also initiates the DoD Victim Assistance Leadership Council ("the Council"). The instruction outlines the role of victim assistance, the approach that victim assistance personnel should adopt, and the types of skills that they must possess.

The DHA Procedural Instruction	In process. This instruction will address how to make a report of suspected CAN both within the DoD and to external CPS agencies, consistent with CAN reporting requirements under 34 U.S. Code § 20341 and Talia's Law. This instruction will include contact information for the local or state entity that will receive the report. This instruction will also include information about expert resources within the DoD.[65]

B2. BACKGROUND

A 2017 DoD report on CAN and domestic abuse in the military for FY 2016[15] noted a slight increase among military children in the year-to-year rate of reported incidents that met criteria for CAN between FYs 2009 to 2014. A subsequent review, released in April of 2018 for FY 2017, attributed these increases to data process improvements rather than a true rise in child maltreatment rates.[15] Consistent with this interpretation, results indicate a 5% decrease in reported incidents of CAN in the DoD in FY17.[15]

Figure 2. Number of Military Children

Leadership remained concerned, however, about the health and well-being of military children and about the potential impact of stigma and knowledge deficits on CAN reporting and treatment seeking. In June of 2018, the Board was asked to review the policies and practices in place to prevent, detect, assess, and treat abusive behavior and the resulting injuries that occur in military families.

This charge reflects the Department's view of child maltreatment as antithetical to healthy development and inconsistent with military values. It underscores the importance of military family well-being, both for its own sake and as "an important indicator of the well-being of the overall force."[66(p.1)] The DoD acknowledges that military families, including military children, serve alongside the Service member (Figure 2).[67] In 2018, Ms. Stephanie Barna, Senior Advisor to the USD(P&R), stood before the United States Senate Armed Services Subcommittee on Personnel to underscore the family's unique and important role in military life, and the importance of caring for and protecting its youngest and most vulnerable members.[68]

> "The entire enterprise is committed to seeking efforts to develop and implement processes and practices that provide the highest caliber of support for families, especially those impacted by domestic abuse and child maltreatment."
> *Ms. Stephanie Barna, Senior Advisor to the USD(P&R)*
> *To the United States Senate Armed Services Subcommittee on Personnel, 2018*

Families confront numerous challenges as part of military life: periodic moves, extended separations, and anxiety about the safety of loved ones. Through it all, they are an important source of support for deploying, returning, and wounded Service members; in some instances, families are called upon to "survive fallen heroes."[66(p.1)] The contribution of family health and adjustment to readiness cannot be understated. When families are strong, Service members can devote more of their attention and energy to the mission at hand. When families are weakened from outside or within the family, Service member effectiveness may be compromised. Family crises can also precipitate early returns from deployment and relational challenges can negatively impact a Service member's return home.[69]

Figure 3. National Child Abuse and Neglect Data

- In the civilian sector, health care providers provide 27.3% of CAN reports for children under 1 year old.
- According to national level data, 28% of child maltreatment victims are younger than 3 years old, with 2.5% under 1 year old.
- Over 70% of abuse and neglect related fatalities occur to children under 3 years old, with 50% of victims under 1 year old.

Health care providers play a crucial role in combatting CAN. In the civilian sector, health care providers comprise the largest percentage (27.3%) of reports of CAN for children younger than one year old.[16(p.19)] The significance of this observation becomes apparent when juxtaposed against the finding that young children are most at-risk for abuse and neglect.[16] National level data, summarized in Figure 3, indicate that over 28% of child maltreatment victims are younger than three years old, with 2.5% of victims under one year of age.[16] More significantly, over 70% of abuse and neglect related fatalities occur in children three years old or younger; just under half (49.6%) were less than one year of age at time of death.[16] Given these sobering statistics and the Department's commitment to military family readiness, the MHS must train and equip its providers to prevent, identify, and treat child abuse and neglect.

Defining Abuse

The Child Abuse Prevention and Treatment Act (CAPTA) 2010[70] established minimum federal standards for state level definitions of child maltreatment, which is consistent with the DoD definition. Beyond CAPTA, definitions of child abuse vary across states and between the military and civilian sector.[71-76] Definitions also vary in countries that host U.S. military installations.[77] Inconsistent definitions introduce variability into screening and data capture, and complicate efforts to determine cases and quantify incidence of maltreatment.[78]

The DoD has sought to strengthen the validity of surveillance throughout the Department[15,73] by creating universal definitions and a standardized reporting protocol for child maltreatment across Services.[73-75] The Services are able to tailor these standards to address unique needs and demands of installations and to accommodate the varied Service missions.[73] More detail about each Service's protocol can be found in Appendix D.

The *DoD Instruction 6400.06* provides the definition of child abuse as "the physical or sexual abuse, emotional abuse, neglect of a child by a parent, guardian, foster parent, or by a caregiver, whether the caregiver is intra-familial or extra-familial, under circumstances indicating the child's welfare is harmed or threatened. Such acts by a sibling, other family member, or other person shall be deemed to be child abuse only when the individual is providing care under express or implied agreement with the parent, guardian, or foster parent."[79(p.33)] Subtypes of abuse and neglect within the DoD definition are discussed below. These categories are used across all states in the civilian sector, but definitions may vary.

Physical Abuse

Physical abuse is defined as "intentional physical injury (including death) to a child inflicted by a parent, caregiver, or the person with responsibility over the child."[80,81] The status of corporal punishment within this definition has not been universally determined. Corporal punishment includes "physical force used and intended to cause some degree of pain or discomfort, however light, as well as non-physical forms of punishment that are cruel and degrading."[81] Fifty-three countries have declared corporal punishment to be against the law and 18 host a U.S. military installation.[81,82] However, it is currently legal across the U.S. and Canada[81] and is not uncommon. According to a 2012 study, "48% of adults [in a nationally representative sample] reported a history of physical punishment; having something thrown at them or being pushed, grabbed, shoved, slapped, or spanked, without having experienced more severe physical or sexual abuse."[83(p.185)] Research has linked the use of harsh physical punishment in the absence of child maltreatment in the general population to the incidence of mood disorders, anxiety disorders, substance use/dependence, and personality disorders.[83(p.184)] Public health researchers note that from a social determinants of health perspective, reducing physical punishment may reduce the prevalence of mental disorders in the general population.[83(p.191)] To realize these benefits, health care providers must educate their patients about this relationship.[83] Advocates for outlawing corporal punishment in the U.S. call this type of 'discipline' a form of interpersonal violence; further, they classify its legality as a violation of the right to equal protection under the law.[81]

Abusive head trauma (AHT), also known as shaken baby syndrome,[84] is a particular type of physical abuse. AHT may result in permanent neurologic disability, mental retardation, lack of oxygen, and skull fractures or fractures to other bones such as the ribs, collarbone, and limbs.[84] In the most extreme cases, such trauma can result in death.[84] Research suggests a higher rate of AHT in the military compared to the civilian population.[34,85] Findings indicate that infants born to single mothers were 3.1 times more likely to experience AHT and infants born to dual military families were 2.5 times more likely to experience AHT.[85]

Child abuse homicides are rare but their price far exceeds their rate of occurrence. In about 80% of cases of child homicide, one or both parents are the perpetrator(s) ("filicide").[86] In one such case, five-year-old Talia[31] Williams was beaten and killed by her father, an Army specialist stationed at Wheeler Army Airfield in Hawaii, in 2005. Subsequent investigation revealed that various individuals failed to report Talia's case to state CPS, depriving the family of state intervention. Legislation entitled "Talia's Law" was passed in 2016 to require the DoD mandated reporters to report suspected cases of child abuse and neglect to the appropriate state CPS agencies.[87]

Sexual Abuse

Sexual abuse "includes any involvement of a child in a sexual activity to provide the offender with sexual gratification or financial benefit, such as forcing the child to engage in sexual acts or pose for child pornography."[72, (p.2)] One study conducted a meta-analyses to examine the prevalence of sexual abuse and the results varied widely–from 2% to 62%–due to differences in "definition of abuse, method of data collection, and type of sample assessed in the general population."[88(p.350)] Findings indicate that approximately 80% of sexual abuse in males occur outside the family, while approximately 67% of sexual abuse in girls occur within the family.[89]

A history of physical or sexual abuse during childhood is strongly associated with a lifetime of psychopathology, including higher rates of depression, post-traumatic stress (PTS), anxiety, and substance use, among other emotional disorders.[90] The trauma of sexual abuse can also lead to interpersonal difficulties such as relationship distress or poor sexual functioning. Childhood sexual abuse occurring within the immediate family is associated with poorer long-term outcomes in adulthood, especially if the abuse involved the use of force.[91] Findings suggest a stronger relationship between psychiatric illness and history of childhood maltreatment for women than men.[90] However, strong emotional support and learning healthy coping mechanisms can help to mitigate poor outcomes for either gender.[91] Pediatricians are the most likely providers to identify sexual abuse even though over half of sexually abused victims do not report their abuse until adulthood.[92] The role of the comprehensive pediatric medical care provider is to assess and report suspected abuse, educate parents, coordinate referrals accordingly, and perform follow-up visits.[93] Additionally, prevention is essential to addressing the problem of sexual abuse.[91] Prevention may include teaching the victim assertive interpersonal skills, or raising awareness about risk-assessment, intervention, and treatment strategies that target patient history and emotional development.[91]

Notably, research shows high rates of sexual trauma among military women. Prevalence estimates obtained in a 2006 systematic review of childhood sexual abuse among female military personnel and veterans ranged from 42%-49%; civilian estimates ranged from 23%-33%.[91] In addition, female veterans reported experiencing childhood sexual abuse for longer durations, including into adulthood, and more often by a parent than non-veterans reported.[91] These results suggest that some in these circumstances women may choose to enter the military to escape unsafe families or environments.

Emotional Abuse

Emotional abuse is defined as "any act or omission, not including physical or sexual abuse, which caused or had the potential to cause adverse effects on the child's psychological well-being. It includes but is not limited to verbal abuse, child exposure to violent acts"[72,76] and emotional neglect.[76(p.1433)] The definition for emotional abuse/neglect lacks standardization and varies widely throughout the U.S. When the CAPTA was enacted in 1974 to ensure the development of programs and services for abused children and their families, specific definitions were given for certain types of maltreatment (e.g., sexual abuse), but no definition was provided for emotional abuse.[88,92] The American Professional Society on the Abuse of Children (APSAC) has since deemed six parental behaviors as emotionally abusive: scorning, terrorizing, isolating,

exploiting/corrupting, denying emotional responsiveness, and mental health/medical/legal neglect.[92] An alternative and complementary research framework identified the following elements as emotional abuse/neglect: the failure to provide adequate cognitive stimulation for development, failure to assure timely attendance at school, or failure to respond to requests for involvement at school through teacher conferences and other activities intended to support children's academic growth.[76] Given the absence of a standardized definition for emotional abuse, prevalence is difficult to determine. However, the potential impact on the victim's emotional health and well-being, and the likelihood of co-occurring neglect and physical [92] or sexual abuse, is significant.

Neglect

In 2007, CPS investigations determined that approximately 59% of U.S. child maltreatment victims were victims of neglect, and approximately 34% of CAN-related fatalities were attributable to neglect.[94] Other findings identify neglect as the most prevalent type of child maltreatment, both historically and today.[76,95] However, some argue that the prevalence of neglect is hard to calculate due to broadly defined terms leading to tracking challenges.[94] Neglect is a difficult concept to define and measure, due in part to an overly simplistic dichotomous characterization, i.e., neglect or no neglect. It is often conceptualized as "the absence of a desired set of conditions or behaviors, as opposed to the presence of an undesirable set of behaviors,"[94(p.609)] but may be better understood as a continuum. Defining neglect is made more complex by the context in which it occurs. It can be difficult, for example, to determine if apparent neglect is due to parental omission or to a paucity of social, economic, social support, and psychological treatment resources. Public policies that aim to reduce systemic correlates of neglect, like poverty, highlight the relationship of social stressors to child maltreatment.[94]

Supervisory neglect is the "failure of a parent or caregiver to provide adequate supervision of and/or safety precautions for a child based on the child's age and abilities."[96(p.746)] Supervisory neglect may result in unintentional drowning, smoke inhalation, asphyxia, unintentional gunshots, head trauma, poisoning, and accidental electrocution. Inadequate supervision is the most highly reported neglect-related CPS incident and is responsible for majority of "injury-related deaths among children under 6 years of age."[97(p.208)] Of note, however, "supervision issues are not commonly documented in the emergency department record."[97(p.208)] Child neglect is not easily assessable due to the lack of screening measures available for parents. Currently, structured interviews are the recommended methodology for assessing neglect.[78]

Within the DoD, child neglect is defined as "acts or omissions by an individual responsible for the child's welfare under circumstances indicating the child's welfare is harmed or threatened."[15(p. 15)] Neglect includes conditions that lead to non-organic failure to thrive, medical neglect (failure to provide medical or dental care for the child), and abandonment. Comparative studies demonstrate lower rates of neglect (but higher rates of physical abuse) in the military population than among civilians.[85,98,99] Periods of deployment appear to be a time of increased risk for child neglect. One study found that child neglect increased by 124% in families in which a parent was deployed.[73] The same study found that the rate of child neglect for female civilian parents was almost 4 times greater when the active duty spouse was deployed than when the

spouse was at home.[73] The impact of military-specific factors on child abuse and neglect are addressed in Appendix C.

Civilian and Military Statistical Trends in Child Maltreatment: A Comparison

Child Maltreatment in the Civilian Sector

Incidence and prevalence data regarding CAN vary across sources due to definitional inconsistencies, study methodology and populations sampled, and non-standardized tracking and reporting systems across states. This section highlights three high-level reports with differing methodologies to determine the rate of child maltreatment in the U.S. Table 6 displays these comparative child maltreatment rates from the *Child Maltreatment Report*, the National Incidence Study of Child Abuse and Neglect 4 (NIS-4), and the Second National Survey of Children Exposed to Violence (NatSCEV II).

Table 6. Comparative Child Maltreatment Rates per 1,000 Children Aged 0-17 Years, Department of Health and Human Services[ix]

	Child Maltreatment Report 2011[17]	NIS-4 2004-2009[18]	NatSCEV II 2011[19]
Neglect	7.9	30.6	47.0
Physical Abuse	1.8	6.5	40.0
Emotional Abuse	0.9	4.1	56.0
Sexual Abuse	0.9	2.5	22.0[x]

The Department of Health and Human Services (HHS) amalgamates information from states and other sources to produce two key publications regarding child maltreatment in the U.S., the *Child Maltreatment Report* [80] and NIS-4.[100] The *Child Maltreatment Report*, an annual publication, leverages data collected through the National Child Abuse and Neglect Data System (NCANDS). NCANDS is a voluntary database of official, state-level maltreatment data submitted by CPS agencies across the U.S. and Puerto Rico.[80] Collected data include the number of cases overall that are "referred" to CPS; the number of referrals that reached the level of a "report" (i.e., are "screened in" or deemed appropriate for a CPS response) and those that are "screened out." The greatest limitation to this approach is that reports are contingent upon accurate event reporting to CPS. Therefore, factors such as stigma, poor training in maltreatment identification, and duplicate event reporting significantly impact reported rates.[10,25,26]

The NIS, in contrast, is produced once every 10 years and collects data from a wider range of sources to capture reported, reported but screened out, and non-reported instances of child maltreatment. Using a combination of CPS, law enforcement, and professional agencies, NIS attempts to capture data for maltreatment cases that are not reported to CPS. NIS-4 recruitment

[ix] Earlier reports were used to show a more direct comparison of rates.
[x] Based on fewer than 10 cases.

for sentinel agencies and sources began in 2004, with actual data collection occurring in two 4 month segments (September to December 2005 and February to May 2006).[101] Analyses and congressional report creation ended in 2009, thus the NIS-4 study is commonly referenced as NIS-4 2004-2009.[101] The NIS results suggest that child maltreatment is more widespread and significant than CPS statistics indicate. It is important to note that the percentage of unreported events that would be judged by existing CPS standards to warrant action is unknown. The NIS-4 study faces similar limitations as the *Child Maltreatment Report*. Law enforcement, CPS, and professional agencies must volunteer to submit data/reports, which are subject to errors in identification, duplication, and underreporting.[100] However, it does aim to capture cases that may meet the definition of maltreatment, but do not reach CPS.

The NatSCEV project also aims to address this issue, but uses a significantly different approach. The NatSCEV, a joint effort of the U.S. Department of Justice and the Centers for Disease Control and Prevention (CDC), provides further data about child maltreatment (and other forms of violence against children) occurring outside of or in addition to official reporting channels.[19] The NatSCEV II data were obtained through telephone administration of the 2011 Juvenile Victimization Questionnaire to a population of 4000 children aged 0-17. Results indicate that nearly one in four (24.9%)[19] children experience maltreatment in their lifetimes. However, there are limitations in this methodology. Data collection relied on participant disclosure of events, which may have been over or understated. Furthermore, participants, particularly caregivers, may be unaware of maltreatment performed by other individuals or define maltreatment differently than government agencies, leading to disparities between incidence/prevalence reported by NIS or HHS. Conversely, by interviewing participants directly, this approach does have the potential to capture unreported or equivocal cases of maltreatment that do not reach official agencies.

Civilian Sector Benchmarking for Comparison with the DoD

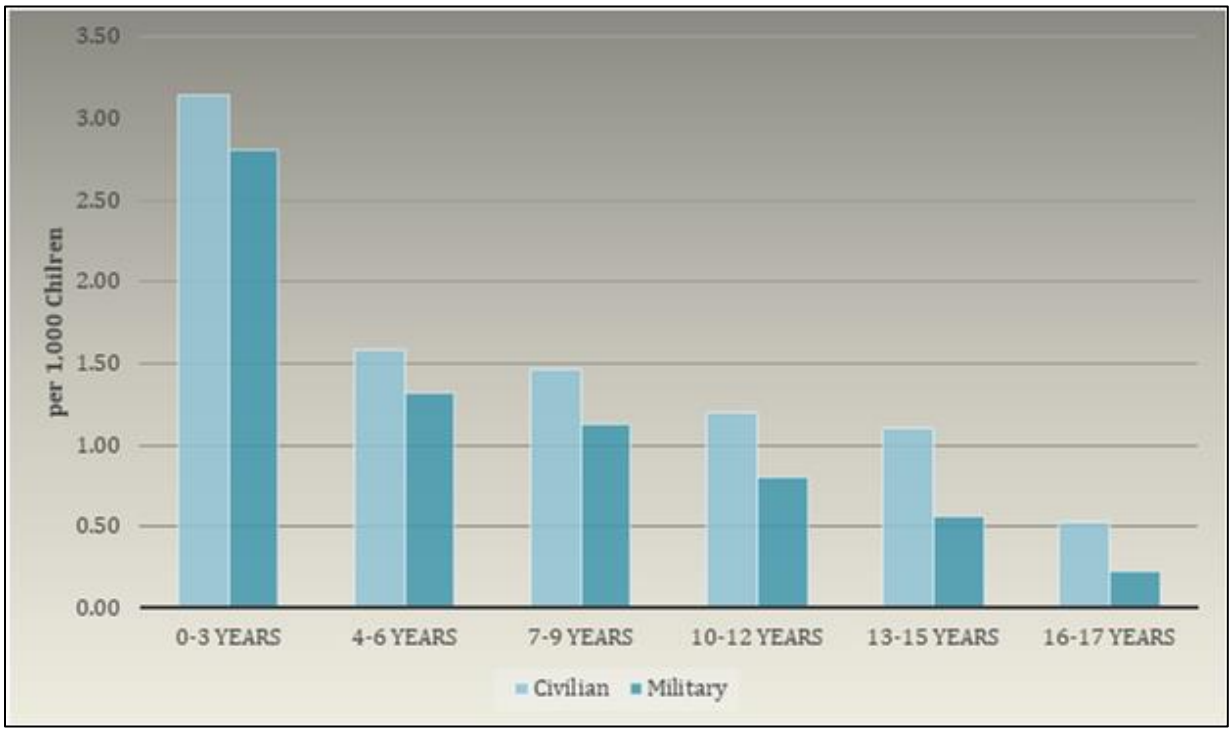
The compilation of official data sets from CPS agencies into an annual report, such as the *Child Maltreatment Report*, most closely mirrors the approach to child maltreatment surveillance and reporting in the DoD. (More information about the DoD processes will be provided in Appendix C.) While this CPS data provide the best benchmark for the DoD,[21] any comparison of CPS and the DoD data is imperfect due to varied missions, different methods for gathering data and non-standardized definitions, and criteria for met cases across states and the military.[21] With this caveat in mind, *Child Maltreatment Report* data from this report will be used for comparison purposes for the remainder of this report. A summary of CPS statistics is provided in Figure 6.[102,xi]

In 2017, 4.1 million referrals involving more than 7.4 million children were made to CPS. Approximately 2.4 million of those referrals, or 57.6%, reached the level of a "report," i.e., were "screened in" or deemed appropriate for a CPS response.[102] Of the 3.5 million children who were subjects of a CPS response, 674,000–including 1720 fatalities–were classified as victims with "substantiated" or "indicated" reports.[102] This figure amounts to a national victim rate of nine out of every 1000 children in the United States. The majority of children in this group were

victims of neglect, followed by physical, and then sexual abuse (74.9%, 18.3%, and 8.6%, respectively).[102] This distribution is generally consistent with prior years.

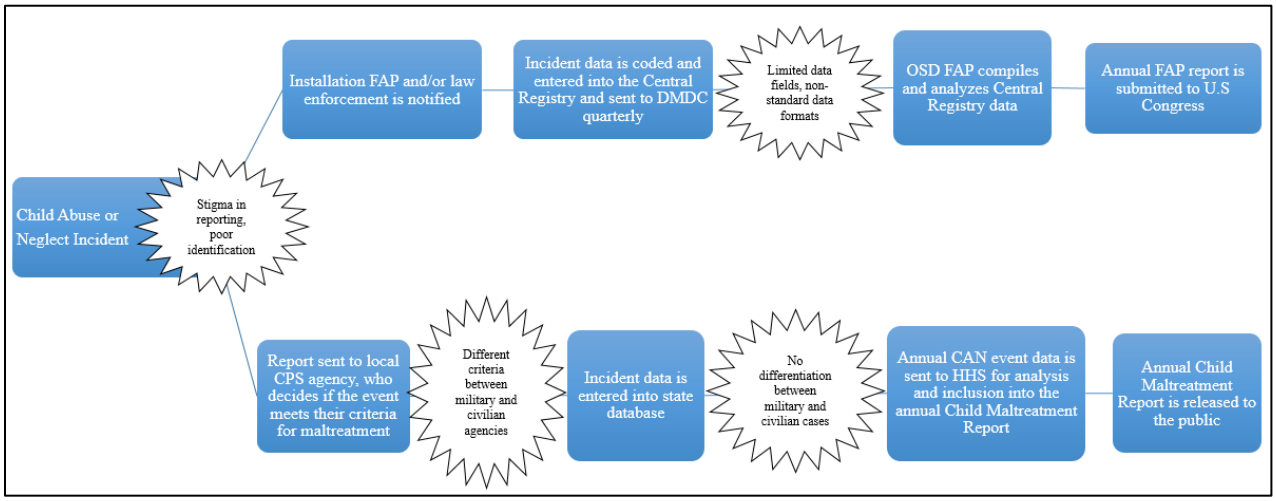
As illustrated in Figure 4, young children are most at-risk for abuse and neglect. More than 70% of child maltreatment fatalities were three years old or younger; just under half (49.6%) were less than one year of age. In total, 2.5% of child maltreatment victims are less than one year old and 28.5% are younger than three.[16] See Table 8 for rates distributed by maltreatment type.[21]

Figure 4. Comparison of "Met Criteria" Case Rates per 1,000 Children[15,102]



It should be noted that a significant limitation of comparing CPS and FAP data is that some military cases are included in the total number of CPS cases reported to HHS. Per Talia's Law, military installations must report all cases of suspected child maltreatment to the local CPS agency. Unfortunately, military and civilian cases are not differentiated when CPS data is submitted for the Child Maltreatment reports. Therefore, incidence rates reported in the Child Maltreatment reports include both military and civilian cases (Figure 5).

Figure 5. Child Abuse and Neglect (CAN) Data Flow for Family Advocacy (FAP) and Child Protective Services (CPS) Reports of Suspected CAN of Military-Connected Children[10,15,25,26,28,102]

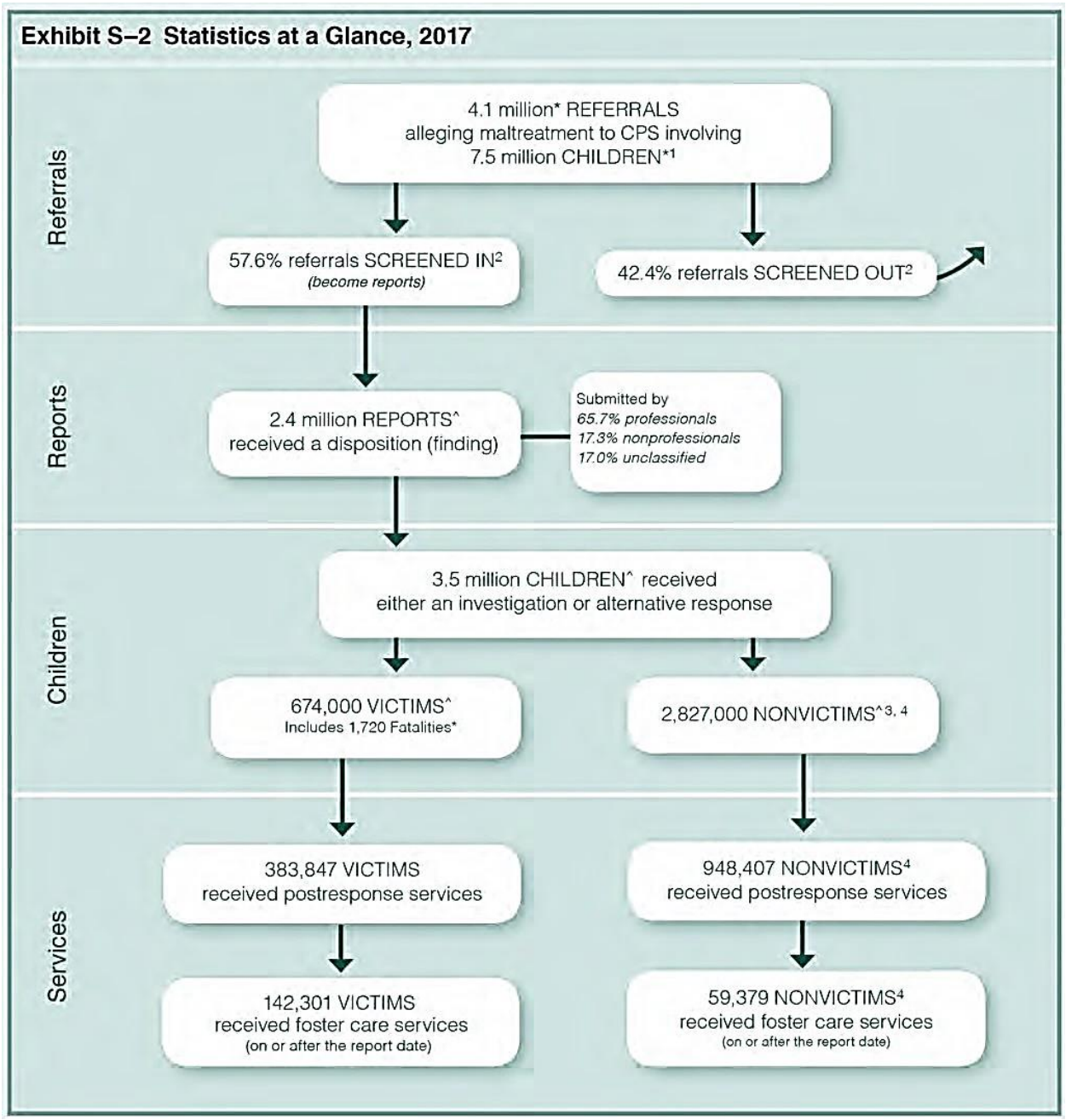


DMDC - Defense Manpower and Data Center; OSD - Office of Secretary of Defense; HHS - Health and Human Services

Maltreatment risk does not vary by gender (49% boys versus 51% girls).[16] With respect to race and ethnicity, rates are highest for American Indian or Alaska Native (14.3 per 1,000) and African American children (13.0 per 1,000) and lowest for Asian children (1.6 per 1,000).[103] It is important to note that these rates may reflect factors other than incidence; studies indicate that cultural differences in reporting practices and views on what constitutes abuse vs. discipline may impact recorded incidence rates.[103] Cultural considerations for CAN are addressed in Appendix C.

Referrals to CPS grew from 2013 to 2017, yielding a 10% increase in "screened-in" referrals (i.e., reports) and a 2.7% increase in the number of victims (656,000 to 674,000).[16] Note that this victim increase may not be due to an overall population increase as there was only a 0.09% difference in the total population of the reporting states' child population between 2013 and 2017.[102] Health care providers comprised the largest percentage of reporters for children younger than one (27.3%);[16] legal and law enforcement were the most frequent reporters for children ages one through four; and educational personnel were the most frequent reporters for children older than four. Screened-out referrals also grew at a rate of 18.8% over the five-year period.[16] Of note, reasons for screening-out cases vary across states, but may include a child being the "responsibility of another agency or jurisdiction, i.e., military installation or tribe."[16(p.6)]

Figure 6. Child Maltreatment Statistics, 2017[16]



Indicates a nationally estimated number. ^ indicates a rounded number. Please refer to the relevant chapter for information about thresholds, exclusions, and how estimates were calculated. 1. The average number of children included in a referral was 1.8. 2. For the states that reported both screened-in and screened-out referrals. 3. The number of unique non-victims was calculated by subtracting the unique count of victims from the unique count of children. 4. Includes children who received an alternative response.

Child Maltreatment in the Department of Defense

Within the DoD, each Service maintains comprehensive clinical case management systems, which include mandatory, but limited, data elements for CAN cases that have "met criteria"

established by an Incident Determination Committee (IDC). Each Service submits required data quarterly to the Central Registry maintained by the FAP, the DoD agency responsible for collecting data on family violence.[21] The aggregated data are reported annually, as required by *NDAA FY 2017 Section 574*.[15] More information on data collection and reporting protocols for child maltreatment in the DoD can be found in Appendix C. Reported rates of child maltreatment in the DoD are presented in Table 7, along with civilian rates for comparison. Statistics suggest that rates of child maltreatment are lower in the DoD than in the U.S. civilian population.[80]

In 2016, 12,849 cases of suspected CAN were reported to FAP. Approximately half of those cases (6,450; 50.2%) met criteria for CAN.[15] More than half (55.9%) of all victims of child maltreatment in the DoD were less than six years of age.[15]

Within the last FY, the DoD rate of reported CAN decreased by 5 percent.[15] In FY17, approximately 3,528 of the cases that met criteria for CAN incidents involved child victims who were age five or younger.[15] The most frequently reported paygrades of Service member whose families are involved in CAN are the junior to mid-career enlisted paygrades of E4-E6.[15] E1-E3 Service members are 3.75 times more likely to have met criteria for a CAN incident.[15] There were 17 child abuse-related fatalities involving 23 offenders that were taken to the IDC and entered into the central registry in FY17.[15] All victims were under five years old, and 64.7% of the child victims were one year old or younger, as shown in Table 7.[15]

Table 7. 2017 Civilian and Military Child Maltreatment Statistics

	Civilian Sector[16]	Military Population[15]
Number of Reports of Child Maltreatment (Rate per 1,000 Children)	55.7	13.7
Victim Rate (per 1,000)	9.1	5.0
Percent Change from Prior Year	-2.4%	-5.0%
Fatalities	1,720	17
Fatality Rate (per 1,000 Children)	0.02	0.02[xii]
Fatalities Under Three Years of Age (percent)	71.8%	70.5%
Fatalities Under One Year of Age (percent)	49.6%	64.7%

As indicated in the maltreatment distribution categories in Table 8, the greatest percentage of met cases within the military population concerned neglect (57.4%), followed by physical abuse (19.7%), emotional abuse (18.5%), and sexual abuse (4.4%). The distribution of types of maltreatment is fairly consistent across the DoD and the civilian sector. However, neglect and sexual abuse are reported more frequently in the civilian sector than to the DoD FAP, while emotional abuse is reported much more frequently in the DoD (18.5%) than in the civilian sector (5.7%). Rates of physical abuse appear to be similar across populations. It should be noted that current FAP data do not include maltreatment types subdivided by age, further limiting risk factor analysis.[21]

[xii] The population number used to calculate the DoD fatality rate is not reflective of the entire population of child beneficiaries within the military. Therefore, this rate may not be accurate.

Table 8. 2017 Distribution of Maltreatment across Maltreatment Categories

	Civilian Distribution[16]	Military Distribution[15]
Neglect	74.9%	57.4%
Physical Abuse	18.3%	19.7%
Emotional Abuse	5.7%	18.5%
Sexual Abuse	8.6%	4.4%

Some researchers suggest that child maltreatment may be under-reported in the DoD. A study performed by the Children's Hospital of Philadelphia (CHOP) found a low linkage rate between medically diagnosed maltreatment cases and substantiated FAP reports.[11] Using medical claims data from the Army Central Registry and the TRICARE Management Activity's Patient Administration Systems and Biostatistics Activity system, 5,945 maltreatment episodes related to Army dependents aged 0-17 were analyzed to determine the relationship between child, episode, soldier characteristics, and associated substantiated FAP reports.[11] Of these cases, only 20.3% of diagnosed maltreatment incidents had a substantiated FAP report, with most substantiated cases categorized as physical abuse.[11] In contrast, some research has shown a 44% linkage rate between CPS reports and medically diagnosed child maltreatment in civilian populations.[12]

Incidents involving military-dependent children diagnosed in civilian facilities were less likely to have a related FAP report than incidents diagnosed in military medical treatment facilities (9.8% versus 23.6%). This may reflect the lack of an established feedback loop for the DoD beneficiaries who seek care in the civilian sector and a lack of civilian familiarity with FAP and military reporting procedures. Reporting may be further impacted by stigma surrounding emotional, behavioral, and family challenges and treatment seeking among military personnel.[71,104] FAP is commonly associated with the command structure and law enforcement, which may lead to concerns about the impact of help-seeking on a military career and/or reputation within in the community.[21]

B3. Risk Factors

Crying is a common trigger for child abuse and is the most common driver of AHT or shaken baby syndrome.[84] Other common triggers for maltreatment include the "seven deadly sins of childhood: colic, awakening at night, separation anxiety, normal exploratory behavior, normal negativism, normal poor appetite, and toilet-training resistance."[105(p.834)] Children with physical, developmental, or emotional/behavioral disabilities, and those who are unplanned or unwanted, are at increased risk of maltreatment.[16,105] Additionally, children aged zero to three have been found to be the most vulnerable population at-risk for maltreatment and related fatality.[16,105]

Parental risk factors include low self-esteem, poor impulse control, poor anger management, substance and alcohol use, and young maternal and paternal age. Young parental age in particular is associated with infant homicide. Parents who were abused or neglected during childhood are at risk for continuing the abuse cycle. Research on Adverse Childhood Experience, or ACEs, suggests a pathway through which parental experience influences that of a child. Child abuse and neglect, in concert with other ACEs, has been linked to decreased adult life expectancy by up to 20 years.[40,106,107] The role of ACEs in later abusive or neglectful

parenting behavior is of significant interest to CAN researchers and practitioners. ACEs are further discussed in Appendix E.

The increased likelihood of CAN is associated with social factors such as poverty, unemployment, low maternal education, and single parenting.[105] CAN may also create additional social problems; victims of child abuse were found to be nine times more likely to participate in criminal activity and as many as two-thirds of the people in treatment for drug use reported being neglected as children.[86]

It is important to note that protective factors may mitigate the risk incurred by the experience of adversity. Supportive relationships are consistently associated with resilience across studies; good nutrition, mindfulness, exercise, and sleep can also help.[40,106-109]

Risk factors specific to the military population are discussed in Appendix C.

B4. Bringing Violence out of the Dark: Reducing Stigma and Gaze Aversion

The DoD instills values that encourage Service members to build a healthy military family system and does not tolerate family violence. CAN and the other forms of violence thrive on secrecy. Secrecy is tied to stigma and fear of repercussions, among other factors. The DoD is engaged in ongoing efforts to change the perception that help seeking is a sign of weakness, particularly in the area of suicide prevention. Similar efforts must be made to change the stigma around seeking help for struggles that lead to child maltreatment and other forms of violence. The issue of career repercussions stemming from CAN must also be reviewed. While sometimes indicated and necessary, the potential loss of one's livelihood can also serve as a formidable obstacle to seeking help in challenging and escalating circumstances.

The role of barriers to help-seeking in perpetuating problem behaviors is widely acknowledged. Barriers to help *provision* – which can also act to sustain maladaptive behaviors – are less understood. The phenomenon of "gaze aversion," or the failure to see child maltreatment when it has likely occurred,[89] is one such barrier to help provision. Gaze aversion may contributes to the failure to identify CAN, particularly in equivocal cases, when another more palatable – but less likely – cause could be cited. Gaze aversion may also occur on a systematic basis, curtailing the allocation of time, attention, resources, and effort to issues of significance like CAN.

Addressing barriers to help-seeking and help provision are crucial in combatting CAN and other forms of violence in the DoD. A large body of research exists on promotion of positive health behaviors, such as help-seeking, which targets stigma and related factors. This approach fits in to the larger public health framework applied by the World Health Organization's (WHO) Global Campaign for Violence Prevention. A public health approach to violence is designed to de-stigmatize and treat the risk factors for violence within a framework of problem surveillance, risk and protective factor identification, intervention and outcomes evaluation, and scale up of successful interventions.[44]

Research on health promotion and a description of the public health approach applied to violence are described in Appendix F.

B5. Military Health System in an Important Partner in DoD's Anti-CAN Efforts

> "Pediatricians are in a unique position to identify and prevent child abuse"
> *Dr. Cindy Christian, American Academy of Pediatrics, Clinical Report, The Evaluation of Suspected Child Physical Abuse*

The MHS is one of America's largest and most complex health care institutions that cares for 9.5 million beneficiaries in one of the nation's largest health benefit plans.[4] It is a joint system of uniformed, civilian, and contract personnel at all levels of the DoD. The DHA acts as a Combat Support Agency within the MHS managing the Army, Navy, Air Force, and Marine Corps medical services to provide a medically ready force and ready medical force to Combatant Commands during both peacetime and wartime.[4] TRICARE, or the Purchased Care network, is operated by the DHA, and is designed to provide integrated high quality health care benefits for military families.[110]

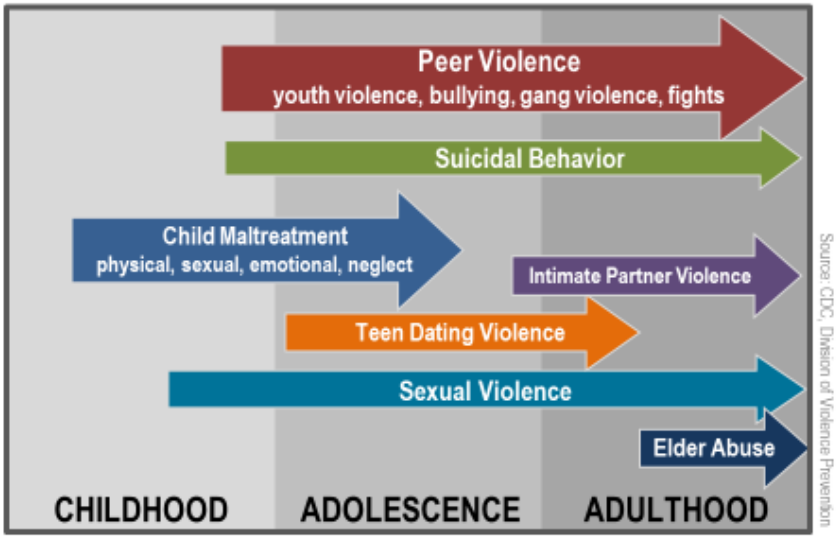
Defining CAN as a public health issue requires the MHS to serve a significant role in eradicating child maltreatment across the DoD. Child/adolescent health care providers, including pediatricians[111] and family practitioners, are in a unique position to identify and prevent child maltreatment. The MHS's role in eradicating CAN and fostering healthy families is essential as health care providers are the most frequent identifiers of CAN within the most vulnerable population: children ages zero to three.[38] Well-child and other relevant health care visits, including obstetrical visits, provide an important opportunity to integrate prevention, screening, and treatment for CAN into routine care. Current CAN efforts across the Direct Care system (MTFs) and Purchased Care system (TRICARE) in the MHS are described in Appendix D. Models for integrating CAN prevention, screening, and treatment will be discussed in Appendix F.

B6. Child Abuse and Neglect in Context

> "Many forms of violence are experienced together, share common underlying risk factors, result in common outcomes, and share similar protective factors and solutions."
> *Dr. Brigid McCaw, Medical Director, Family Violence Intervention Program, Kaiser Permanente*

Experts contend that individuals who experience one type of violence are more likely to experience other types, as well.[3] Violence, including child maltreatment, can occur throughout an individual's lifespan with overlapping experiences of multiple types (Figure 7).[5]

Figure 7. Violence Occurs Across the Lifespan



The relationship between CAN and Intimate Partner Violence (IPV), for example, is well known.[112] When IPV co-occurs with CAN, additional complications arise. Chronic IPV exposure is associated with physical changes in the brain and can reduce a child's ability to self-regulate; children exposed to IPV are three times more likely to use mental health services.[6,113] IPV can also be a barrier to children receiving preventative care.[6] For example, children of mothers who disclosed IPV are less likely to have five well-child visits within the first year of life and are less likely to be fully immunized at age 2.[6,7] However, pediatric visits may be the only access abused mothers have to health care services; therefore, having comprehensive case management services available during these visits is crucial.[6]

The links among various types of violence go beyond CAN and IPV. In 2014, the CDC's Prevention Institute published *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence* to better understand the connections between different forms of violence and to describe how these connections affect communities.[5,9] Strong partnerships and a systems approach are deemed essential to ending family violence and all forms of violence.[5] The DoD's efforts to end various forms of violence are currently distributed across condition-specific offices or initiatives, including the FAP, which addresses CAN and IPV in the DoD; the DoD Suicide Prevention Office (DSPO); and Sexual Assault Prevention and Response office (SAPR). Coordination among these initiatives and offices holds promise for improving the lives of beneficiaries experiencing violence in the military community.

APPENDIX C. CHILD ABUSE AND NEGLECT IN THE MILITARY

C1. INTRODUCTION

This appendix outlines the relationship between child abuse and neglect (CAN) and the impact of unique features of military life, such as the deployment cycle, on CAN. This appendix also addresses CAN-related data and tracking capabilities within the Family Advocacy Program (FAP), the MHS, and the Purchased Care network (TRICARE). Specifically, Appendix C will address the following objectives in the Terms of Reference (ToR):

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children, as well as demographic and socioeconomic factors that affect the risk of being abused, and evaluate/identify effective interventions and metrics such as HealthySteps and Adverse Childhood Experiences (ACEs), intended to proactively prevent abuse and aggressive behavior, and promote healthy development.
- Review the policies related to TRICARE Network healthcare providers regarding identification of and appropriate intervention in cases of child abuse and neglect in Purchased Care. Assess how Network providers can be incentivized to work with military resources—clinical and nonclinical—to support victims of child abuse.
- Examine current reporting procedures outlined in Talia's Law and current military health providers' practices for reporting suspected child abuse and neglect to the appropriate authorities including Family Advocacy Program Offices and state child welfare services agencies, by noting and eliminating barriers and developing recommendations to track reporting compliance.
- Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.
- Note opportunities to track health outcomes of children who were abused or neglected, including parents' ACEs, within the Millennium Cohort Family Study to determine the full impact on the MHS.

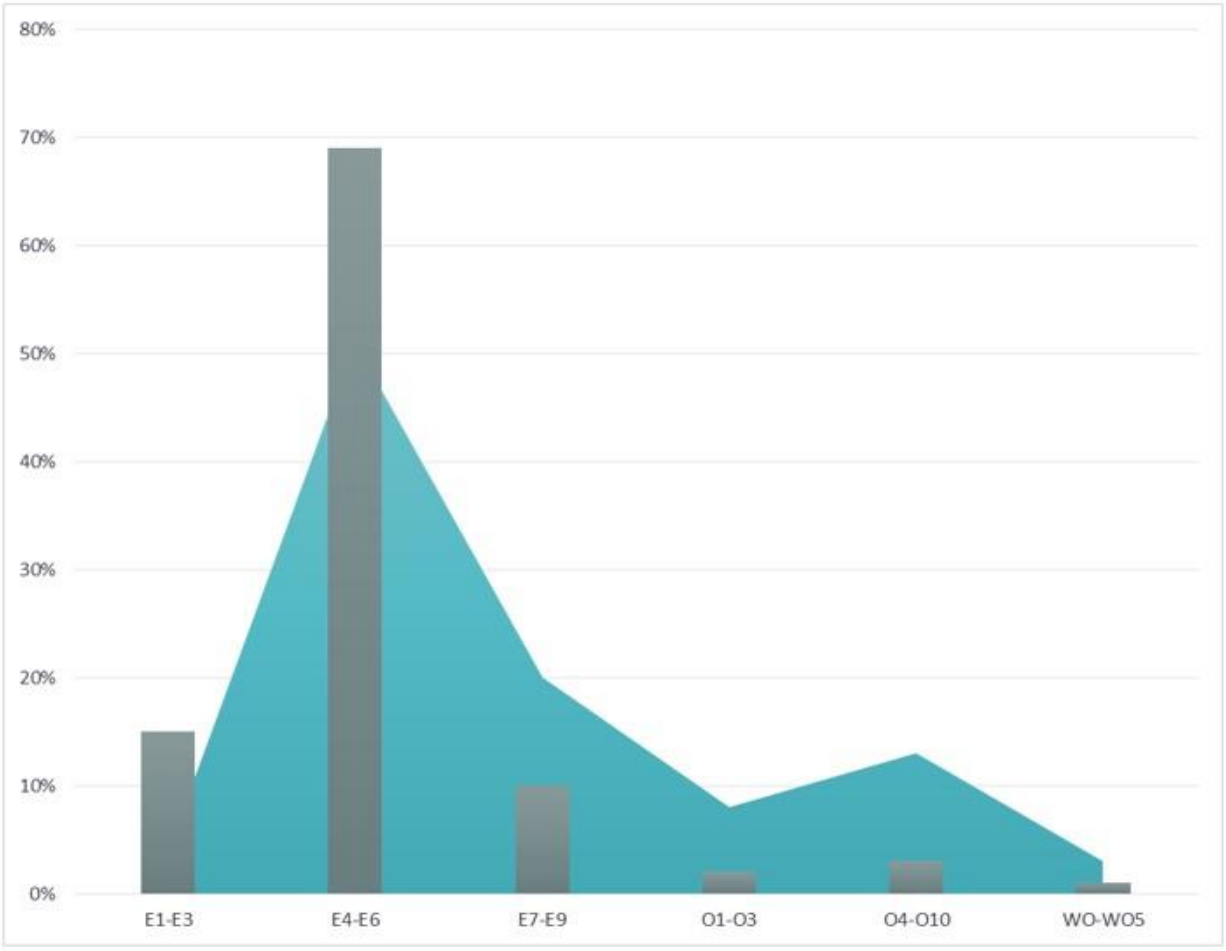
C2. MILITARY FAMILY READINESS

The *DoD Instruction 1342.22* defines family readiness as "the state of being prepared to effectively navigate the challenges of daily living experienced in the unique context of military service."[114] Family readiness is closely tied to mission readiness; family concerns have been found to cause more stress for deployed Service members than combat-related concerns.[115] Conversely, positive family factors such as spousal employment and adequate childcare have been found to contribute to military retention.[115] Given that children from military families are 8 to 10 times more likely to serve in the military than those from non-military families,[115] family well-being supports operational preparedness both now and in the future. Understanding and responding to the unique challenges and strengths of military families is a force multiplier, with long-term effects.[115]

C3. Military Specific Risk and Protective Factors for CAN

Family violence occurs across all occupational and demographic categories. The overall pay grade percentage distribution for active duty parent offenders for FY 17 is shown in Figure 8. CAN in the DoD is most frequently reported in families of the junior to mid-career enlisted paygrades of E4-E6; the highest rate of offenders for CAN are Service members in the E1-E3 pay grade who are 3.75 times more likely to have met criteria for a CAN incident.[15]

Figure 8. Relative Distribution of Military Parents and Offenders by Rank[21,23]



	E1-E3	E4-E6	E7-E9	O1-O3	O4-O10	WO-WO5
Paygrade of Parents in Population of Military Families	4%	51%	20%	8%	13%	3%
Paygrade of Offenders in Met Criteria in Incidents	15%	69%	10%	2%	3%	1%
Relative Risk	3.75	1.35	0.5	0.25	0.23	0.33

Elements unique to military life may explain the elevated risk of child maltreatment in these populations. Research has shown that young parental age is a strongly associated risk factor for child abuse.[105] A large proportion of the active duty population – almost half – are 25 years old or younger.[116] Military personnel also tend to start families at a younger age.[117] These young families must adjust to the stress of frequent relocations and separations from extended family

members, who might otherwise have provided help and support.[15,38] Conversely, many military families include two parents or caregivers,[118] which can help to protect against CAN.[72]

Families of active duty personnel within the junior enlisted ranks also face financial challenges, another risk factor for child maltreatment. A study compared military pay to poverty level in 1999 and found that by definition, about five percent of enlisted personnel earn pay that fell below the poverty line. However, when Regular Military Compensation (RMC), defined as "the sum of basic pay, average basic allowance for housing (BAH), basic allowance for subsistence, and the federal income tax advantage,"[119] is included, no enlisted personnel were considered poor (Figure 9).[120] For 2018, the U.S. poverty threshold, which defines the minimum income needed to meet basic needs, was $25,554 for a family of four (two adults, two children).[120,121] The annual basic pay for an E-3 with less than two years of Service is $23,774;[122] however, this pay does not include average BAH. In addition, nearly 1 in 4 enlisted families also contend with spousal unemployment due in part to frequent moves.[38] Tangible military family benefits, such as guaranteed housing, the continuity of health care, and a job for at least one parent, for example, can mitigate some of the financial stressors a non-military family might face.[72]

Figure 9. Poverty thresholds and military pay in 1999 (in dollars)[120]

Poverty thresholds			Military pay		
No. of children	Single adult	Two adults	Paygrade	Basic pay	RMC
0	8,677	11,156	E-1	11,512	21,565
1	11,483	13,410	E-2	12,910	23,216
2	13,423	16,895	E-3	13,940	24,514
3	16,954	19,882	E-4	16,551	27,622
4	19,578	22,261	E-5	20,353	32,517
5	21,845	24,934	E-6	23,855	36,915
6	23,953	27,412	E-7	28,975	42,885
7	27,180	33,499			
8+	32,208	32,208			

Deployment Impacts on CAN

Financial incentives may drive more deployments, especially in families in the high risk group, creating an increased risk of CAN for some throughout the deployment cycle.[38] Deployment is often illustrated as a cycle with three distinct periods: pre-deployment, deployment, and post-deployment.[72] Some studies use the term "non-deployment" when talking about pre- and post-deployment.[72] Pre-deployment refers to the time spent preparing for the departure of the Service member. The deployment phase begins the day the Service member leaves home and ends when the Service member returns home (post-deployment).[72] During deployment, the family dynamic readjusts and reorganizes responsibilities and daily structure. Post-deployment refers to the time

spent reintegrating the Service member back into daily family life. Research has confirmed that families who feel more prepared for a deployment are able to cope better during and after deployment.[117]

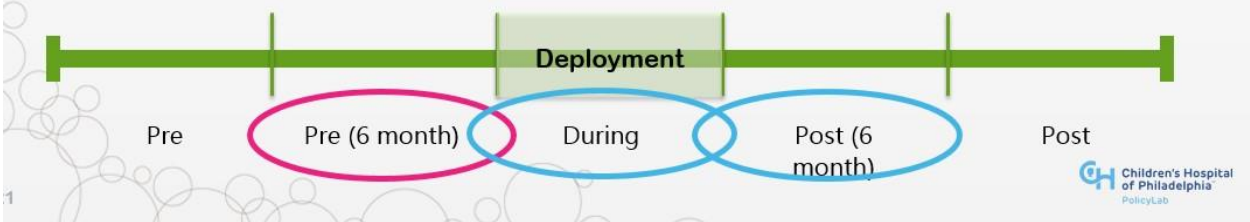
Studies have yielded different results regarding the relationship between deployment and rates of CAN.[11,72] Generally, research suggests that increased stress associated with deployments and redeployments and medical conditions associated with deployment, such as posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), may contribute to abusive behaviors in Service members and their spouses, significant others, and families.[123,124] Of note, the Air Force has found that CAN-related child fatalities were more likely at times of change in family composition, such as a temporary separations due to deployment, the addition of another child, or divorce.[10]

Some findings suggest that the operational tempo for families experiencing multiple deployments puts them at higher risk of behavioral health problems, divorce, family violence, and other consequences of family stress.[69,123,125-127] Interestingly, a study of active duty Army families revealed varied patterns among soldiers who were deployed once and those deployed twice. Children of Soldiers who deployed once were at an increased risk of maltreatment during the post-deployment phase, suggesting increased challenges during reintegration. Children of soldiers deployed twice were at greater risk of maltreatment during the second deployment, rather than during the first reintegration phase. Among soldiers deployed twice, the rate of substantiated reports of child maltreatment made to the Army Family Advocacy Program during the first deployment was 2.8 per 10,000 child-months, and rates significantly increased to 4.8 episodes per 10,000 child-months during the second deployment (Figure 10).[12,126] Many factors may contribute to this increase, including mood and behavior changes due to the change in family dynamics and the trauma of separation.[126] This provides insight on how to support and ensure additional resources to families experiencing multiple deployments as well as those reintegrating back into the family after being deployed. Additionally, children of female Soldiers showed greater risk of maltreatment during the pre-deployment phases, while children of male Soldiers showed greater risk post-deployment, suggesting an interaction between gender and deployment status, as shown in Figure 11.[12,13]

Figure 10. Substantiated FAP Reports based on U.S. Army Soldier Deployment Status[12]

Figure 11. Risk of Child Maltreatment Related to Deployment by Parent Sex[12,13]

Time Period	Male Soldiers		Female Soldiers	
	HR	p-value	HR	p-value
7 + months pre-deployment	-	-	-	-
≤ 6 months pre-deployment	0.9	0.62	1.82	0.05
Deployment	1.3	0.03	0.55	0.20
≤ 6 months post-deployment	1.7	<0.001	1.15	0.15
7 + months post-deployment	0.9	0.62	1.11	0.72



Deployment periods have primarily been associated with increased neglect, manifesting as insufficient supervision and response to children's emotional needs.[14] Children's mental health difficulties are among the most significant issues facing military families during deployment separations,[58,71,108,123] placing a burden upon families and also upon the Military Health System.[123] The DoD, specifically the Uniformed Services University of the Health Sciences (USUHS), is conducting a study to identify "Military-specific Risk Factors Associated with Child Abuse and Neglect" which will inform policy for child abuse and neglect prevention[14,22] as well as provide more information on the impact of deployment on child well-being.[32]

Military Culture and CAN

Aspects of military culture may impact the likelihood of CAN in various ways. The structure and support inherent in military service may be a protective factor for parents at risk for child maltreatment.[128] Once a Service member joins the military, core values such as "integrity" and "honor" provide a foundation for effective decision-making and the achievement of daily missions.[128] However, the military's focus on strength and self-sufficiency can reduce seeking help in the face of family challenges. Occupational stressors, including frequent relocations and separations from family members, may overburden already challenged Service members and families, or may be valued as growth opportunities[128] that teach new skills, adaptability, and flexibility in new situations and environments.[108] Finally, military-connected children may benefit from a sense of affiliation, taking pride in having parents who serve their country.[118]

C4. CAN Data Capture and Related Challenges

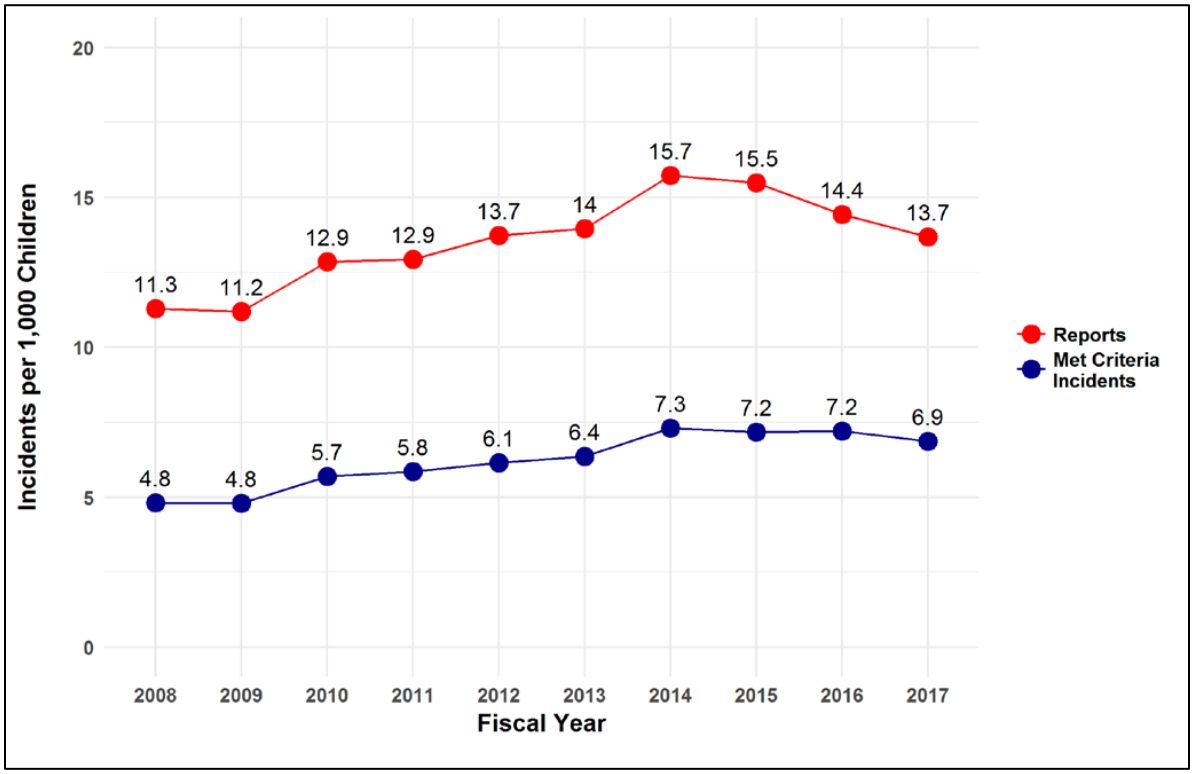
There is no single, reliable measure for surveying child maltreatment at this time due to differences in definitions and thresholds, varying types of abuse, and multiple modes of reporting.[126] Additionally, weaknesses in CAN data collection and analysis in the DoD create a significant barrier to understanding the scope of the issue in military populations. For example, children of military retirees are not included in aggregated military CAN data, leading to a potential underrepresentation of CAN among DoD beneficiaries. The following sections

describe the status and current issues of CAN data capture across the DoD and MHS.

Family Advocacy Program Data

Per DoD Manual (DoDM) 6400.01, Volume 2, FAP is required to maintain a central database that houses information on reported incidents of child abuse and domestic abuse.[23] Data fields include incident details, an indication if the victim is deceased, indicating if the alleged abuser is associated with a prior case entered into the Child Abuse and Domestic Abuse Central Registry ("Central Registry"), and the alleged abuser's relation to the child. Additional data, such as substance involvement, severity of the event (e.g. physical or psychological impact on the victim), and beneficiary status are also collected. Currently, Services submit coded data to the Defense Manpower Data Center (DMDC) quarterly to be incorporated into the DoD Central Registry and published in the annual FAP report presented to Congress.[21]

Figure 12. CAN Reports vs. Met Criteria Incident Rates per 1,000 Children of Military Families[21]



The *Report on Child Abuse and Neglect and Domestic Abuse in the Military* (referenced herein as "CAN Report") is an annual report presented to Congress as required by section 574 of the *National Defense Authorization Act* for FY 2017. This report describes current incidence and trends in CAN and domestic abuse in the military as reported to installation FAP offices. In the FY17 CAN report, trends suggest that there have not been appreciable differences in incidents that met criteria since FY13. The rate of reported child abuse and neglect has decreased since FY15, while the rate of child abuse and neglect incidents that met criteria has remained steady.

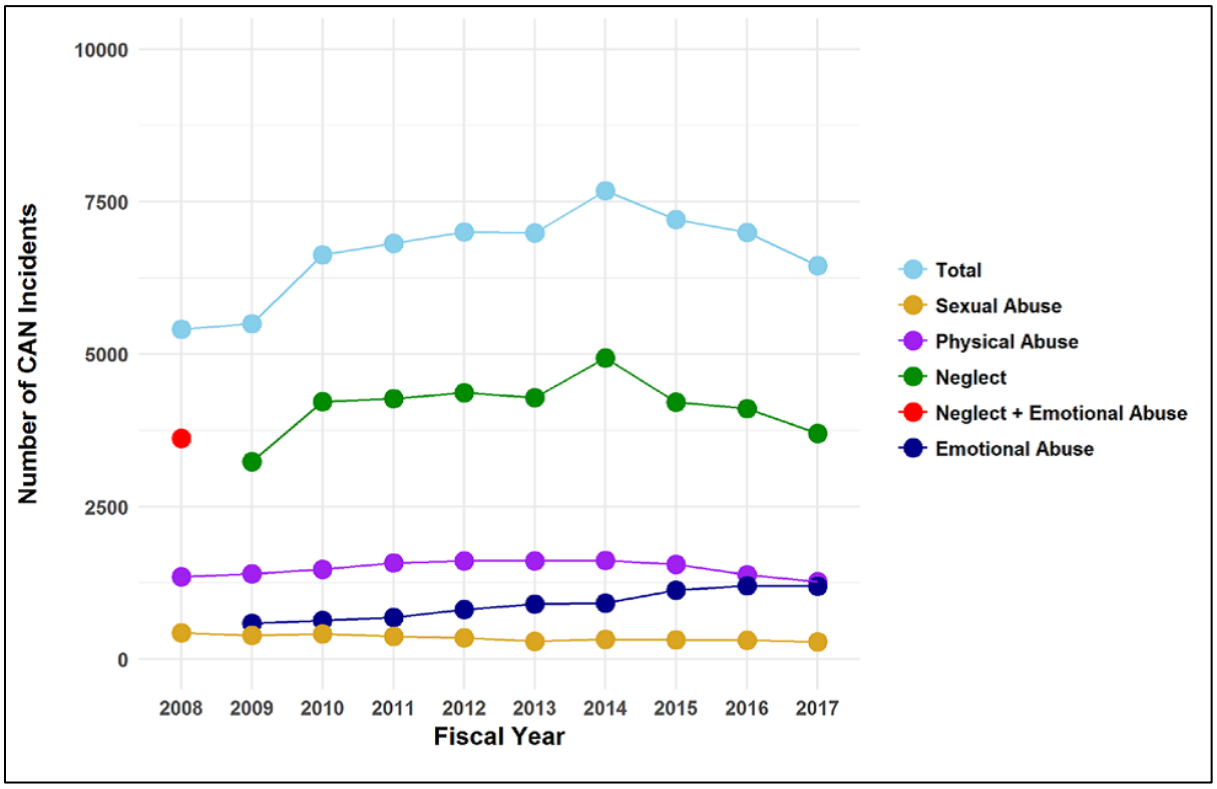
However, neither of these differences were found to be statistically significant.
Figure 12 illustrates these trends. It should be noted that the increased trend in reporting and met criteria cases between FY09 and FY14 were primarily the result of process improvements, such as the implementation of the Incident Determination Committee (IDC) and differentiating parents as unique offenders. Previously, both parents were counted as a single offender, in contrast to current practices, where each parent is counted as a unique offender. As a result, incidents of CAN increased during this time period, not because of an actual increase in CAN events, but due to a change in how offenders were counted.[15]

Table 9. Characteristics of Fiscal Year (FY) 2017 Reported Child Maltreatment Cases[15]

	FY 17 Maltreatment Distribution[15]
Victim Sex	
Female	49.0%
Maltreatment Type in Met Criteria Incidents	
Neglect	57.4%
Physical	19.7%
Emotional	18.5%
Sexual	4.4%
Victim Age in "Met Criteria" Incidents	
0-1 Years	23.8%
2-5 Years	32.1%
6-11 Years	25.9%
12-17 Years	18.3%

As seen in Table 9, neglect represents the largest percentage of met criteria incidents in FY17 (57.4%), followed by physical abuse (19.7%), emotional abuse (18.5%), and sexual abuse (4.4%). There were 3,528 met criteria incidents with child victims age 5 or younger, representing more than one-half (55.9%) of all victims of child maltreatment in FY17.[15] With the exception of emotional and sexual abuse, males were slightly more likely to experience maltreatment than females. Despite these small differences, the sex of victims was almost evenly divided with 49.0% of met criteria incidents involving females.[15] In analyzing rates by maltreatment type, neglect remains the largest proportion of maltreatment incidents over time (Figure 13).

Figure 13. CAN Met Criteria Incidents by Maltreatment Type, Over Time [15]



Fatality data are limited. While some fatality data are presented in the FY17 FAP report, Services review fatalities retrospectively.[15] Service-level fatality reviews occur about 2 years after the event or in the first year that the disposition is closed. The goal of this timing is to ensure that all available information is available for review. There were 17 child abuse-related fatalities involving 23 offenders that were taken to the IDC and entered into the Central Registry in FY17.[15] Twelve of the child victims were under 5 years old, and 65 percent of child victims were 1 year old or younger.[15] For FY16, there were 18 child abuse-related fatalities involving 23 offenders.[129] Of note, the Air Force has found that some characteristics such as past history of disciplinary action, reported anger issues or depressive attitudes, and male gender are significant in assailant populations.[24] Additionally, victims showed evidence of medical/material neglect post-mortem and old injuries and had parents with little understanding of child development.[24] Families with an abuse fatality also showed distinct characteristics such as financial troubles, frequent conflict, and change in family disposition within the 90 days prior to the child's death.[24] Therefore, based on Air Force analysis, these factors could be used to identify families at risk of child maltreatment and warrant further investigation through longitudinal or other population studies.

FAP data suffer from several limitations which include: (1) the data reported by the Services to OSD FAP do not report information on demographics (e.g. gender distribution between offender and victim,, lack of breakout of maltreatment type by age) and offender deployment status; (2) FAP does not collect data on cases deemed unsubstantiated or that do not meet IDC criteria; (3) FAP only tracks active duty beneficiaries that seek services or are directly reported to FAP,

leading to potential underrepresentation of CAN victims within the DoD beneficiary population[23]; and (4) FAP has limited access to the electronic health record (EHR) and most Service FAPs do not enter data into the EHR.

Although FAP data in the Central Registry suggests that rates in the military are lower than those in the civilian sector[15,102] the variability of data collection makes definitive conclusions suspect. Additionally, civilian sector data includes military cases. The majority of CAN cases in the military are related to neglect (57.4%),[15,21] a finding also noted in the civilian population, where three-quarters (74.9%).of the cases are related to neglect.[16] However, the proportion of physical abuse is consistently higher in the military (19.7%)[15,21] compared to the general population (18.3%), although this difference may not be statistically significant.[16] Abusive Head Trauma (AHT) in infants and young children, also known as "shaken baby syndrome,"[84] is also more common in the military population, particularly in infants of active-duty mothers.[34,85] A study showed that infants born to military families between 1998 and 2005 with single military mothers had 3.1 times greater odds of being cases of AHT and those born to dual military families had a 2.5 greater odds of being cases of AHT.[85] It should be noted that these results are from a singly study and that overall, there have been limited studies conducted on this topic.

Of note, independent peer-reviewed studies suggest that data collected by FAP is not an accurate representation of the scope of child maltreatment in the military. Two Children's Hospital of Philadelphia (CHOP) studies found a low linkage rate between medically diagnosed maltreatment cases and substantiated FAP reports, indicating issues in identification and reporting of CAN cases.[11] Specifically, in the first CHOP study, approximately 5,900 maltreatment episodes related to Army dependents aged 0-17 between 2004 and 2007 were analyzed to determine the relationship between child, episode, soldier characteristics, and associated substantiated FAP reports.[11] Of these cases, only 20.3% of diagnosed maltreatment incidents had a substantiated FAP report, with most substantiated cases involving physical abuse.[11] In contrast, some research suggests a 44% linkage rate between CPS reports and medically diagnosed child maltreatment in the civilian health care system.[12] A similar second study analyzed 3,265 maltreatment cases related to Army dependents aged 0-18 between 2014 and 2015.[20] This study expanded upon the original methodology by analyzing all reports made to FAP (both substantiated and unsubstantiated), and by performing a secondary analysis which extended FAP report linkage time from six months before a medical encounter for CAN (as opposed to the one month before) to one month after the episode.[20] Of the cases that included a FAP report one month prior or after a treatment episode, 35.7% of diagnosed maltreatment incidents had a FAP report (substantiated or unsubstantiated) and 24.6% had a substantiated FAP report.[20] The secondary analysis, with the extended timeframe, found 48.7% of the diagnosed maltreatment episodes had FAP cases (substantiated or unsubstantiated).[20] The study also indicated that beneficiaries who were non-White were more likely to have a FAP case (Black: 27.4%, Other: 27.4%, White: 22.9%), suggesting the need to further evaluate the indication that maltreatment episodes related to ancestry are more likely to be reported to FAP, irrespective of rank or gender.[12] These differences in reporting mirror other disparities in health care based on race and ethnicity, and the potential for provider bias based on stereotypes, prejudice, and uncertainties should also be considered.[130] In both studies, the linkage rate for maltreatment episodes diagnosed in the Purchased Care sector (TRICARE) was less than half the rate for the Direct Care system (2004-2007: 9.8% vs 24.2%; 2014-2015: 16.1% vs 42.9%). These findings

suggest a modest increase in FAP reporting in the past decade, with the medical treatment/FAP reporting gap most significant in Purchased Care (TRICARE).

MILITARY HEALTH SYSTEM DATA

Health care providers are mandated reporters for CAN. However, beyond reporting to civilian CPS agencies and FAP, there is little data tracking within the MHS Direct Care system. Data collection opportunities exist within the Tri-Service Workflow (TSWF) forms used during patient encounters.[33] Data collection and monitoring at this point is especially important in capturing CAN incidents in 0-3 year olds, as health care providers are most likely to be in a position to identify potential cases within this age range because of the frequency of well child visits.[33]

TSWF forms are standardized templates used in the Armed Forces Health Longitudinal Technology Application (AHLTA) across all ambulatory care settings; TSWF forms are also being adapted for the new electronic health record, MHS GENESIS. There are 32 forms, four of which are specialized for pediatric patient care. Provider-patient interactions such as interviews are supported by TSWF forms and details can be captured within the free text boxes within each form.[33] However, many of these free text boxes and screening tools are optional, and thus may not be completed during each visit.[33] Providers have limited time with patients and increasing the number of screening tools and data fields may further limit the time for rapport building and referral discussion to address current health issues and stressors.

There are three form sets designed for well-child visits. The '4' form, also known as the General form, is used for unwell/sick visits. Not all elements in the forms require completion. The clinician documents past medical history, such as trauma and stress in a free text box, which correlate with the American Academy of Pediatrics (AAP's) Bright Futures National Health Promotion Initiative.[33] The screening section of the TSWFs include the question "Is the patient or parent currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?" and has "yes", "no", and "declined to answer" check boxes as well as a link to "Sexual Assault Resources" for the patient.[33] Under social history, the child/adolescent health care provider has a list of cues to inquire about the patient's daycare/school, who lives in the home, and information about the number, duration, and last return date of parent deployments next to a free form text box.[33] These questions provide an opportunity for the provider to further assess potential signs of maltreatment, particularly if the patient is malnourished or provides a positive response to the question regarding safety.[33] However, as discussed earlier, many of these questions are voluntary. The DHA data analytics team sampled 122,932 patient encounters over one week and found providers documented the safety question for 63.0% of female patient encounters, indicating a need for improved implementation of this screening question.[33]

In addition to a general review of behavior-related symptoms, the behavioral health section of the TSWF encounter forms also has several screening tools, including ones for depression, anxiety, drug and alcohol use, and ACEs. The review of behavioral health symptoms includes attention issues, depressive behavior, and internalization or externalization of problems. There is an option for the provider to print out the screening questionnaires and review of symptoms for the patient or guardian to take home and complete.[33]

The development section includes the HEADSSS Assessment (Home, Education/Employment, Activities, Drugs, Sexuality/Sexual Activity, Suicide/Depression, Safety) free text box.[33] A clinician reference guide and key questions for use during the patient encounter are available. Note that this documentation becomes available in the TSWF form when the patient is 11 years or older.[33] This assessment could also serve as a prompt for discussion regarding maltreatment and/or family difficulties.

The remaining sections focus on the physical exam, which is key for identifying signs and symptoms of physical abuse.[33] While there are medical codes for suspected abuse that could be recorded, it is unclear how often providers use these codes compared to recording codes only related to the injury observed.

TRICARE

TRICARE claims provide the only information available for identifying possible CAN cases. TRICARE providers are required to notify the referring MTF or military provider if there is any suspicion of serious harm to self or others, including cases of CAN, per the TRICARE participation agreement and TRICARE Policy Manual. However, there is no tracking mechanism to ensure this occurs. Additionally, TRICARE Prime and Select beneficiaries can seek mental health services without a referral in some instances,[37] negating a potential coordination mechanism. Additionally, TRICARE providers are not currently given a list of contacts within DoD (e.g. FAP, MHS) to facilitate referral and coordination.

Given these coordination gaps, incident data for families who seek medical services outside the MTF may not be communicated to the local FAP, and thus not included in Central Registry entries and appropriately actioned by DoD.[10,25,26] Efforts to mitigate this data sharing issue are ongoing. Twenty states have revised their child welfare laws to require sharing of military-family relevant information with the FAP office, and MOUs/MOAs are being put in place to increase collaboration and data sharing between civilian and military offices.[21]

Other Data Collection Mechanisms in the MHS

There are ongoing efforts within the DoD to assess active duty service member and family readiness and well-being that may have bearing on CAN. For example, The Millennium Cohort Study links to FAP and other sources of data, including various health care databases.[43,131] Additionally, a measure has been added to TSWF forms to obtain parental reports of child ACE exposure in the hopes of gaining a better understanding of child maltreatment experiences in the military.[42] Millennium Cohort researchers may also add a sub-cohort of parent-child dyads to the study to reflect the increased likelihood that military children go on to serve as active duty service members themselves.[43] Direct assessment of adolescent well-being is being incorporated into The Millennium Cohort Family Study.[43] However, collecting identifiers and creating useful questions on sensitive topics within the context of mandated reporting requirements remains a key hurdle.[43]

C5. Optimizing Care for Military Families

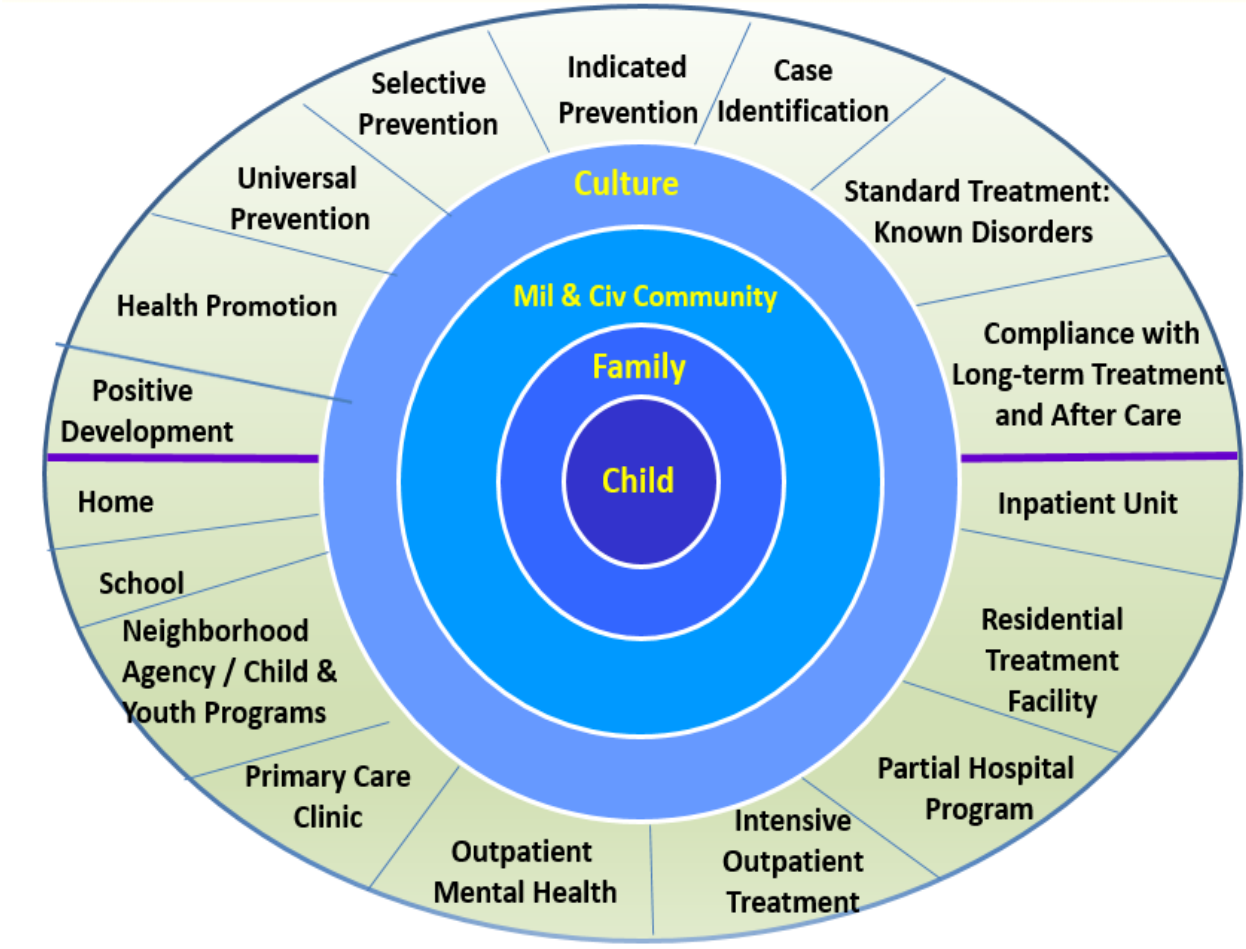
Families in the military community share unique experiences, including frequent family separations or moves, childcare difficulties due to nontraditional work hours and separation from extended family, and civilian spouse unemployment.[115] Some of these experiences may build resilience, while other experiences exacerbate stress, leading to serious challenges.

According to a Pew Research survey, military culture is not well understood; 77% of veterans and 71% of civilians report that the general public does not understand Service members' stressors.[132] Though some military families may support each other and maneuver through challenges exclusive of civilian support, there is a need to further educate and train the civilian sector and build a stronger sense of community, especially since the majority (78%) of military families do not live in base housing.[133] Figure 14 displays a conceptual model of identified health prevention and treatment programs for children within military and civilian communities. These programs have the potential to complement each other at different stages in addressing an identified problem in a population, such as within a specific community or within a cultural group.[134] The bottom half of the figure illustrates common treatment programs and interventions that are readily available.

> "Like any large organization with a well-established history, the U.S. Armed Forces has its own culture, language, and ways of conducting business"
> *SAMHSA, 2010*

Approximately 50% of beneficiaries obtain their primary care outside of a MTF.[117] By building overall community support, such as accessible childcare, and engaging civilian providers about military culture, there are opportunities to understand population needs, more efficiently coordinate care, reduce overall stressors, and optimize military family readiness.[58,98,109,117,135] Thus, it is essential for both military and civilian health care providers to be knowledgeable about military family challenges and work together across the continuum of health care delivery, linking prevention and treatment through an integrated model.[134,136]

Figure 14. Coordination of Care Applicable to CAN[136]



APPENDIX D. ADDRESSING CHILD ABUSE AND NEGLECT IN THE DEPARTMENT OF DEFENSE

D1. INTRODUCTION

Appendix D of this report provides information about the organizational structures through which the Department of Defense (DoD) addresses child abuse and neglect (CAN). It describes the current state of CAN capabilities in relevant parts of the DoD (Military Community and Family Policy [MC&FP]) and the Military Health System [MHS]) and CAN coordination efforts across the DoD and between military and civilian agencies and hospitals. Specifically, Appendix D addresses the following objectives in the Terms of Reference (ToR):

- Review the policies, protocols, and methods used by health providers and health care teams caring for military families to screen for child abuse and neglect, including recognizing symptoms of physical, emotional, and sexual abuse; identifying patterns indicative of child abuse and neglect; discussing child abuse and neglect; and reporting suspected child abuse and neglect to appropriate programs and authorities.
- Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.
- Review existing support programs for victims of child abuse and neglect in the MHS, as well as the continuity of care coordination with medical and social services to strengthen the interface between medical and non-medical communities (military and civilian).
- Review the policies related to TRICARE Network healthcare providers regarding identification of and appropriate intervention in cases of child abuse and neglect in Purchased Care. Assess how Network providers can be incentivized to work with military resources—clinical and nonclinical—to support victims of child abuse.

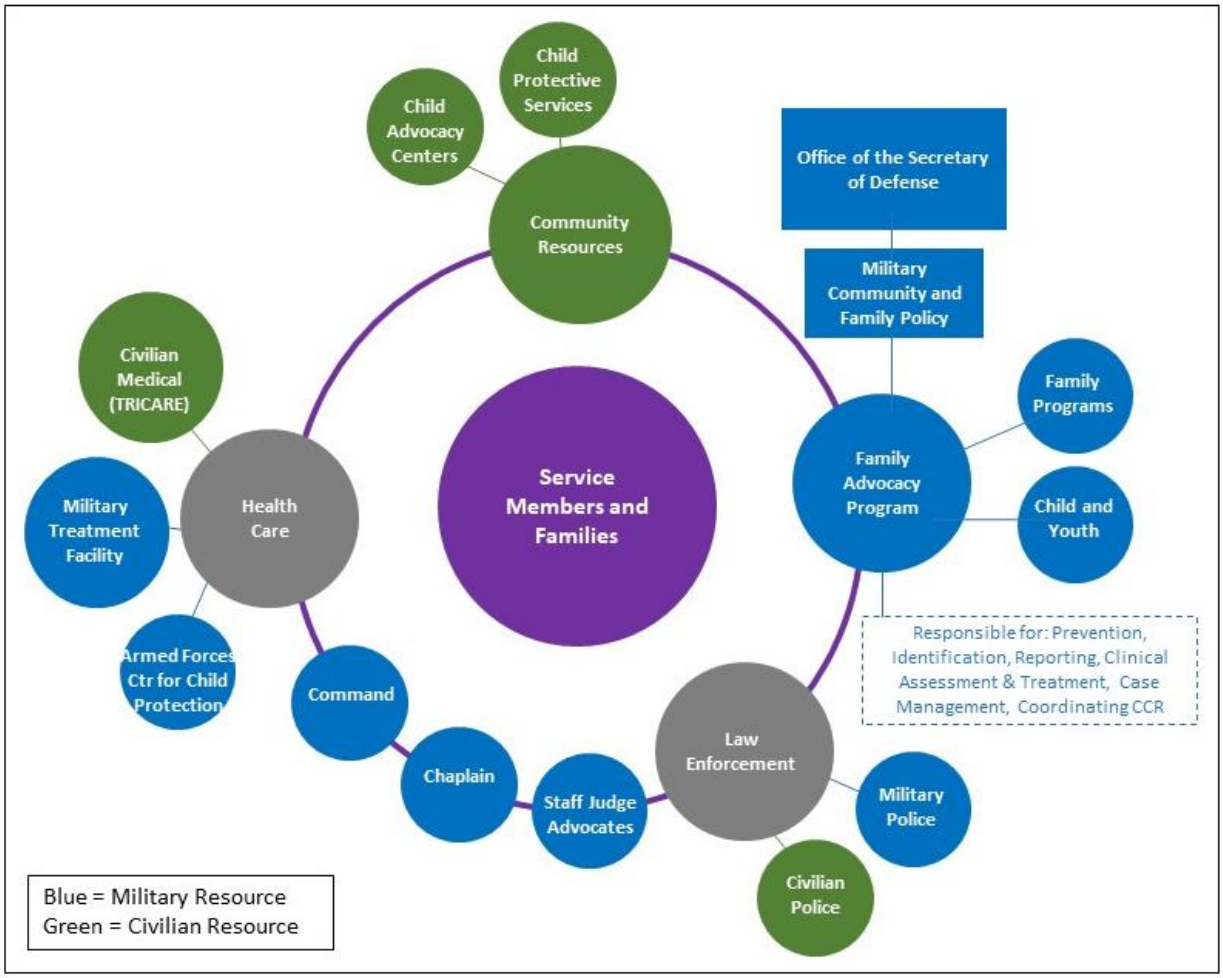
D2. THE FAMILY ADVOCACY PROGRAM

The Family Advocacy Program (FAP) is a congressionally mandated program under MC&FP in the Office of the Secretary of Defense (OSD). FAP is dedicated to preventing and responding to incidents of child abuse and neglect (CAN) and intimate partner violence (IPV) in military families. OSD FAP establishes policy and provides oversight for Service FAPs in accordance with *DoD Instruction 6400.01*[23] to ensure consistent training, education, and treatments throughout military communities.[15] OSD FAP also facilitates DoD-level campaigns, such as "April is CAN Prevention Month," that are tailored for use at each installation.[28]

FAP plays a central role in the DoD's Coordinated Community Response (CCR; Figure 15[137]) approach to family violence. The CCR is designed to facilitate communication and collaboration between agencies responsible for identifying, reporting, responding, and tracking incidents of abuse. The CCR team includes, but is not limited to, FAP, military law enforcement, Staff Judge Advocates (SJA), military comprehensive pediatric medical care providers, and chaplains.[15] Local Child Protective Services (CPS) and other community based CAN and IPV support

resources are also engaged in the military's CCR process when needed or required.
It is important to note that FAP is not involved in legal investigations; FAP is responsible for military community CAN and IPV prevention, identification, reporting, clinical assessment and treatment, case management, and coordination with CCR components and community based resources for services that FAP does not provide.[10,137] FAP policy directs the Services to establish memoranda of understanding/agreement (MOU/MOA) between installations and civilian agencies.[137] The DoD is working with the Department of Health and Human Services (HHS) to increase the number of these agreements across the enterprise.[26]

Figure 15. An Example of the Coordinated Community Response (CCR) for Child Abuse and Neglect[137]



Service FAP responsibilities include determining which reported incidents of CAN "meet or do not meet the DoD criteria to be considered abuse," and the intervention services best suited to address the safety of victim and related family dynamics to prevent a subsequent incident from occurring.[15] The DoD's process to determine if an incident meets or does not meet the DoD criteria for abuse was informed by a collaboration between the Air Force and New York University researchers, which yielded a decision-tree algorithm, subsequently adopted by each of the Services.[74] The algorithm is applied by an Incident Determination Committee (IDC)

comprised of the installation or garrison commander (Chair), a senior noncommissioned officer, a representative from the Service member's command, an SJA representative, a military law enforcement representative, and the FAP manager.[15] Research results suggested that the definitions in the decision tree algorithm were robust enough that comprehensive pediatric medical care providers were not needed to determine if an incident met criteria and therefore comprehensive pediatric medical care providers were not recommended for inclusion as core members of the IDC; comprehensive pediatric medical care providers and other providers could be asked to contribute clinical information as needed to the committee.[10,25,26] The *DoD Instruction 6400.01* recommended all Services adopt this procedure for standardization; all Services except the Army currently follow the IDC model.[23] The Army uses a case review committee approach (CRC; see Army section, below) and is transitioning to the IDC.[25]

The DoD FAP Central Registry is designed to capture reliable and consistent information on CAN and IPV incidents reported to FAP from each of the Services.[138] Each Service maintains a comprehensive clinical case management system, which includes the required FAP Central Registry data elements that are extracted and submitted quarterly to the Defense Manpower Data Center (DMDC).[138] Per DoD policy,[23] DMDC operates the FAP Central Registry and provides OSD FAP with aggregate data.[138]

The DoD FAP Central Registry contains limited information on reports of abuse that did not meet criteria for CAN or IPV; identifiable individual information is not tracked.[138] The Central Registry includes more detailed information on reports of abuse that meet objective, standardized criteria and are linked to identifiable Service members, their family members, and the alleged offenders.[138] Specifically, the Services are required to submit information on 46 data elements on met criteria incidents, delineated in DoD Policy, which include:

- Sponsor Service, location, relevant dates, type of maltreatment, and case status
- Demographic data on the military sponsor, victim, and alleged offender(s) including name, social security number, branch of Service, military status, sex, age, and relationship indicators[138]

In addition to the Central Registry, OSD FAP also captures annual information to measure the performance and effectiveness of family readiness programs via quantitative annual metrics on the success rates of the New Parent Support Program (NPSP) and IPV offender clinical treatment.[138]

Both data collection efforts are implemented by the Services and administered by FAP at the installation level.[138] Each of the Services collects information for these metrics and submits the data annually to OSD FAP for analysis and reporting.[138] Although OSD FAP aggregates data from each of the Services upon receipt, there is some minor variation in interpretation of current implementing guidance and how definitions are operationalized across the Service FAPs.[138]

See Appendix C for more information on data capture and related challenges.

Service FAPs operate on every installation, including U.S. Coast Guard (USCG) stations.[15] Each FAP has a different relationship to the military medical treatment facility (MTF). The following section addresses each Services' efforts related to CAN.

ARMY

The U.S. Army currently follows *Army Regulation 608-18,* published in 2007 and updated in 2011.[139] This regulation is undergoing another revision to align more directly with the *DoD Instruction 6400.01*.[23,25] As of March 21, 2019, the Army requires major juvenile offenses, such as sexual assault, that occurred on an Army installation be reported to FAP as well as civilian authorities.[140] Additionally, if the child is relocating to another Army or non-military community, the installation's FAP will notify the gaining installation's FAP or civilian CPS.[141]

The Army FAP is organized in a bifurcated fashion with FAP treatment located within the behavioral health service line as part of the MTF and overall program management under Garrison Command.[25] Army FAP goals include promoting prevention, strengthening family functioning, and preserving families in which abuse has occurred.[25] The Army currently uses a CRC to determine met criteria cases of CAN. The FAP Clinical Chief chairs the CRC; other members include a physician (usually pediatrician or other comprehensive pediatric medical care provider for child maltreatment cases), installation chaplain, criminal investigative command representative, Army Substance Abuse Program (ASAP) Clinical Director, Program Management Office (PMO) representative, SJA representative, the FAP manager, and case manager.[25] The Army is in the process of transitioning to the IDC model.[25]

NAVY

The Navy FAP is located within the Counseling, Advocacy, and Prevention program of Fleet and Family Support Center, external to the health care system.[26] The Fleet and Family Support Program is organized into four core areas to meet mission readiness: work and family life; counseling, advocacy, and prevention; sexual assault prevention and response program; and the Navy Gold Star Program.[26] The Navy currently follows *DoD Instruction 6400.01*[26] and utilizes the IDC in determining if allegations meet criteria for abuse and neglect.[142] Consistent with *DoD Instruction 6400.01*, health care providers, including comprehensive pediatric medical care providers, do not serve as a member on the IDC but can be invited by the IDC Chair and FAP when specialized medical interpretations are needed to understand a specific medical injury.[26] Additionally, the Navy is able to provide MHS professionals visibility on CAN cases by inputting FAP case information into the EHR.[26]

The Navy FAP services include prevention initiatives (e.g. the NPSP), treatment, risk assessment, and safety planning.[26] Of note, the Navy promotes and emphasizes victim advocacy.[15,26] The Navy extends support advocacy to the non-offending parent or guardian through an assigned victim advocate.[15,26] Much like intimate partner violence (IPV) situations, FAP victim advocates (VAs) provide a wide variety of advocacy services, including providing information and referral services, support, and ongoing safety planning.[26] All allegations of child abuse that meet reasonable suspicion for abuse are assigned a FAP VA.[26] FAP VAs provide resources for the non-offending parent or caregiver from initial referral through case

closure and/or until the non-offending parent or caregiver no longer desires services.[26] After an alleged report is made, the victim advocate offers necessary tools and referrals, including possible prevention techniques, such as providing skills to maintain a strong support system for the child in order to develop resiliency and improve overall well-being within the family system.[15,26]

The Navy strives to implement a coordinated community response (CCR) model in response to CAN. The CCR is designed to improve communication, establish standardized protocols for responding to family violence, and educate the community on abuse issues.[26] The Navy CCR is comprised of key organizations involved in preventing and responding to family violence, including commands, health care providers, law enforcement, legal personnel, and other allied professionals.[26] Communication within the CCR is supported through MOUs between Navy installations and local or state CPS agencies.[26] Of note, Navy FAP is working to improve the process for notifying the gaining command and FAP of "closed unresolved" FAP cases at time of making a permanent change of station (PCS) for the purpose of risk management.[26]

AIR FORCE

The Air Force was the first military branch to formally establish a child advocacy program.[143] Today, the Air Force FAP serves active duty members, activated Guard and Reserve members and their families, same gender partners, unmarried intimate partners of active duty members, retirees on a space available basis, and all family members eligible for care in the MTF.[10] The Air Force currently follows *Air Force Instruction 40-3014*[144] which is being revised to align more directly with *DoD Instruction 6400.01*.[10,23] The Air Force FAP varies from the other Services in that the FAP is located within the MTF.[35] However, there is concern regarding the effect that *National Defense Authorization Act Fiscal Year 2017 (NDAA FY 2017) Section 702* will have on Air Force FAP, a Service-specific readiness program, as the DHA assumes management and administrative responsibilities for all MTFs.[61]

Air Force FAP works to reduce the stigma associated with mental health outreach and relationship counseling and encourages Service members and beneficiaries to seek services.[10] If a Service member is found not guilty in a court of law, FAP does not necessarily close the case; clinical assessment and treatment may still be provided.[10]

The Air Force is focused on primary prevention, such as public awareness campaigns and community support.[144] Efforts include, but are not limited to, consultations and training to MTF providers, behavioral health marketing education, and monthly events.[144] Secondary prevention efforts include provision of services, conducted by licensed clinical social workers (LCSWs), to clients who may indicate risks of partner violence or child maltreatment. These interventions include family advocacy strength-based therapy, or "FAST."[144] The Air Force FAP also emphasizes secondary prevention, such as the NPSP, through individual, couples, and group modalities, aimed at psychosocial skill development.[144] The Air Force NPSP is a promising, evidence-based program that pro-actively addresses potential parenting issues.[10] See Appendix E for more information on the NPSP.

MARINE CORPS

The U.S. Marine Corps (USMC) currently follows *Marine Corps Order 1754.11*, which is under revision to include the policy updates in the newly reissued *DoD Instruction 6400.01*.[28] The USMC FAP is housed under USMC behavioral programs oversight, which includes non-medical counseling for the victim, the alleged abuser, non-abusing parents of child victims of abuse, and families or individuals impacted by problematic sexual behavior in children and youth.[28] Currently, evidenced-based prevention programs and universal curriculums address anger management, parenting skills, work stress, family stress management, and the NPSP.[28] The USMC FAP offers counseling to children old enough to receive such services.[28] FAP also offers training and education, including reporting protocols and requirements, to all mandated reporters on the installation.[28]

The USMC is a Service within the Department of the Navy and does not have its own medical enterprise; Naval MTFs serve both the USMC and U.S. Navy (USN) populations.[28] If a Service member or other beneficiary requires medical attention, they are referred to a health care provider. FAP/MTF coordination is governed by MOUs between USMC and the Navy Bureau of Medicine and Surgery (BUMED).[28] MOUs also govern coordination between the USMC and local CPS agencies across installations.[28] Additionally, laws in 22 states require CPS to screen for military affiliation and refer to FAP when identified.[28]

Of note, research suggests that younger families are more likely to encounter issues of abuse.[71,98,104,117] The USMC has the youngest population among the Services; the majority of these Service members are not married and do not have children.[28] These marital/dependent demographics suggest that CAN may be less prevalent in the USMC; however, this cannot be confirmed because data is not reported by Service at the OSD level.[28]

COAST GUARD

The U.S. Coast Guard (USCG) follows *Commandant Instruction 1752.1*.[29] USCG FAP is responsible for the coordination of CAN prevention, training, response, and intervention and for reporting CAN cases to CPS, consistent with Talia's Law.[29] Family Advocacy Specialists (FASs) within USCG FAP provide a range of CAN services.[29] There are 24 FAS positions allocated across 21 different regions of the country; 16 positions are currently filled.[29] The regional model encourages autonomy but also yields challenges in providing needed services, particularly due to limitations in travel funding.[29] Additionally, levels of professional certification vary; licensure is required for those hired after 2012.[29] FAS personnel provide psychosocial assessments to the victim, offender, and family members to include safety and risk assessments and domestic violence counseling.[29] FAS personnel provide FAP prevention training to commanders and Service members within their region.[29] They also provide training to health care providers on the prevention, identification, intervention reporting investigation, and treatment of domestic violence and child maltreatment.[29]

Health care providers are more integrated into the FAP process in the USCG than they are in the other Services. A health care provider participates in the USCG IDC and Clinical Case Staff Meetings and collaborates with FAS personnel regarding CAN assessment and treatment

Services.[29] However, only two of the USCG health care clinics serve dependents and one of the two only serves children ages 12 and older, on a space available basis .[29] USCG beneficiaries leverage various sources for CAN treatment, including FAP, within the MTF, DoD FAP, Behavioral Health Services, the CG SUPRT program, the Armed Forces Center for Child Protection (AFCCP), National Children's Alliance (NCA), CPS, TRICARE, and local medical communities.[29]

The USCG FAP Central Registry is an electronic password protected Excel spreadsheet on a network-shared drive, maintained by Health, Safety, and Work-Life Service Center (HSWL SC).[29] Access is restricted to HSWL SC personnel and the FAP Manager.[29] The USCG uses the Central Registry to track FAP incidents and demographic data. Unlike the other services, these data are not reported to the DoD.

The USCG FAP faces a unique set of challenges.[29] It is modeled on OSD FAP standards but is not structurally aligned under the DoD. As a Department of Homeland Security entity, the USCG does not receive DoD funding like the other Service FAPs. This limits the USCG's ability to maintain staff and manage the overall program.[29] Additionally, due to the lack of clarity and language used, legislation will often (perhaps unintentionally) exclude the USCG by only referencing the "DoD" instead of the "Armed Forces."[29]

D3. The Military Health System and Child Abuse and Neglect

The MHS is one of the largest and most complex healthcare institutions, providing routine care to 9.5 million active duty personnel, their families, and retirees.[145-147] It is a global, comprehensive system that integrates health care delivery, public health and medical education, private sector partnerships, and medical research and development.[145] The challenges of the MHS are unlike any other healthcare system in the world, carrying out mission requirements in both contingency and peacetime environments to include remote, deployed, and forward locations.[4] The contingency mission includes ensuring that Service members are medically ready to deploy, and the medical force is ready and able to provide complex care in combat zones.[4] The peacetime mission includes providing quality healthcare for military members, families, and other beneficiaries domestically and overseas.[4]

Organizationally, the MHS is a "federated system of uniformed, civilian and contract personnel and additional civilian partners at all levels of the DoD."[148] This federated system is undergoing unprecedented reorganization as management of MTFs is consolidated under the command and control of the DHA pursuant to the *National Defense Authorization Act for Fiscal Year 2017 (NDAA FY 2017) Section 702*.[149] The plan is for all CONUS MTFs to be migrated under the direction of the DHA in October 2019, shortening the transition period by one year.[150] Thus, the plan is to launch 20 large markets and establish the small market and standalone MTF Office, then, finally, establish the OCONUS Defense Health Regions, with full operating capability no later than September 30, 2021.[150]

The DHA is the executive agent for the MHS: It acts as a Combat Support Agency, directing joint shared services across the Army, Navy/Marines, and Air Force medical services to sustain a medically ready force and ready medical force to Combatant Commands in both peacetime and

wartime.[146,151] At the same time, the DHA acts as a health agency responsible for the care of a very diverse population of young healthy people, retirees, and families at military MTFs and through Purchased Care network providers (TRICARE). This hybrid system of public and private networks is asymmetric in its approach to and management of CAN.

CHILD ABUSE AND NEGLECT IN THE DIRECT CARE NETWORK

Standardized procedures for addressing CAN do not yet exist at the Enterprise level. The Services have different processes and procedures for addressing CAN in Direct Care outpatient clinics and inpatient hospitals, as do Direct Care facilities that have already moved under the DHA. Processes vary in terms of development and implementation across the outpatient and inpatient facilities within and between the Services. Enterprise standardization could occur through the Clinical Communities (CC) and the Defense Health Agency Procedural Instruction (DHA-PI) process.

Current State: Outpatient Care

Each Service and MTF has its own processes and procedures for addressing CAN in military outpatient facilities; available Service-specific and MTF-specific information is presented below.

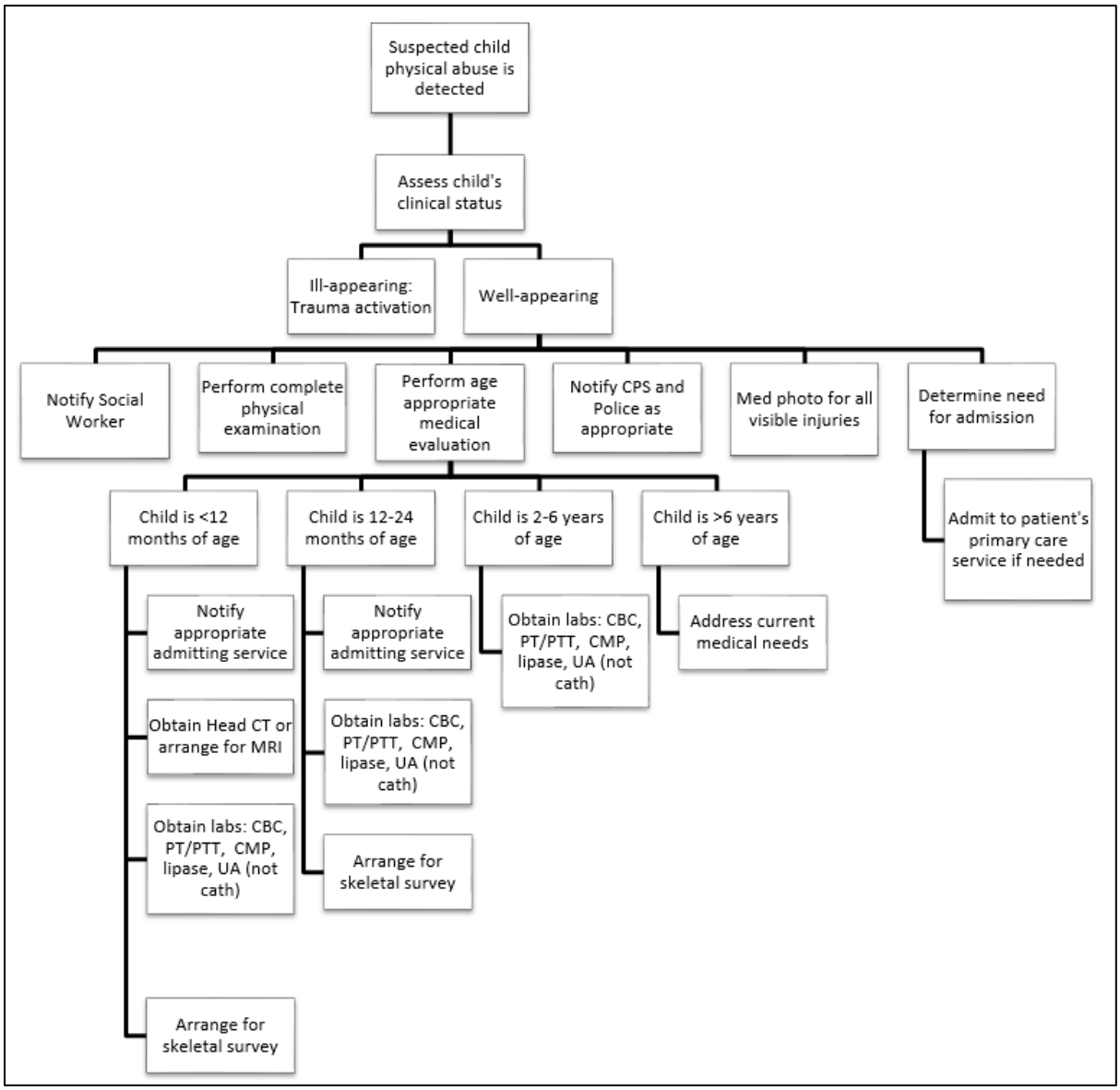
In the Army and Air Force, routine and well-child visits incorporate screening that follow the Tri-Service Work Flow (TSWF) screening questions on feeling safe at home.[152] Medical evaluation and treatment of CAN within the Air Force is coordinated through local MTFs. Army MTFs incorporate CAN screening into local SOPs, which typically include a review of concerning symptoms and signs by age.[152]

The Army has MTF- and department-level SOPs that include specific information for CAN treatment resources based on geographic location.[152] For example, the Womack Army Medical Center (WAMC) *Management of Alleged Child Abuse or Neglect Cases (MEDCEN Memo 608-18a)* provides the policies, procedures, and responsibilities regarding CAN, including mandatory reporting requirements, referral and reporting procedures, the release of medical information, identification of suspected maltreatment (i.e. indicators of abuse and/or neglect), and staff responsibilities (for the WAMC Commander, health care providers, nurses, pediatricians, social worker, FAP worker, Chief of Family Member Behavioral Health, Suspected Child Abuse and Neglect [SCAN] team, Hospital Education and Staff Development [HESD], and law enforcement).[153] Furthermore, the WAMC SOP provides information on referrals, pediatric consults, outpatient and inpatient dispositions, documentation of CAN, and details on what the history and physical examination for suspected CAN should include.[153] *Management of Suspected Abuse for Child Physical/Emotional and Sexual Abuse/Molestation, Or Neglect, and Spouse Physical Abuse/Emotional Abuse (Family Advocacy Program),* in place at Brooke Army Medical Center (BAMC), details the responsibly parties for the different types of abuse similar to WAMC's SOP.[154]

The Madigan Army Medical Center (MAMC) *Screening and Management Guideline for Suspected Child Abuse, Neglect and Non-accidental Trauma* is similar to the WAMC SOP but focuses more on evaluation procedures.[155] The MAMC SOP flowchart for non-accidental trauma is a comprehensive diagram to guide when various "Red Flags" are presented that lead to

the recommendation of evaluation of suspected physical abuse.[155] When a case is recommended for further evaluation of possible CAN, the SOP provides information on laboratory and radiology tasks, as well as procedures related to consultation, disposition, and communication.[155] The Tripler Army Medical Center (TAMC) SOP for child abuse utilizes the clinical pathway shown in Figure 16. The TAMC SOP outlines circumstances of identification of suspected child physical abuse including how to score high-risk symptoms, as well as detailed information on history-taking, explanation of injuries of concern, when to conduct diagnostic testing, and reporting requirements including special considerations for addressing sexual abuse.[156]

Figure 16. Tripler Army Medical Center Child Abuse Clinical Pathway[156]



Systematic coordination of CAN functions varies across the Enterprise. Systematic CAN responses have been established at San Antonio Military Medical Center (SAMMC), Naval Medical Center Portsmouth (NMCP), and TAMC. These installations' approach to CAN

includes child advocacy models and community involvement, with varying degrees of civilian partnerships. For example, SAMMC provides a successful partnership model for the FAP-CPS relationship. The CPS personnel who support SAMMC demonstrate strong military cultural competence, with many being either veterans or family members of Service members. The SAMMC-CPS MOU, in particular, may provide a template across Services and installations.

Across all Services, important specialties in CAN management include but are not limited to Board-certified Child Abuse Pediatricians (CAPs), Pediatricians and Pediatric Nurse Practitioners, Family Practice Doctors and Nurse Practitioners, Doctors and Nurse Practitioners of Obstetrics and Gynecology, Emergency Medicine Doctors, Nurses, and Physician Assistants, and Social Workers. A team-based approach to preventing, identifying, and managing CAN cases has emerged as a best practice and should be formalized within Enterprise level policies/instructions/SOPs.

As might be expected, there are fewer resources available for small/remote hospitals compared to larger facilities, regardless of Service. Specifically, some facilities lack nurse-examiners or child abuse pediatricians with expertise in pediatric sexual assault examination and may also lack medical resources available at larger facilities, such as expert radiographic interpretation of skeletal surveys. Challenges also arise for addressing CAN when considering OCONUS locations that often have even fewer resources as well as a lack of CPS. Funding and supporting a 24/7 synchronous telehealth capability is a potential way to increase the reach of CAP expertise for rural and OCONUS facilities. Further study of the complex issues inherent in addressing family violence overseas is warranted.

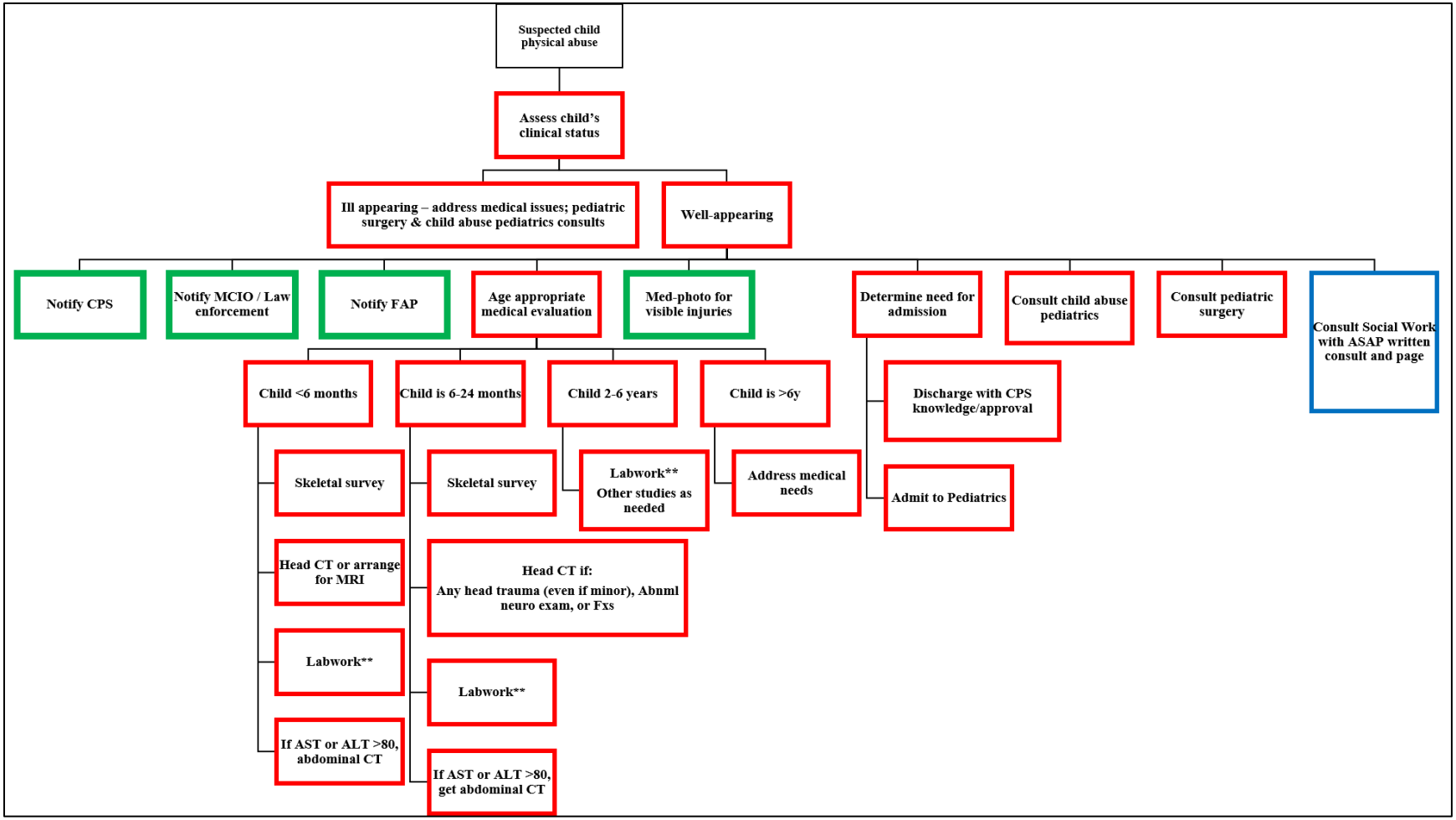
Current State: Inpatient Care

The Department of Pediatrics at Walter Reed National Military Medical Center (WRNMMC) has developed a CAN draft instruction for WRNMMC that incorporates the American Academy of Pediatrics (AAP) clinical guidelines for Non-Accidental Trauma (NAT; see Appendix F for more information). The first version of this instruction was developed in 2012 and was based in part on consultation with various inpatient pediatric services in the MHS at the time.[30] The AFCCP, a central source of CAN expertise in DoD, had a major role in creating the WRNMMC draft instruction and continues to serve a consultation role for WRNMMC staff.[30] Other MTFs, such as BAMC at Fort Sam Houston, TX, are developing policies based on the WRNMMC draft instruction.[30]

The WRNMMC draft instruction describes the policy to protect patients, attempt to prevent CAN from happening, and report when CAN may have occurred.[157] It describes the responsibilities of the WRNMMC Director and the Chiefs of the Department of Pediatrics, Department of Social Work, Department of Surgery, and Department of Emergency Medicine.[157] The draft instruction contains a procedures section with simple CAN screening instructions; at a minimum, each pediatric patient and/or their family is asked "Do you feel safe in/feel your child is safe in your home?"[157] Furthermore, nearly 20 CAN related-considerations are listed in the draft instruction as well as how to report abuse and neglect in Maryland, the District of Columbia, and Virginia since mandated reporting varies by state.

The draft instruction also provides pathways for management of suspected child physical abuse, sexual abuse, and neglect/psychological maltreatment. The child physical abuse clinical pathway, shown in Figure 17, provides an overview of the medical perspective, highlighted in red, with the additional medical evaluation tasks highlighted in green.[157] The medical team's roles and responsibilities are to address and stabilize acute medical issues and conduct a formal evaluation for abuse, including any signs and symptoms that may mimic abuse.[157] The social work role (highlighted in blue in Figure 17) is to serve as the liaison between entities within the CCR.[157] Social work is discussed in greater detail below.

Figure 17. Walter Reed National Military Medical Center Administrative Instruction: Child Physical Abuse Clinical Pathway[157]



The WRNMMC draft instruction also delineates security instructions for the patient's safety plan while admitted at WRNMMC, including but not limited to visitor restriction and line of sight.[157] There is also information on documentation which states that "photo-documentation of a finding or injury is highly recommended."[157] Lastly, the draft instruction provides information on communicating with parents/guardians for CAN-related cases and states that a "team approach to communication of reports to CPS is highly recommended."[157] Further information or examples for communicating with parents/guardians is not included.

Social workers play a significant role in CAN coordination at WRNMMC and at other MTFs across the enterprise.[30] LCSWs serve as liaisons between entities within the CCR and provide support to the victim as the case moves through the medical and legal systems.[30] Other important functions include an understanding of CPS protocol, round-the-clock accessibility seven days a week including on holidays, and an ability to enter CAN related reports into the Electronic Health Record (EHR).[30] These functions allow continuity in a case, particularly given the fact that Service FAPs only operate during regular business hours on a weekday schedule.[30] It is important to note that, despite the importance of their role, not all MTFs have access to LCSWs.[30]

Military treatment inpatient facilities may have more flexibility than civilian hospitals to utilize "social admissions," or admissions based on criteria other than need for inpatient medical treatment, in cases of suspected CAN.[30] A social admission allows a child to be protected from suspected abuse or neglect while an investigation is conducted.[30]

Armed Forces Center for Child Protection (AFCCP)

The AFCCP provides expertise in CAN prevention, assessment, mandatory reporting, medical management, training, consultation, and expert testimony in courts-martial, both domestically and internationally, to the DoD, the Coast Guard, and the State Department.[158] The AFCCP is staffed by two of the five DoD CAPs, a child abuse pediatric nurse practitioner (PNP), a social worker/forensic interviewer, and an administrative support person.[27] Staff are presently housed in and funded by the WRNMMC Department of Pediatrics.[158] In the past both Navy and Air Force FAPs provided funding for some of the billets, equipment, and travel to provide training at military bases; however, due to a decrease in FAP funding, these contributions to the AFCCP ceased.

The AFCCP staff have traditionally traveled to remote or OCONUS locations that lack trained personnel to evaluate or collect evidence, particularly in cases of reported sexual abuse.[34] However, travel has become more challenging due to funding and staffing limitations. Telehealth/telemedicine, currently used to provide CAN services in the civilian sector, and clinical consultation platforms such as Project ECHO (Extension for Community Healthcare Outcomes),[34] are potential ways to extend CAP reach across the Enterprise. Fostering champions of CAN prevention and treatment in remote and OCONUS locations also holds promise.[34] This could be particularly helpful given the likelihood of a different or absent structure, such as CPS, dedicated to CAN intervention in OCONUS locations.[34]

Of note, AFCCP is currently facing challenges to the viability of its current and future mission. WRNMMC, as well as all other MTFs, have no CAN-specific sub-specialty billets;

consequently, the AFCCP is included in the WRNMMC Department of Pediatrics manning and funding allocation.[158] The AFCCP must compete with WRNMMC Department of Pediatrics priorities for equipment and personnel to support the current mission[27] and lacks the formalized requirements to plan for sustainment. The two CAPs at AFCCP are planning to retire in the next few years, as is the child abuse PNP, and a CAP pipeline is yet to be established in the DoD due to the need to train active duty pediatricians in other subspecialties. Finally, a draw down in military medical personnel that is currently underway may impact the small number of pediatric sub-specialty billets currently allocated to CAN efforts Enterprise-wide. With limited community resources, OCONUS MTFs are particularly vulnerable if billets for comprehensive pediatric medical care providers, including CAPs, are reduced in these areas.[35] No MTFs DoD-wide have CAP billets and there have never been CAP billets anywhere. The five current CAPs are all in general pediatrics billets.

The AFCCP's unique position in the DoD helps shape its perspective on CAN gaps and challenges. According to AFCCP, military health care providers do not systematically employ validated screening measures of CAN.[27] Providers screen beneficiaries for intimate partner violence (IPV), which is correlated with CAN, but there is a need to determine valid screening tools so that CAN victims may be better identified.[27] There is an opportunity to strengthen health care provider's ability to identify, report, and medically manage CAN through EHR-based decision analyses and standardized training.[158] There is also a need for providers to gain more training and competency in identifying abuse and performing forensically appropriate physical examinations as well as a multidisciplinary approach to training.[158] A multidisciplinary approach, which is more standard in the civilian sector, improves CAN case outcomes and may be a best practice.[27] On the whole, CAN-focused military medical practices remain in silos.[27]

Child Abuse and Neglect Training

CAN-related training is obtained in some Service residency programs; however, most training occurs "on the job." Army and Air Force pediatric personnel have completed training related to "purple crying," the term used to refer to the intense period of crying in a baby's life and a vulnerable time when parental frustration can lead to shaken baby syndrome and other abuse. Pediatric residency training programs at WRNMMC, MAMC, and TAMC include interactions with FAP. BAMC requires CAN training and MAMC has an annual conference on CAN. The majority of Air Force pediatric residents are trained within one of the four military pediatric residencies that have a 2-4 week required rotation in child abuse (WRNMMC, San Antonio Military Medical Center [SAMMC], NMCP, Wright-Patterson AFB).[152] Navy pediatrics training programs emphasize a military-specific curriculum for CAN, such as a rotation at Naval Medical Center San Diego (NMCSD) that includes training on identification and reporting of CAN.[152] The Navy does not require ongoing education or training for pediatricians following residency; routine practice and refresher courses/conferences are utilized for updates to addressing CAN.[152]

With regard to advanced training, Child Abuse Pediatrics (CAP) is a relatively new area of Board certification. Requirements include an additional three years of full-time fellowship in child abuse pediatrics after pediatric residency training.[36] There are 339 Board-certified CAPs in the U.S., including five in the DoD.[34] In 2019, there are two CAPs at WRNMMC, one CAP at SAMMC, one CAP at NMCSD and one CAP OCONUS at Landstuhl Regional Medical Center

(LRMC). Three of the five provide the majority of consultation services across CONUS and OCONUS, including to remote areas.[27] Two of the five CAPs manage the AFCCP, a centralized capability for expert CAN evaluation, consultation, training and testimony for the enterprise, described below.[28,29]

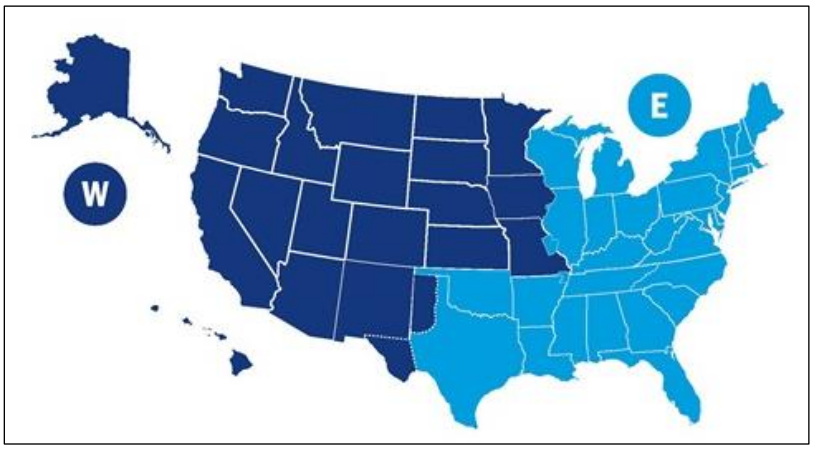
There are 17 military and civilian CAP positions projected for 2019 and 19 for 2020.[36] For FY 19 only three military CAPs are expected to serve in the DoD and four military CAPs in FY 2020.[36] This trend is consistent with reported planning for a 50 percent reduction in Air Force pediatrics billets over the next five years.[35] In the individual services' training year plans and at the Joint Service Graduate Medical Education Selection Board where training billets are allocated and individuals selected, CAP training slots compete against other pediatric subspecialties and/or all other specialties to be allotted one of the finite number of training positions.[159] Lack of interest in the specialty due to compensation or the nature of the work is also a contributing factor to the shortage of this specialty in the civilian and military workforce.[160]

PURCHASED CARE NETWORK (TRICARE)

Portions of the following section originally appeared in *Low-Volume High-Risk Surgical Procedures: Surgical Volume and Its Relationship to Patient Safety and Quality of Care: Second Report to the Defense Health Board (2019).*[161]

The MHS is one of the largest and most complex health systems in the U.S., delivering health care services to 9.5 million beneficiaries, including 1.4 million active duty and 331,000 reserve-component personnel in nearly 700 military facilities and additional civilian facilities through TRICARE health plans.[145,162] As the DoD's healthcare program, TRICARE provides care to Service members (Active Duty) and Guard/Reserve (on Active Duty greater than 30 days) and their families, retirees and their families, survivors, and certain former spouses.[163] The Purchased Care system, provided through contracted health plans, which then contract with civilian providers and facilities worldwide, is an essential element in ensuring the health care benefit: "The DoD relies on the MHS to provide a ready medical and medically ready force. The MHS maintains integrated medical teams to deliver health services in support of America's military—anytime, anywhere."[163, p.2]

Figure 18. Two TRICARE Regions in the United States



"The TRICARE health plan provides care to all members of the Uniformed Services, their families, and retirees and their families, rendering TRICARE the fourth largest health plan in the U.S.[162] The aim is to provide access to the full range of high-quality healthcare services while preserving the capability to support military operations.[163] TRICARE Purchased Care is divided into three regions—two regions in the U.S. and one region overseas (anywhere outside of the U.S. is considered overseas). The two U.S. regions have their own regional contractors: Health Net Federal Services, LLC for the West Region and Humana Government Business for the East Region, as shown in Figure 18.[164] As of January 1, 2018, TRICARE North and South were combined to form TRICARE East, while TRICARE West remained mostly unchanged.[163] TRICARE provides comprehensive coverage to all beneficiaries, including health plans, special programs (supplemental programs tailored specifically to beneficiary health concerns or conditions), prescriptions, and dental plans.[164,165] The DHA, under the leadership of the Assistant Secretary of Defense (Health Affairs), manages TRICARE.[164]

TRICARE is an "any willing provider" system.[37] There are two types of providers: "Network" and "authorized."[37] Network providers are state-licensed or certified (when state licensure is not applicable) civilian providers who have completed the credentialing process and have signed a TRICARE contracted agreement.[37] Authorized/non-network providers are state-licensed or certified civilian providers who are authorized to provide care to TRICARE beneficiaries, but have not signed a network agreement.[37]

TRICARE offers beneficiaries several health plans based on the following options:

- **TRICARE Prime®** is comparable to health maintenance organization (HMO) benefits. Each enrollee chooses or is assigned a primary care manager (PCM), who is a health care professional responsible for assisting the patient with management of his/her care, promoting preventive health services, and arranging for specialty provider services. Access standards for TRICARE Prime apply to the travel time to reach a primary care or specialty care provider, as well as the waiting times to get an appointment and in doctors' offices. The TRICARE Prime point-of-service (POS) option allows enrollees to acquire care from TRICARE-authorized providers other than the assigned PCM without a referral; however, there may be deductibles and cost shares significantly higher than those under TRICARE Standard.[163] There are currently 4.8 million beneficiaries enrolled in TRICARE Prime.[166]

- **TRICARE Select®** is a self-managed, fee-for-service plan that replaced TRICARE Standard and Extra effective January 1, 2018.[164,167] There are currently 2 million beneficiaries enrolled in TRICARE Select.[166]

- **TRICARE for Life (TFL)** is Medicare wraparound coverage for TRICARE-eligible beneficiaries who have Medicare as their primary healthcare coverage. With TFL, in most instances, Medicare pays first, then TRICARE pays second.[163] There are currently 2.5 million beneficiaries enrolled in TFL.[166]

- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors, such as the premium-based health plan TRICARE Young Adult (TYA), available for purchase by qualified dependents up to the age of 26.[163]

An additional TRICARE Prime option is the Uniformed Services Family Health Plan (USFHP) available through networks of community-based, not-for-profit care systems in six areas of the United States.[168] To enroll in the USFHP, the beneficiary must live in one of the six designated service areas, shown in Table 10.[168] Beneficiaries within this plan receive all care from a primary care provider that they select from the network of private health care providers affiliated with one of the not-for-profit healthcare systems (Table 10).[168] Enrollees in the USFHP do not receive care at MTFs or from TRICARE network providers.[168] The USFHP is managed through separate contracts.

Table 10. Uniformed Services Family Health Plans and Their Service Areas[168]

Designated Provider	Uniformed Services Family Health Plan Service Area
Johns Hopkins Medicine	• Maryland • Washington D.C. • Parts of Pennsylvania, Virginia, Delaware, and West Virginia
Martin's Point Health Care	• Maine • New Hampshire • Vermont • Upstate and Western New York • Northern Tier of Pennsylvania
Brighton Marine Health Center	• Massachusetts, including Cape Cod • Rhode Island • Northern Connecticut
St. Vincent Catholic Medical Centers	• New York City • Long Island • Southern Connecticut • New Jersey • Philadelphia and area suburbs
CHRISTUS Health	• Southern Texas • Southwest Louisiana
Pacific Medical Centers	• Puget Sound area of Washington state

"Processes to modify, update, or expand the TRICARE benefit are complex due to statutory and regulatory constraints."[169, p.5] Congress may mandate changes to the MHS through the annual NDAA legislation, which the DoD must then interpret the statute, propose updates to regulatory guidance and administrative rules included in the Code of Federal Regulations, and acknowledge public commentary on the proposed change before implementation.[169] Once regulatory guidance is final, TRICARE manuals (*TRICARE Operations Manual [TOM]*), which govern the operations, policy, reimbursement, and systems of the Managed Care Support Contractors (MCSCs), must be updated as well as modification to the contracts.[169] Thus, "each step of this process is lengthy in its implementation, and the governmental, administrative, and contractual approvals needed to comply with the law delay substantive changes."[169, p.5]

TRICARE and Child Abuse and Neglect

The *TRICARE Policy Manual (TPM)* is incorporated into the MCSCs "and is the primary vehicle for policy and benefit guidelines and instructions."[170] The most recent edition of the *TPM (6010.60-M)* is from 2015 and updated June 2019.[170] According to *TPM 6010.60-M Chapter 11, Section 12.3 Participation Agreement Requirement*s, providers seeking authorization status under TRICARE must: "notify the referring military provider or Enhanced Multi-Service Market (eMSM) referral management office (on behalf of the military provider) when a Service member or beneficiary, in the provider's clinical judgment, meets any of the following criteria:

- *Harm to self.* The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition.
- *Harm to others.* There is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence.
- *Harm to mission.* There is a serious risk of harm to a specific military operational mission. Such a serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.
- *Inpatient care.* Admitted or discharged from any inpatient mental health or substance use treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards.
- *Acute medical conditions interfering with duty.* Experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the beneficiary's ability to perform assigned duties.
- *Substance abuse treatment program.* Entered into, or is being discharged from, a formal outpatient or inpatient treatment program."[170]

TRICARE providers are required to notify the referring MTF or military provider if there is any suspicion of serious harm to self or others, including cases of CAN, per the *TPM*.[170] However, there is no tracking mechanism to ensure this occurs. Additionally, TRICARE Prime and Select beneficiaries can seek outpatient mental health services without a referral in most instances,[37] negating a potential coordination mechanism. At present, TRICARE claims provide the only established information source for identifying possible CAN cases. TRICARE providers are not currently provided a list of contacts of the available resources within the DoD to facilitate referral and coordination.

TRICARE covers most CAN treatments, including mental health, inpatient care, preventative counseling, and emergency room visits.[37] In the event a Service member is separated from the military due to CAN, the family's TRICARE benefits may be retained for a certain period of time.[37] Consistent with the Health Insurance Portability and Accountability Act (HIPAA), an explanation of benefits will not be sent to the patient if CAN is alleged.

D4. Standardization and Coordination of CAN Efforts

The Clinical Communities

The Clinical Communities are "networks of MHS clinicians who collaborate on clinical process improvement and standardization to improve patient outcomes…[designed to] encourage and enable MHS-wide improvements, [greater reliability] at the point of care, and…[accountability] to standards and clinical outcomes."[171] Clinical Community Goals include 1) defining, prioritizing, and implementing initiatives to enable readiness, and 2) decreasing variation, improving outcomes, and positively impacting the delivery of medical care [172] Thus, Clinical Communities allow for MHS practices to be quickly identified and disseminated across the MHS.[172] Five Clinical Communities have been stood up by the DHA thus far: Behavioral Health, Women and Infant, Primary Care, Neuromusculoskeletal, Complex Pediatric Care, and Dental.[171]

The Complex Pediatric Care, Women and Infant, and Primary Care Clinical Communities will be three important groups of stakeholders in CAN prevention, identification and treatment, and will offer opportunities to integrate services such as the NPSP and HealthySteps into pre- and post-natal care and pediatric care. The frequency of appointments in expectant and new families and those with young children can provide the opportunity for routine, universal touchpoints for all families at a time of increased vulnerability to CAN. CAN is not yet a focus topic of any of these communities, but priorities are still being developed. It is important to note that the development of clinical pathways is important in the civilian sector as well. The Children's Hospital of Philadelphia (CHOP) Clinical Pathways, described in the Appendix F, provides an excellent resource for the DHA.

The work of the already established Behavioral Health Clinical Community (BHCC) is very relevant to CAN treatment in the DHA. The BHCC has issued an approved list of trauma-informed therapies available in the MHS are listed in Appendix E.[173] The utilization of the evidence-based treatments are monitored through the Behavioral Health Data Portal.[173]

Defense Health Agency Procedural Instructions

The DHA-PI process was developed "to establish and maintain, for functions assigned, a publication system for regulations, instructions, and reference documents."[174] A DHA-PI "implements…clinical processes within Enterprise Activities (EAs), functions, and activities of the DoD Components in the administration of all authorized DoD medical and dental programs…that are assigned to the DHA."[175] With the transformation of DHA in response to *NDAA FY 2017 Section 702*, DHA-PIs play an integral role in procedural standardization. Of note, a DHA-PI specifying reporting processes and channels for MHS providers is forthcoming.

Additional violence response-related DHA-PIs are also forthcoming, including implementation guidance to improve health care in response to disclosure of sexual assault.

Issues and Challenges

It is unclear the extent to which civilian providers handling CAN situations are aware of DoD resources. For example, civilian providers may not be informed or educated about FAP and may not understand available resources, especially in areas rural areas without large military installations.[12] Furthermore, even when the provider is aware of FAP resources, referrals are difficult in some geographic U.S. areas where FAP is not within close proximity to the patient and family.[12]

Coordination of CAN issues between state and local CPS agencies and FAP is variable and challenging. There is no federal legislation that CPS reports must be shared with FAP; instead, the DoD has MOUs with CPS in a number of states.[12] Challenges of standardization across the MOUs and the various states are problematic. The MOUs are not infallible; there is a need to rely on relationships and to monitor and enforce policy to make them work.[12] Federal legislation may be required to ensure more consistent and comprehensive sharing of CPS reports with FAP.[12]

The DoD is governed by Talia's Law, which requires mandated DoD reporters to promptly notify the appropriate CPS agency of suspected instances of child abuse and neglect.[31] This law is essential for the safety of suspected CAN victims because CPS is the agency charged with making removal and placement decisions for all children, including military-connected children. There is no equivalent requirement for CPS to notify the DoD of military-connected children who come to its attention without DoD involvement.

Talia's Law has had one known unintended consequence: the generation of multiple referrals from different entities, such as FAP and a DoD Child Development Center, for a single incident.[28] Multiple referrals can be a burden for CPS agencies because of requirements to complete an investigation on all cases that meet criteria, even if it involves the same incident.[28] CPS agencies are considering updating this procedure and are receptive to duplication mitigation strategies.[28]

Finally, health care involvement in FAP processes is variable. The health care-FAP interface is more robust in the Air Force and the Army than in the Navy or Marine Corps, which may reflect the placement of some or all FAP services within MTFs. Typically, MTF providers transfer cases to FAP and report to CPS and law enforcement. There may be little opportunity for medical follow up post transfer, particularly if the allegation was made outside of primary care or an ongoing behavioral health treatment relationship.[27] Patient case managers change frequently and may be unaware of long-term medical needs;[27] consequently, it is essential that CAN be documented in the medical record. This is also true for referrals for civilian pediatric emergency departments by MTFs who cannot provide this service.[158] LCSWs play a vital role in case coordination between the MHS and CPS; however, social workers are not present in all MTFs.[35]

Some of these issues will be addressed in a forthcoming DHA-PI. This instruction will clarify reporting requirements and channels and to provide information on whom health care providers can contact for expert consultation on CAN.[65]

APPENDIX E. THE SPECTRUM OF CARE FOR CHILD ABUSE AND NEGLECT IN THE DOD: PREVENTION, SCREENING/ASSESSMENT, AND OFFENDER TREATMENT

E1. INTRODUCTION

This Appendix addresses the spectrum of care available for child abuse and neglect (CAN) within the Military Health System (MHS) and throughout the Department of Defense (DoD). Prevention programs such as Military OneSource, screening tools such as the adverse childhood experiences (ACEs) questionnaire, parenting programs, and universal treatment, such as non-medical counseling, are discussed. Wellness initiatives and rehabilitative treatment programs for alleged CAN offenders in the military correctional system can also be found in this Appendix. Specifically Appendix E addresses the following objectives in the Terms of Reference (ToR):

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children, as well as demographic and socioeconomic factors that affect the risk of being abused, and evaluate/identify effective interventions and metrics such as Healthy Steps and Adverse Childhood Experiences (ACEs), intended to proactively prevent abuse and aggressive behavior, and promote healthy development.
- Determine mechanisms to advocate treatment options in health care settings that address potential factors for increased risk of child abuse and neglect (i.e., mental health or relationship counseling, nonclinical counseling such as provided by Military OneSource, referral to programs focusing on socioeconomic factors such as food insecurity, etc.).
- Review the policies, protocols, and methods used by health providers and health care teams caring for military families to screen for child abuse and neglect, including recognizing symptoms of physical, emotional, and sexual abuse; identifying patterns indicative of child abuse and neglect; discussing child abuse and neglect; and reporting suspected child abuse and neglect to appropriate programs and authorities.[5]
- Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.
- Review existing support programs for victims of child abuse and neglect in the MHS, as well as the continuity of care coordination with medical and social services to strengthen the interface between medical and non-medical communities (military and civilian).
- Assess the role and management of rehabilitative treatments/programs and wellness initiatives in place for abusers, including examining the accessibility of programs that provide support, such as mental health treatment programs, home visiting programs, social services such as family and parenting programs, and counseling. This review should include programs provided to military personnel incarcerated for child abuse/neglect crimes in military disciplinary facilities.
- Note opportunities to track health outcomes of children who were abused or neglected, including parents' ACEs, within the Millennium Cohort Family Study to determine the full impact on the MHS.

E2. CAN Prevention and Treatment Programs in Use within DoD

According to Rose's Paradox of Prevention, there is greater societal gain when a small reduction in a problem or disease is achieved within a larger group than when large changes are achieved within a smaller group.[176] Consistent with this assertion, experts underscore the importance of a universal approach to CAN prevention, including preparing parents for normal developmental stages that can trigger child maltreatment, and identifying and enhancing protective factors. A coordinated, multi-sectoral approach tailored for military families[6] may have the largest impact. It is important to note that, according to a 2019 report of the U.S. Preventative Services Task Force (USPSTF), there is currently insufficient evidence to conclude that primary care interventions can prevent child maltreatment among children who do not already have signs or symptoms of abuse.[60] Therefore, it will be important to track to inform ongoing or future intervention and investment.

Military OneSource

Military OneSource, established in 2004, is a 24/7 call center and website that serves as a connection to information and support within the military community.[38] Military OneSource is not an automated service.[38] Master's-level consultants are readily available to provide support and resources regardless of activation status or immediate family status.[38] The caller is made aware of this information and referred to the proper entity as indicated.[38] Those eligible for Military OneSource resources include active duty Service members, National Guard and Reserve Component Service members (regardless of activation status), immediate family members, Coast Guard (when activated with the Navy), expeditionary civilians (90 days pre- until 180 days post-deployment), retired or honorably discharged Service members (to include those with a general discharge, up to 365 day post separation or retirement), survivors, non-married spouses, and children. Many available services are illustrated in Figure 19.[38]

Military Community and Family Policy (MC&FP) houses quality of life policies and programs that help Service members, their families, and survivors to be well and mission ready. MC&FP includes a wide-range of programs, such as the Family Advocacy Program (FAP), Morale Welfare & Recreation/Resale (MWR) programs, the Exceptional Family Member Program, the Military and Family Life Counseling (MFLC) Program, and Military OneSource.[38] Military OneSource, which includes a universal prevention approach focused on non-medical counseling, is available to the entire military community worldwide.[38] Additionally, Military OneSource and MFLC are supported by the *Department of Defense (DoD) Instruction 6490.06 Counseling Services for DoD Military, Guard and Reserve, Certain Affiliated Personnel, and Their Family Members*, 2009, updated in 2017, which promotes a culture to encourage counseling, attempts to remove the negative stigma associated with receiving treatment, empowers providers, and enables easier access to services for early intervention to enhance family readiness.[177]

Figure 19. Military OneSource Services for Service Members and Families

Other helpful tools intended to be used include evidence-based tools and webinars for anger management, stress, and mood.[38] The "mood hacker" allows participants to track their mood in efforts to increase self-awareness and self-regulation.[38] However, if a participant contacts Military OneSource with an incident of domestic violence or CAN, the incident will be reported to appropriate authorities and handed off to FAP.[38] Additionally, Military OneSource is not a typical treatment resource that FAP uses for clients with open cases since FAP has more intense programs specific to the cases related to violence.[38] Of note, FAP also does not have access to Military OneSource data or other non-medical counseling entities.[38]

MC&FP aims to better promote Military OneSource as a holistic source of support for service members and families.[38] Commanding officers' (CO) involvement is important in raising awareness of these resources. COs are well positioned to educate and train subordinate officer and enlisted leaders who interact daily with vulnerable Service members most in need of these resources. In addition, Service members could benefit from the resources on Military OneSource if promoted through training or required curriculum early in their careers.[38] Further, this resource could also be used as part of the transition package when a Service member is separating or retiring, thereby extending the outreach beyond the active duty population.

Finally, health care providers have the potential to play an integral role in raising awareness of Military OneSource as well. Team-based care, focused on providing Military OneSource resources, is not systematically built into military clinics.[38] Providers could leverage the electronic health record (EHR) as a systematic tracking and patient education/resource tool.[38] Provider education regarding these resources could prove beneficial; however, integrating this process into the providers' daily routine still poses a challenge due to time constraints.[38]

The Military and Family Life Counseling Program

The Military and Family Life Counseling (MFLC) Program is another source of non-medical counseling and provides in-person counseling for the military community.[49] Counselors provide up to 12 sessions of free services to the community and are available both on and off the installation.[49] One-on-one, couple, or group sessions are available for issues similar to what is available through Military OneSource, such as stress management, relationship building, and grieving processes.[49] MFLC counselors are trained to discuss military-specific challenges such

as deployment adjustments, relocation, reintegration, and occupational stress.[49] MFLC does not treat abuse cases or other mental health issues that require long-term attention or medication.[49]

An October 2017 RAND report noted the positive outcomes associated with the non-medical counseling programs offered through Military OneSource and Military Family Life Counseling. This report stated that 90% of participants reported positive experiences using these programs; there was a significant decrease in problems regarding work or daily routines after receiving non-medical counseling, and over 90% of participants reported satisfaction with their counselors.[50]

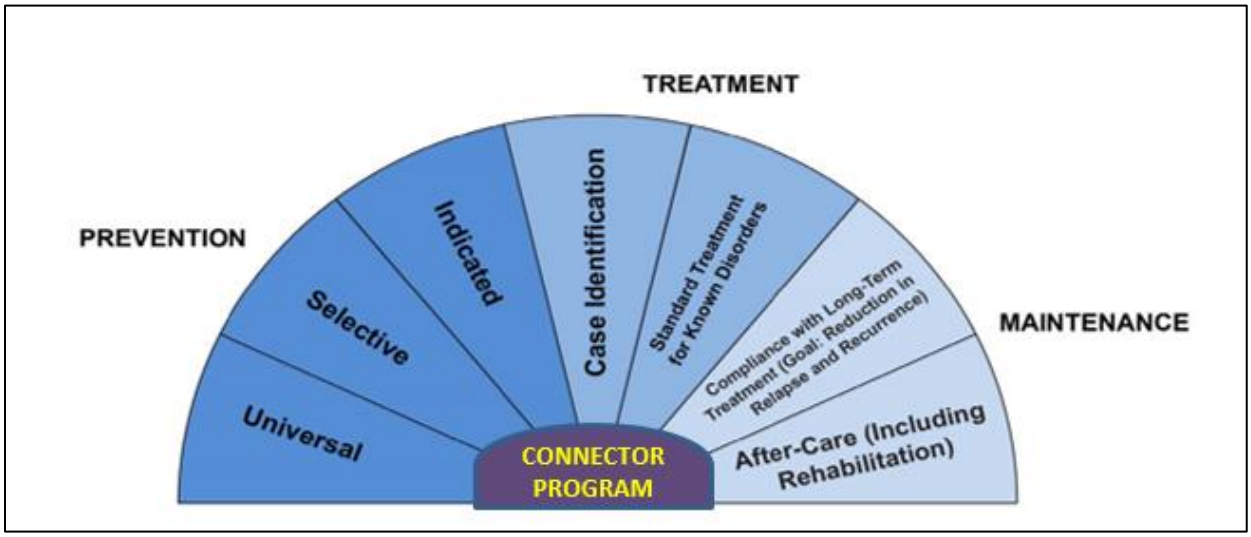
UNIT CHAPLAINS

In addition to Military OneSource, chaplains are available throughout the military. Military chaplains are commissioned officers serving as religious leaders responsible for performing worship services and other religious ceremonies.[51] Additionally, chaplains provide confidential counseling on topics such as grief, substance abuse, combat stress, and relationships.[51] Typically, chaplains are not licensed counselors or social workers; however, the sessions are completely confidential and aim to help Service members and families overcome life challenges.[51]

THE DOD CONNECTOR PROGRAM

The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016, Section 114-557, "Military Dependents and Mental Health," required the SECDEF to develop a program to identify children at-risk of mental health conditions with parental deployment and to develop tools, education, and guidance for providers and parents.[136] Literature documents increased anxiety, depression symptoms, levels of fear, attention difficulties, and reduced school performance linked to parental wartime deployment.[136] This issue impacts medical and family readiness of Service members.[136] In response, the DoD partnered with over ten entities across the Enterprise, such as DoD Education Activity (DoDEA), the Substance Abuse and Mental Health Services Administration (SAMHSA), Connected Health's Military Kids Connect, and Military Community & Family Policy (MC&FP), including Military OneSource, to establish the DoD Connector Program.[136] The DoD Connector Program links military families to appropriate providers at the right level of services that already exist within the public health spectrum of prevention and treatment as seen in Figure 20.[136] Further, resources from the Connector Program are available online through live-streamed KSOC-TV events, webinars, and podcasts and Connected Health, Military Kids Connect.[136] Additionally, signed Memorandum of Agreement (MOA) between DHA and MC&FP (including Military OneSource) and DHA and DoDEA support beneficiary engagement and shared communication.[136] This effort would further provide convenient community support to transient military families and children at-risk, not only for CAN, but also for other mental health and family challenges.[136] Currently, this effort is not resourced to meet all implementation milestones.[136]

Figure 20. The DoD Connector Program Model[136]



HEALTHYSTEPS IN THE DOD

> "The best way of helping children is to help their parents, and the best way of reaching parents is through their children." —*Parker and Zuckerman, 1998.*[1]

The HealthySteps Program, initiated in 1994 by the Commonwealth Fund, is an evidence-based, interdisciplinary pediatric primary care program designed to support positive parenting and healthy development of babies and toddlers.[38] The DoD is piloting the HealthySteps program in several MTFs and is currently evaluating the effectiveness of integrating the program into its services for military families.

A key intervention of the HealthySteps program is inclusion of a HealthySteps Specialist, a professional with training in early childhood development, nursing, or social work, into the primary care team. The specialist meets with families during well-child visits.[1] However, within the DoD, a health care provider reviews recommended child screenings, discusses family concerns and typical child behavior and development, collaborates with parents to identify goals, and provides positive parenting information, including referrals.[38]

The initial program utilized the pediatric primary care system to convey parenting techniques and services to families during early childhood development.[1] This framework is unique in that it introduces a developmental specialist into pediatric practices.[1] Additionally, this framework was among the first to highlight the importance of young children's relationships with their primary caregivers and the impact of the stress on the caregiver, which can impact meeting the needs of the child.[1] This program is also unique because it was made available to children and families of all socioeconomic levels and was easily adaptable in various practice settings.[1] ZERO to THREE, a non-profit policy center that educates the public and policy leaders on early childhood and promotes strong families, acquired HealthySteps in 2015 to scale the program.[178]

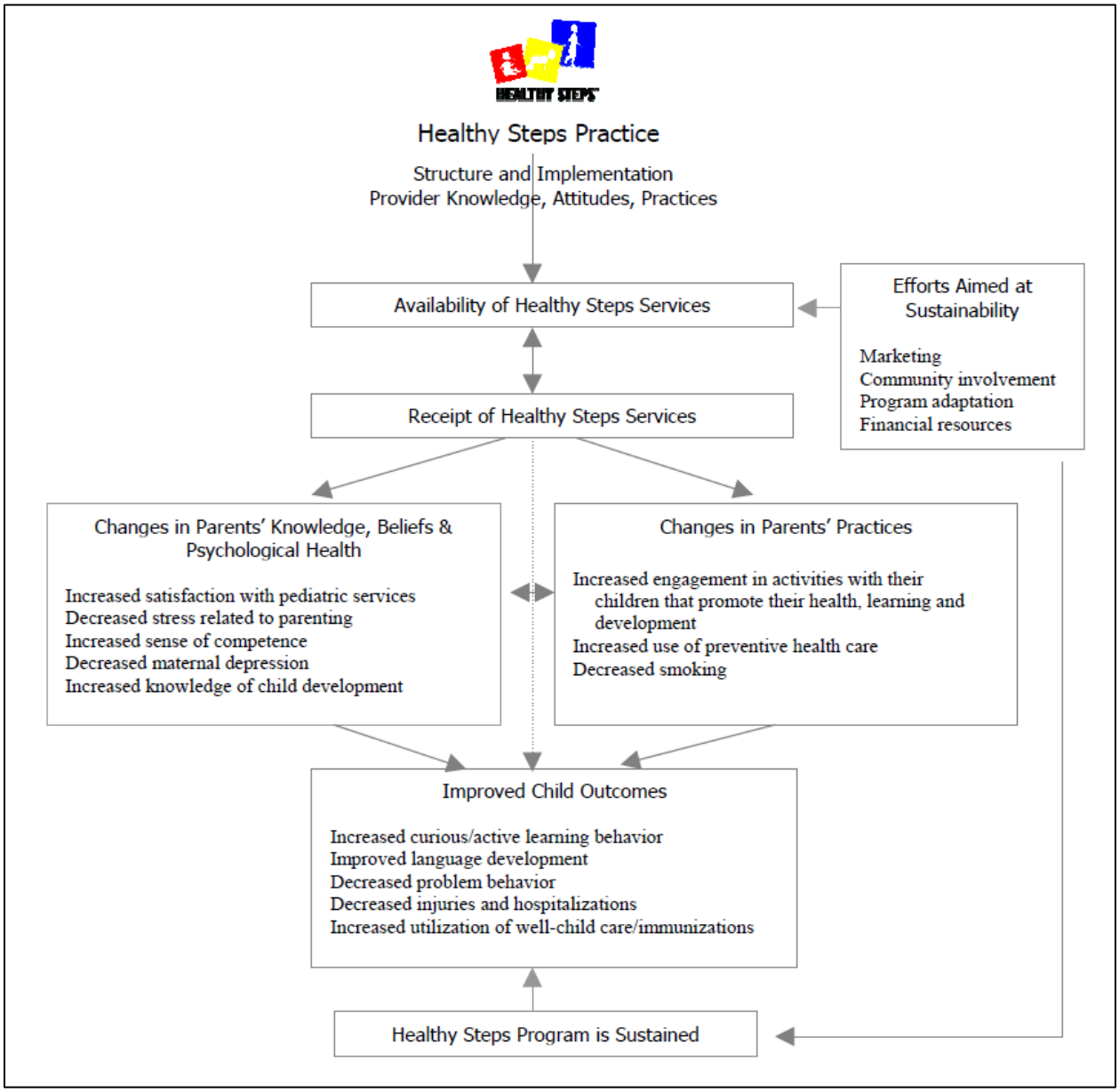
Today, the national ZERO to THREE HealthySteps Program has eight core components, or services, that are available and distributed based on a Tiered-Model: child development, social-emotional, and behavioral screenings; screenings for family needs; child development support line; child development and behavior consults; care coordination and systems navigation; positive parenting guidance and information; early learning resources; and ongoing, preventive team-based well-child visits.[178]

Tier 1 includes universal services available for all families with children from zero to three.[178] HealthySteps uses a team-based, preventive approach to support parents with challenges such as stress and unemployment.[178] Tier 2 includes services from Tier 1 plus short-term support for families with mild concerns, such as, positive parenting guidance and information and early learning resources.[178] Finally, comprehensive interventions are available for families most at-risk in Tier 3.[178] These services include components from Tier 1 and 2 in addition to HealthySteps Specialists that are integrated into the primary care team and meet with families during well-child visits.[178] Figure 21 demonstrates the overall program model efforts and expected outcomes.

A 2003 National Evaluation was conducted to determine the effectiveness of HealthySteps Specialists; outcomes included cost sustainability of program design; changes in mothers' knowledge, beliefs, and psychological health; engagement with child activities that promote health, learning, and development; and satisfaction with pediatric care.[1,38] The overall evaluation found that the program significantly improved practices in parenting support and core developmental services to young child and their families.[1] For example, mothers were 1.4 times as likely to have a referral for maternal depression; 23 percent of children were less likely to visit the emergency department for injury-related causes; 27 percent of parents were less likely to use severe discipline such as spanking; 22 percent of parents were less likely to use harsh punishment like yelling or threats; mothers were more likely to raise intimate partner violence (IPV)-related issues with a health care provider; and families were 1.4 times more likely to have a non-medical referral, including CAN intervention.[1]

The DoD is interested in adopting this model into military treatment facilities (MTFs) for military families. Currently, two MTFs (Madigan Army Medical Center and Naval Medical Center San Diego) are piloting HealthySteps; Womack Military Medical Center at Fort Bragg, NC, will be joining the pilot soon.[38] Child and Youth Behavior MFLCs who are under MC&FP and work within the MTF have been trained as HealthySteps specialists.[38] A full evaluation of this program is in the planning stages with measures of effectiveness including maternal depression, emergency department medical resources, parental satisfaction with HealthySteps Specialists, and positive health behaviors.[38] It should be noted that health care providers in the MHS will also require further education and training to input HealthySteps information into the EHR correctly.

Figure 21. HealthySteps Conceptual Model



DoD Parenting Programs

Evidence suggests that young military families may be at elevated risk for a variety of problems, including child maltreatment. DoD offers a number of programs and supports for military families that can enhance child development, strengthen family relationships, and support mission readiness. This section highlights many of those programs and supports; the Services may have others that did not come to the attention of the Board during this investigation.

New Parent Support Program

The New Parent Support Program (NPSP) is housed under MC&FP within the Office of the Under Secretary for Personnel and Readiness (USD[P&R]).[53] NPSP, under the auspices of FAP, is a prevention-based program supported by years of data as a means to proactively address parenting concerns.[52] A 1990 Government Accountability Office (GAO) report and civilian research suggest that providing parents with education and support when a child is first born is the most effective strategy for preventing child abuse.[53] Subsequently, Congress initially established NPSP funding in fiscal year (FY) 1995.[53]

NPSP aims to prevent CAN in young families by promoting safe, stable, and nurturing parent-child and co-parenting relationships through home visits, referrals to other resources, prenatal classes, and parenting classes to expecting parents and parents who have children 3 years old or younger on and off the installation.[179] *DoD Instruction 6400.5, NPSP,* published in 2005 and updated in 2012, standardizes NPSP components across Services[179] and addresses personnel requirements although implementation of these standards may vary.[53]

Dissemination of best practices is done through quarterly meetings with NPSP leaders from each Service.[53] Services are not required to uniformly follow these best practices but are strongly encouraged to adopt those that support their Service-specific NPSP implementation.[53] The Army NPSP is community-based under the Installation Management Command (IMCOM) and primarily uses nurses with social work support. All Navy FAP services are community-based; they are housed under Fleet and Family Services and use the Nurturing Parent Program, an initiative that offers education, intervention, and home visits.[53] All Marine Corps FAP services are also community-based but use Parents as Teachers, an internationally recognized evidence-based model and includes the use of nurses, social workers, and licensed marriage and family therapists (LMFTs) when needed.[53] All Air Force FAP services are located in the MTF and utilize nurses along with a standards-based program issued through Air Force Instructions.[53] It should be noted that success may depend on parent engagement and the background and experience of the home visitor.

All NPSP services include the administration of the Family Needs Screener distributed in MTF OBGYN clinics, OB orientation, and other forums in Family Service Centers. In FY 2018, approximately 350 home-visitors provided support to 79,000 families with 42,000 designated as "high needs" families and 37,000 as "low-needs" families per the Family Needs Screener. The Family Needs Screener is detailed later in this Appendix. However, due to the voluntary nature of the NPSP, services may not reach the most vulnerable groups; moving to an opt-out model

might extend its reach. In addition, better integration of the NPSP (and FAP) into Army, Navy, and Marine Corps MTFs, either administratively, physically, or both, provides an opportunity to extend the programs' reach. This approach would allow families who need NPSP services to be captured during pre-and post-natal care, pediatric appointments, and family practice visits.

The NPSP is consistent with the Five Protective Factors Framework, which is part of the Strengthening Families approach developed by the Center for the Study of Social Policy. The framework examines factors that are associated with reduction in CAN; these include: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children.[53] This framework informs online courses through the National Child Traumatic Stress Network.[53] Moreover, these protective factors are infused into *DoD Instruction (DoDI) 6400.05*.[53] Specifically, the Methods section of the DoDI (Section 5, pg. 9) states: "NPSP services shall be provided through a strengths-based family centered developmental approach that promotes protective factors associated with the reduction of risk for child abuse and neglect: (1) Parental resilience, (2) Social connections, (3) Concrete support in times of need, (4) Knowledge of parenting and child development, and (5) Nurturing and attachment."[53,180] Including this effort, the NPSP provides opportunities to improve federal-civilian partnerships in other continuous learning and collaborative environments, such as the Safe Sleep initiative through a relationship with the Eunice Kennedy Shriver National Institute of Child Health and Human Development, which is adapting practices for military families to reduce risk of sleep-related infant death and sudden infant death syndrome (SIDS).[53]

THRIVE Initiative and the DoD

The Clearinghouse for Military Family Readiness at Penn State, in partnership with the DoD's Office of Military Community and Family Policy, developed the THRIVE Initiative to empower parents as they nurture their children from the prenatal period until 18 years of age.[54] THRIVE includes the programs *Take Root!* (0-3 year olds) and *Take Root Home-Visiting*, as well as *Sprout!* (3-6 year olds), *Grow!* (5-10 year olds), and *Branch Out!* (10-18 year olds).[52,54] The THRIVE Initiative includes face-to-face and online parenting programs as well as several free online resources and interactive learning modules.[54] Currently, *Take Root!* and *Grow!* are available online for free in full development, while *Sprout!* and *Branch Out!* are under development.[54] Through its proactive and supportive platform for parents, "THRIVE fosters resourceful parents, resilient children, and ready families."[54]

Period of PURPLE Crying®

The DoD has a contract with the National Center on Shaken Baby Syndrome for the Period of Purple Crying® initiative to prevent abusive head trauma related to shaking.[52] The intense period of crying in a baby's life is a vulnerable time when parental frustration can lead to shaken-baby syndrome and other abuse.[181] Period of PURPLE Crying® is an evidence-based program of the National Center on Shaken Baby Syndrome aimed to: 1) Support caregivers in their understanding of early increased infant crying, and 2) Reduce the incidence of shaken baby syndrome/abusive head trauma.[55] As shown in Figure 4, the phase of infant development addressed by the program typically begins at approximately two weeks of age, increasing in

month two, until three to five months of age when the baby can cry for hours but still be healthy and normal.[181] The program includes a 10-page booklet, parent reminder card, 10-minute video, and a 17-minute video intended for parents of new infants.[55]

Figure 22. The Period of PURPLE Crying® Acronym

The *Period of PURPLE Crying*® is provided through the Three Dose Model to ensure that all parents and caregivers receive and understand the program messages.[55] Dose One is the 'Delivery of the *PURPLE* Program Materials to Parents' of newly born infants; this includes demonstration of intervention materials and takes place within the first two weeks of the baby's life.[55] Dose One may include home visiting programs, pediatric well-baby visits, and public health.[55] Dose Two is the 'Reinforcement of the Messages' and often takes place at public and state department health programs, home visits, and/or pediatric well-baby visits to reinforce important messages.[55] Dose Two is more flexible than Dose One in terms of timing; it can generally occur throughout the first three months of birth.[55] Dose Three is the 'Public Education Campaign Toolkit' to ensure that all community members understand the *Period of PURPLE Crying*® and can be implemented at any time after or before the baby's birth.[55] There are resources for small or large campaigns including media advertisements.[55] Additionally, there are several free online training materials, including the PURPLE app; however, experts contend that this information is best shared person-to-person.

Utilization of the resources provided for by the contract are not universally used in the MHS. There is still a need for child/adolescent health care providers and obstetric providers to impart more 'purple' crying information to parents during the most critical period (when the baby is two to four months old).[52] MTFs provide site-specific new parent training, including information on shaken-baby syndrome and crying, while the mother is recovering in the hospital and during well-child visits. There is opportunity to standardize and universalize the training on shaken baby syndrome during the critical period, and the Period of PURPLE Crying could serve as the model.

After Deployment: Adaptive Parenting Tools (ADAPT)

The After Deployment: Adaptive Parenting Tools (ADAPT) intervention is a 14-week web-enhanced parenting program delivered in two-hour sessions to groups of six to 15 parents per group.[56] ADAPT was developed with the Minnesota National Guard and Reserves "to help families as they cope with the stress of deployment and reintegration."[57] The program addresses "six core parenting skills: teaching through encouragement, discipline, problem-solving, monitoring, positive involvement with children, and emotion socialization."[56, p.590] ADAPT is a modification of the theory-based Parent Management Training-Oregon model (PMTO™), an intervention to help parents manage their children's behavior designed to promote prosocial

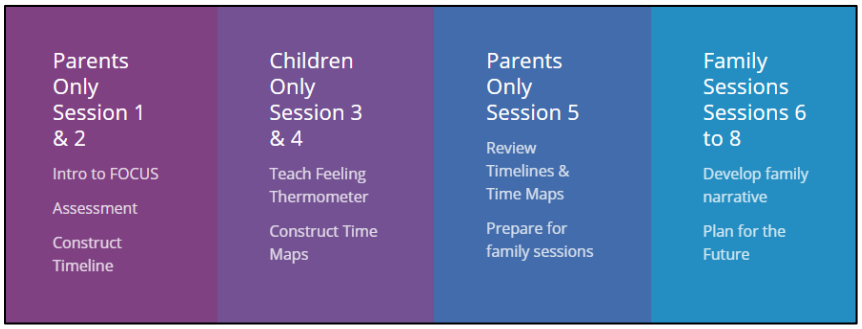
skills and cooperation and to prevent, reduce, and reverse conduct problems in children 4 to 12-years old.[182,183]

Since development in 2010, ADAPT has partnered with 336 families in the Minnesota National Guard and Reserve Units to evaluate the program through a randomized control trial.[57] A 2014 study evaluated the first cohort of families (42 families) to participate in the ADAPT program.[184] In this cohort, parenting practices were taught in weekly two-hour groups using active teaching methods such as role play.[184] Three specific adaptations were made based on data collected from the first phase of the project: 1) military culture and context (needs specific to the nature of reintegration), 2) how combat stress reactions may influence parenting and the family context, and 3) barriers of weekly participation.[184] The study found that the program is feasible and acceptable; once a family attended at least one session, average participation was extremely high.[184] Participants indicated high satisfaction for every group session.[184] A 2018 study using all 336 military families improvements in parenting were significantly associated with improvements in child adjustment.[56]

Families OverComing Under Stress (FOCUS)

Families OverComing Under Stress (FOCUS) is a family-centered, evidence- and trauma-informed resilience training program for military families with school-aged children.[58,59] It provides customized, evidence-based preventative interventions for military families, children, and couples by teaching practical skills to help overcome military life challenges.[59,185] FOCUS has shown effectiveness for active duty families with school-aged children with improvements in positive coping, prosocial behaviors, family functioning, and parent and child psychological health outcomes, such as the prevalence and severity of anxiety and depression.[58] The centerpiece of FOCUS is improving communication among family members by bridging family members' experiences through their stories.[59] The five key skills of FOCUS are emotional regulation, communication, problem-solving, goal-setting, and managing trauma and stress reminders.[59,185]

Figure 23. FOCUS Family Resilience Training by Session



FOCUS resilience training is a multi-session program, usually six to eight sessions that are organized around the development of a family timeline.[185] The sessions include consultations (typically 30-60 minutes), skill building groups, educational workshops, and briefs.[185]

The FOCUS 'On the Go' app provides additional resources including games for children focused on problem solving, videos that highlight strategies to support military families, and a survey to identify the family's unique strengths.[185]

The FOCUS for Early Childhood (FOCUS-EC) model is for families with children between the ages of 3 and 5-years old, comprised of the same core FOCUS elements.[58] The FOCUS-EC model has further been modified and examined as a pilot through the FOCUS-EC Virtual Home Visiting model. The Virtual Home Visiting pilot is delivered through six virtual home visiting sessions that leverage a secure web-based platform for the family and FOCUS-EC facilitator to meet online for 30 to 90 minutes depending on the family's needs.[58] During the virtual session, the family learns and practices the skills, commits to practicing the skills during the week, and reports on their experiences during the following session to reinforce the skills.[58] By leveraging telehealth with virtual home visits, families who may otherwise not be able to travel are provided prevention resources; clinicians can serve more families at lower costs, and stigma associated with receiving mental health treatment is reduced.[58]

FOCUS is available at 29 military installations in the U.S., 4 in Japan, and at 4 USMC Wounded Warrior Regiments.[185] Additionally, installations can request consultations for specific sessions for parents, children, or families, for training sessions to implement FOCUS, and for skill building groups, workshops, and briefs.[185] These options are available to community providers and families. Also, after consultations, families can choose to participate, or ask to be linked to other services.[185]

E3. Screening and Assessment for CAN in Military Families

In this Appendix, the term "screening" refers to the "process for evaluating the possible presence of a particular problem," – in this case, CAN. The term "assessment" refers to "a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis"– used here to indicate in-depth assessment of child maltreatment involving differential diagnosis. CAN screening and assessment processes vary within the DoD and in the civilian sector.

No specific CAN screening measure is used across the MHS and screening processes vary within the Direct Care Network of the MHS. Providers within the Purchased Care Network (TRICARE) are required to notify the referring MTF or military health care provider if there is any suspicion of serious harm to self or others, including cases of CAN, per the TRICARE participation agreement and TRICARE Policy Manual. However, TRICARE does not specify network provider requirements for screening and/or assessing CAN. Such a requirement, and any formal tracking mechanism for compliance with screening, assessment and reporting, would have to be specified in the Managed Care Support Contract (MCSC).

In cases of suspected CAN, a more in-depth assessment may be indicated to aid in differential diagnoses or investigate various facets of complex cases to provide expert, objective forensic and/or medical recommendations. Tools and processes available for purposes of differential diagnoses in the DoD include the American Academy of Pediatrics (AAP) best practices and guidelines for physical and sexual abuse evaluation, the gold standard in the civilian sector for making differential diagnoses in cases of child maltreatment. The AAP best practices and guidelines are discussed in Appendix F. Of note, information regarding the extent and fidelity of AAP best practices implementation within the DoD is not currently available. In addition,

information regarding investigation of complex cases is provided in the discussion of the Armed Forces Center for Child Protection (AFCCP) in Appendix D.

Standard Operating Procedures (SOPs) for addressing CAN vary across Services and MTFs, as discussed in Appendix D. The Clinical Communities, also discussed in Appendix D, offer a mechanism within the MHS to standardize the pathway of care for child maltreatment, including identification of CAN screening and assessment processes. Civilian best practices include but are not limited to the Child Abuse and Neglect Clinical Pathway defined by the Children's Hospital of Philadelphia (CHOP), discussed in Appendix F.

Of note, some Direct Care health care providers express reservations about mandating another screening tool to child preventive care visits. Nevertheless, it is critical to ensure that screening for CAN is conducted universally and with rigor in order to protect this vulnerable population. This systematic process is especially important in the 0-3 year old population, as well-child visits provide an important opportunity for identifying potential CAN in this age group.[33] It is important to determine the best resolution to this issue and to ensure that appropriate screening and assessment is conducted across the Direct and Purchased Care Networks. Three screening tools in use in the DoD are discussed below: the TSWF, Adverse Childhood Experience (ACE) screening, and the Family Needs Screener (FNS).

THE TRI-SERVICE WORKFLOW (TSWF)

TSWF forms are standardized templates used in the Armed Forces Health Longitudinal Technology Application (AHLTA) across all ambulatory care settings; TSWF forms are also being adapted for the new electronic health record, MHS GENESIS. There are 32 forms, four of which are specialized for pediatric patient care. Provider-patient interactions such as interviews are supported by TSWF forms and details can be captured within the forms' free text boxes.[33] However, many of these free text boxes and screening tools are optional, and thus may not be completed during each visit.[33] Because providers have limited time with patients, the increasing the number of screening tools and data fields may further limit the time for rapport building and referral discussion to address current health issues and stressors.

There are three form sets designed for well-child visits. The '4' form, also known as the General form, is used for unwell/sick visits. Not all elements in the forms require completion. The clinician documents past medical history, such as trauma and stress in a free text box, which correlate with the American Academy of Pediatrics Bright Futures National Health Promotion Initiative.[33] The screening section of the TSWFs include the question "Is the patient or parent currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?" and has "yes", "no", and "declined to answer" check boxes as well as a link to "Sexual Assault Resources" for the patient.[33] Under social history, the provider has a list of cues to inquire about the patient's daycare/school, who lives in the home, and information about the number, duration, and last return date of parent deployments next to a free form text box.[33] These questions provide an opportunity for the provider to further assess potential signs of maltreatment, particularly if the patient is malnourished or provides a positive response to the question regarding safety.[33] However, as discussed earlier, many of these questions are voluntary. The DHA data analytics team sampled 100,000 patient encounters over one week and

found providers documented the safety question for 65.0% of female patient encounters, indicating a need for improved implementation of this screening question.[33]

In addition to a general review of behavior-related symptoms, the behavioral health section of the TSWF encounter forms also has several screening tools, including ones for depression, anxiety, drug and alcohol abuse, and ACEs. The review of behavioral health symptoms includes attention issues, depressive behavior, and internalization or externalization of problems. There is an option for the provider to print out the screening questionnaires and review of symptoms for the patient or guardian to take home and complete.[33]

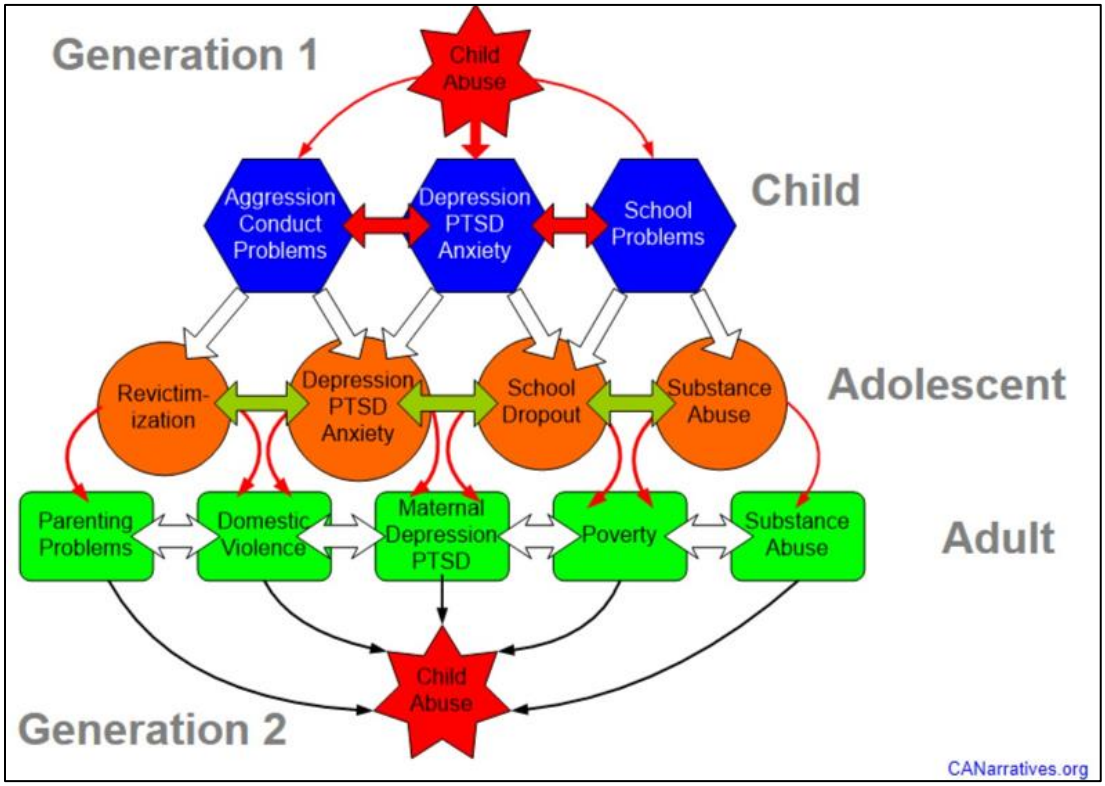
The development section includes the HEADSSS Assessment (Home, Education/Employment, Activities, Drugs, Sexuality/Sexual Activity, Suicide/Depression, Safety) free text box.[33] A clinician reference guide and key questions for use during the patient encounter are available. Note that this documentation becomes available in the TSWF form when the patient is 11 years or older.[33] This assessment could also serve as a prompt for discussion regarding maltreatment and/or family difficulties.

SCREENING FOR ADVERSE CHILDHOOD EXPERIENCES WITHIN THE MHS

Adverse Childhood Events (ACEs) are stressful or traumatic childhood events that have been linked to the likelihood of future violence, including victimization and perpetration, as well as decrements to lifelong health and lack of social opportunity.[38] In the late 1990's, the original ACE study began investigating obesity but instead found a link between childhood trauma and the physical and emotional well-being in adults.[39] From this discovery, a questionnaire was developed to ask about exposure to seven categories of ACEs: psychological, physical, and sexual abuse; domestic violence; living with family members who were substance users, or mentally ill/suicidal; and having a family member imprisoned.[39] ACE scores were then compared to the health status of each adult who responded to the questionnaire.[39] This landmark study showed that out of the 17,000 participants, adults with 4 or more ACEs were more likely to suffer from chronic illness than adults who displayed zero ACEs, in addition to a shortened life expectancy of up to 20 years.[39] The ACE study demonstrated that biological processes involving the endocrine system and epigenetic changes mediate the translation of childhood traumatic emotional experiences into organic disease later in life[39] and revealed a powerful relationship between emotional experiences as children and physical and mental health as adults. Today, estimates suggest more than 20 million children and 25% of adults of the total population have experienced at least three or more ACEs.[107]

Additionally, ACEs can lead to toxic stress, with approximately 34 million American children at risk for toxic stress today.[186] Toxic stress is repeated extreme activation of their stress response and is more likely to be experienced by people who have ACEs.[107] Thus, repeated maltreatment, including CAN, may lead to toxic stress.[6] CAN is displayed as an ACE in Figure 24 as it crosses generations with potential physical and mental impacts.[6]

Figure 24. How CAN Crosses Generations[6]



ACEs suggest a pathway through which a parent's own experience impacts that of a child.[38] Therefore, examining ACEs in a younger generation allows the onset time and the impact of trauma on development to be observed[187] and for interventions to be instituted early and break the intergenerational cycle. The Center for Youth Wellness is leading a national effort to provide more scientific evidence on the relationship between ACEs and human physiology; only 11% of pediatricians are familiar with the underlying research.[186,188] This national effort has found that ACEs increase the risk for seven out of 10 leading causes of death and cause multi-systemic alterations including neurologic, immunologic, endocrine, and epigenetic changes. ACEs contribute to long-term changes to: the fight or flight response, causing an over-reactive fear response, leading to toxic stress; the function of the immune system, leading to increased risk of infections, inflammation, and chronic diseases; hormones leading to changes in growth, reproductive health, obesity, and changes to metabolism; and the way DNA is read and expressed, causing premature cellular aging, and increasing the risk of passing down these attributes to the next generation.[186]

The Center for Youth Wellness (CYW) hopes to encourage all child/adolescent health care providers to screen for ACEs by 2028, with currently only 4% of pediatricians screening for ACEs.[186,188] CYW holds that early identification of ACEs through screening with subsequent, tailored interventions, and that the ability to respond is imperative.[186] Early interventions that buffer the toxic stress response, including balanced nutrition, regular exercise, psychotherapy and/or psychiatric care, quality sleep, supportive relationships, and mindfulness/meditation

practices are also important.[186] In addition to early intervention, routine screening at well child exams with identification of the number of ACEs experienced would be beneficial for the patient and family.[186]

ACEs Among Military Populations

In addition to CAN, ACEs include divorce, household dysfunction, substance use, neglect, IPV, and sexual abuse that could lead to adult consequences like posttraumatic stress disorder (PTSD), substance abuse, attempted suicide, physical health conditions, and decreased life expectancy by up to 20 years.[40] Military populations may be a specific cohort of interest regarding ACEs because some may join the military to escape personal problems related to ACEs, such as household dysfunction or abuse,[40] and the culture may offer greater structure and predictability than what was previously available.[38] This may elevate the prevalence of ACEs in the military population.

In 2014, the largest U.S. ACEs military study was conducted.[106] Results indicated that ACE scores differed among men who served in the military during the all-volunteer era versus the draft era.[106] This finding suggests that drafting men from healthy homes mitigated detectable differences in ACEs between these men and men who later enlisted voluntarily.[106] Data show that women with prior experience in the military had a higher prevalence of physical abuse, exposure to IPV, and emotional abuse compared to non-veteran women.[106] Additionally, it should be noted that women were not drafted, so fewer differences were able to be observed.[106] The authors concluded that most people who enlist in the military do so for positive reasons, such as patriotism, self-discipline, self-improvement, and self-sacrifice; the military provides a population to better understand the role of resiliency to overcome the effect of ACEs.[106]

A previous study, conducted in 2011, examined ACEs in voluntary-enlisted men.[106] Findings indicated a higher prevalence of 4 or more ACEs in the military (27.3%) vs. the civilian population (12.9%) in 11 categories.[106] Additionally, the men in the study sample had twice the odds of reporting forced sex before age 18 compared to the nonmilitary population.[106] Study implications could inform the military's approach to prevention and resiliency. These implications include a focus on intergenerational impact, as many children of Service members become Service members themselves.[106] A 2015 study also found that those with military service had more total ACEs than the civilian population.[40] However, that study found that the health effects of ACEs were reduced in male military Service members when compared to civilian males. In contrast, while there was a reduction in health effects of ACEs in military females, the effect was not significant, with the exception of smoking.[40,118] This information suggests that the structure and support inherent in military service may serve as a resilience/protective factor.[40,118]

ACEs Efforts in the DoD

There is potential to leverage ACE screening tools in the MHS.[38] Currently, there are several projects incorporating ACEs within the DoD, including The Millennium Cohort Program, a pilot program at the Pediatric Patient-Centered Medical Home at Walter Reed National Military Medical Center (WRNMMC), and site-specific screening at several other MTFs. The emphasis

in these studies and pilots is to identify ACEs in the population served and to provide intervention to those meeting a certain threshold.

The WRNMMC pilot program includes the development of an SOP for ACE screening; all child/adolescent health care providers at WRNMMC are currently following this protocol.[189] This pilot program started as a process improvement program for the Accreditation Council for Graduate Medical Education (ACGME).[189] However, it should be noted that WRNMMC serves a high number of officers so may not reflect the needs or experiences of the general military population.

ACEs screening in this program occurs during the four-year wellness visit, with a referral process for identified patients.[189] The four-year wellness visit was chosen because there is typically a high attendance rate at this visit in preparation for entrance into school.[189] A screener created by the Center for Youth Wellness is used to obtain information about ACEs and scores are included within the TSWF pediatrics general form. This pilot encourages health care professionals to utilize the TSWF within the electronic health record (EHR) to enter ACEs data from parents prior to the appointment.[189] Moreover, this pilot program also hopes to include ACEs into other TSWF forms and create a template for the new DoD EHR, MHS GENESIS.[189]

Madigan Army Medical Center has taken some initial steps to implement ACEs screening into routine practice.[190] Health care providers are promoting and attempting to inspire other providers to include screening for ACEs into clinics and regular routine.[190] Other efforts across the DoD include an informal assessment of ACEs when determining treatment for offenders. Approximately 80% of offenders at Naval Corrections NAVCONBRIG Miramar have a history of trauma.[46] Those assessed to potentially be at higher risk of re-offending, based on higher ACE scores, are referred for more intense treatment or may "double-up" on treatments.[26]

Leaders of the HealthySteps Program are also considering screening for ACEs. Currently, two pilot sites (Naval Base San Diego and Joint Base Lewis-McChord) use HealthySteps by embedding specialists in pediatric clinics.[38] HealthySteps, with the addition of other mitigation or prevention strategies such as motivational interviewing, may be the best way to engage families who need the most assistance.[53] More information on HealthySteps can be found earlier in this Appendix.

The Millennium Cohort Program and ACEs

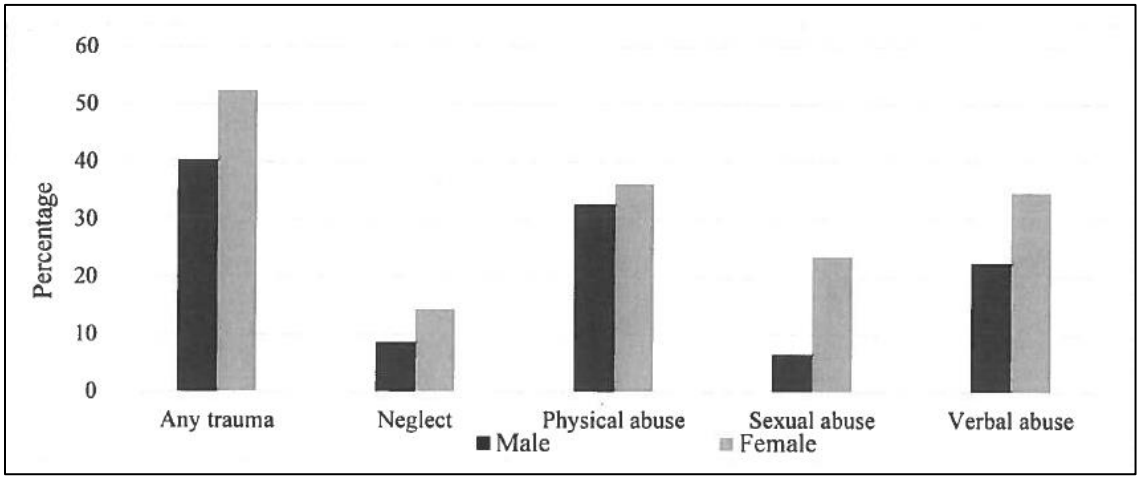
The Millennium Cohort Study was established through the *National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1999* to implement a longitudinal study to evaluate data on health conditions of members of the Armed Forces upon their return from deployment.[43] The Millennium Cohort Study is the largest and longest running longitudinal health study in military history with over 201,000 participants enrolled over four recruitment panels with multiple waves of survey follow-up.[43] There is also an intentional oversampling of underrepresented groups, including women.[43] Participants complete surveys every three years. The next survey panel/wave will launch in 2019 and is planned through 2068.[43]

The Millennium Cohort Family Study was initiated in 2011 in accordance with the DoD's

recommendation to conduct research on post-deployment adjustment for family members.[43] The Millennium Cohort Family Study is a 21-year long longitudinal research program documenting the impact of military life stress on family relationships.[42,43] The Family Study includes six core research program areas: 1) marital and family relationship adjustment, 2) methodological and foundational research, 3) individual and dyadic mental health, 4) physical health and health behaviors, 5) child well-being and parental adjustment, and 6) career and economic well-being.[43] Since its 2011 inception, the Family Study has developed a comprehensive database including self-report and archival data from Service members and spouses.[43] These studies have been linked to FAP Central Registry data, which documents "met criteria" reports of IPV, child abuse, and neglect.[43] Although the use of Central Registry data is beneficial, this information only includes reported incidents; unreported incidents most likely differ from reported incidents.[43]

With respect to ACEs, current focal areas of research include: parental stress and infant well-being, family violence perpetration risk and protective factors, and the long-term impacts of ACEs.[43] The Millennium Cohort Program collected information on ACEs to determine the prevalence and impact of ACEs, with respect to a range of outcomes including sexual functioning, homelessness, comorbid mental disorders, marital quality, work-family conflict, and family satisfaction.[42] Figure 25 illustrates the prevalence of the four ACE items included in The Millennium Cohort Study survey by gender.[41] Neglect was the least reported (10.3%), followed by sexual abuse (11.5%), verbal abuse (26.0%), and physical abuse (33.7%).[41] In total, over half of women reported experiencing any childhood trauma compared with 40% of men, with the largest gender difference reported in sexual abuse.[41]

Figure 25. Prevalence of ACEs in Millennium Cohort Participants[41]



At the request of the DoD Office of MC&FP, a measure was added within The Millennium Cohort Family Study, to obtain parental reports of child ACE exposure.[43] Additionally, a new measure has been added to assess parental engagement as a proximal protective factor for neglect and, under the guidance of DoD FAP, a screening tool has been added for possible IPV in the home.[43] For the 2019 data collection, questions regarding parental stress and caregiving stress have been augmented. Additional risk factors related to family violence, such as marital conflict

and parental aggression, have been added to baseline data collection on both the Family Survey and Millennium Cohort Study.[43] Both The Millennium Cohort Study and the Family Study will include the same ACE victimization-related items in future surveys.[43] With these changes, the researchers will be able to examine dyadic patterns of victimization in childhood and adulthood as predictors of child maltreatment in the Family Study.[43] Researchers hope to develop a sub-cohort of parent-child dyads in The Millennium Cohort Study, especially given the fact that a high proportion of military children go on to serve.[43] In addition, there are future possibilities to directly assess parental stress and infant well-being, family violence perpetration risk and protection factors, long-term impacts of ACEs, and the well-being of adolescents aged 11-17 in Millennium Cohort Program families.[43]

Special Considerations for the DoD

The impact of ACEs on family wellness has been a topic of interest in the DoD in recent years. The ACEs framework implies that exposure to a certain amount of adverse events in childhood impacts long-term health, physiologically and psychologically. There are additional stressors, such as long-term separations from a parent during deployment or living with the risk of parental death, which may be surrogates for traditional ACEs or new and military-specific ones altogether.

> "*More people are clamoring for government policy and health care organization to provide trauma-informed care because data is out there…The sad thing about ACEs is we've known about them since 1997, but there is a lag in translating it to create a system to actually do something about it,"*
>
> *-Dr. Imelda Dacones, CEO of Northwest Permanente (USA Today, 2018)*

The benefits of screening for ACEs in the DoD has been mixed, however. Some suggest that ACEs screening helps to improve the quality of the patient interview and that asking about ACEs is in itself an intervention, allowing discussion of topics that might not otherwise be discussed with anyone.[190] Others suggest that benefits are limited due to potential underreporting due to the potential stigma and social taboos and a culture of secrecy surrounding the topics of ACEs, in addition to the fear of current and future career repercussions. For example, some parents are not comfortable with filling out these screeners; the main concern includes the impact these reports could have on Service member's children who may later join the military themselves.[189] Additionally, the access to a standardized ACEs screener is not yet available throughout the Enterprise, nor has a screener been validated for the military population. Moreover, conflicting research suggests more information is needed in order to understand the relationship between adversity and one's health and behavioral outcomes, especially when considering mediators such as resilience. Some individuals experience trauma and do not endure physiological or psychological effects throughout their lifetime.[191]

A broad alternative approach utilizing universal prevention and focus on family and individual resilience is being used to promote positive outcomes.[6] Of note, research has identified a common set of factors that predispose children to positive outcomes despite adversity. Such factors include a children's sense of mastery, self-regulation, and social and spiritual connections.[6] Additional key drivers for addressing toxic stress include prevention efforts, community and ecological action, universal screening, effective referral systems, comprehensive

and available services, payment for services, a robust research agenda, and biomedical advances.[186]

THE FAMILY NEEDS SCREENER

The Family Needs Screener (FNS) is administered to expectant families through the Family Advocacy Program. The screening tool is designed to identify high-needs families who may benefit from New Parent Support Program (NPSP) services, as described previously. The Air Force developed the FNS for CAN and Intimate Partner Violence (IPV) based on Air Force FAP demographic and "stressor" variables such as substance use, depression, deployment, and prior family violence.[192] Assessment yields a preliminary classification of mothers at low risk for maltreatment (low needs [LN]) or at high risk for maltreatment (high needs [HN]), and identifies appropriate services and/or clinical intervention.[192,193] FNS completion is part one of a two part process; the second part includes the NPSP service provider using his or her clinical judgment to review the FNS's classification of high needs or low needs. According to a study by Travis and colleagues, although 25% the mothers sampled (*n*=27,219) were classified as HN by the FNS, an additional 6% of mothers were identified as HN based on NPSP service provider's clinical judgment.[194]

The FNS includes 58 self-report questions (with a 4-point rating scale for 42 items, yes/no responses for five items, multiple choice for seven items, and free response for four items) and is given to mothers who are pregnant or women with children aged three years or younger.[192] CAN-related questions are primarily associated with physical abuse, as many of the risk factors associated with physical abuse are related to other forms of maltreatment.[192] The screener is divided into 10 subscales with questions associated with various weights: demographics, stress, relationship issues, support availability, substance abuse, violence acceptance, family history of violence and neglect (i.e. sexual abuse, elder abuse, and spousal abuse), self-esteem, depression, and family violence.[192] Those that score a 9/53 overall on the screener are flagged for greater assessment to determine if they meet the "high needs" criteria, making this questionnaire very sensitive to ensure that potential families in need are not missed. Additionally, certain questions, such as "At times I feel out of control, like I'm losing it," "There are times when I feel life is not worth living," and "Have you or your partner been involved in a suspected or verified case of child abuse or neglect?" that immediately flag the family as HN[192,193] Also, teen parents or single parents are also immediately identified as HN.[194,195] All HN parent(s) are offered home visitation services as part of the NPSP as well as referral to other forms of assistance such as parenting classes or counseling.[192,194,195]

The FNS has several limitations. Because responses to the screener are self-reported, the instrument is subject to bias based on the reporter. The FNS is designed to be administered to the mother instead of both parents. This can be problematic as the mother may have limited awareness of the behavior of the other parent; in addition, this typically limits the FNS to 50 percent of the parental dyad. Also, the responder may feel pressure to answer questions in perceived socially acceptable ways, leading to underreporting risk factors or providing inaccurate information. Finally, the FNS is not validated and is optional, and subject to the healthy user bias wherein participants who voluntarily complete the screener may not reflect the average

population and may have better than average health behaviors. Therefore, more research is needed to determine if there is adequate recruitment/outreach to at-risk family populations.[192]

E4. Treatment for Potential/Alleged CAN Offenders Across Services

Service FAPs are primarily responsible for providing programs that support development of life skills to Service members and beneficiaries to prevent family violence. If a reported incident occurs, FAP will determine the best treatment plan to help re-engage the family system. In some instances, health care providers may be involved to coordinate clinical services offered within an MTF. The following list of trauma-focused therapies can be used for CAN situations, depending on the child's age:

- Brief Eclectic Psychotherapy
- Cognitive Behavioral Therapy
- Cognitive Therapy
- Exposure Therapy (imaginal, in vivo, and other)
- Eye Movement Desensitization and Reprocessing (EMDR)
- Interpersonal Therapy
- Medication management
- Narrative Exposure Therapy
- Present Centered Therapy
- Prolonged Exposure
- Stress Inoculation Therapy
- Trauma Focused Cognitive Behavioral Therapy
- Written Narrative Exposure[173]

However, the type of interventions, programs, and classes may vary across installations since the structure of FAP and needs varies across Services. The following section describes the life skills education and programs available to families by Service.

Army: Treatment for Alleged/Potential offenders

The Army FAP is designed in a bifurcated manner with FAP treatment programs located within the behavioral health service line as part of the MTF.[25] FAP is responsible for Service member coordination of care and the behavioral health department manages the behavior treatment plans.[25] For each CAN and IPV incident, each case is individually determined for treatment by a case management team.[25]

Typically, the behavioral health department manages high-risk treatments, individual treatments, and treatments for mental disorders or alcohol use disorders.[196] The Army also provides evidenced-based group programs to address anger, PTSD, and other co-occurring mental disorders seen with potential offenders.[196] Innovative Skills Techniques Options and Plans for Better Relationships (STOP) is a 52-week group treatment program that teaches how to improve relationships with family and partners. Strength at Home is a 12-week group treatment program specific to military couples addressing IPV.[196,197] The program is also informed by the 'survival

mode' model, which suggests that the vigilance developed in a combat zone may lead to inappropriate reactions stateside and a perception of unrealistic threats.[196,197] Additionally, it is important to note that anger is a critical antecedent for CAN, as is detachment and difficulty engaging with family.[196] Helping to re-engage service members, especially after a deployment, could potentially improve the family system.[196]

Currently, the Army does not collect treatment or program data to determine efficacy; however, evaluating internal capabilities may improve the value of the services provided by FAP.[196] There may also be a value in expanding civilian partnerships to aid in program evaluation.[196]

NAVY: TREATMENT FOR ALLEGED/POTENTIAL OFFENDERS

The Navy FAP is located within the Counseling, Advocacy, and Prevention program of Fleet and Family Support Center (FFSC), external to the health care system.[26] The Fleet and Family Support Program (FFSP) is organized into four core areas to meet mission readiness: Work and Family Life; Counseling, Advocacy, and Prevention; Sexual Assault Prevention and Response program; and the Navy Gold Star Program.[26] CAP programs are an integral part of the FFSP and support the Navy philosophy of "taking care of its own." The ability to cope and problem-solve is key to quality of life. Giving clients the skills to cope with life's challenges, as well as preventing and intervening in domestic abuse, is the right thing to do and exemplifies the Navy's core values and philosophy. Service members and their families who request FFSC clinical services when needed can greatly enhance their quality of life.

Clients are referred to counseling through their involvement with the Family Advocacy Program.[198] Active duty Service members and eligible family members are referred for FAP services through self-referral, Clinical Case Staff Meeting (CCSM) recommendations, or court-mandates. [198]

The Navy uses four evidenced based curriculums for domestic violence (DV) offenders.[198] The primary goal of this standardization is to ensure a consistent model of practice is being applied across the enterprise that increases program effectiveness and reduces recidivism rates in cases of DV.[198] Since each region/installation has unique demographics (e.g. location, resources, and state requirements) installations have the ability to select a curriculum that best meet its unique needs.[198] For individual treatment, installations use the STOP DV Program or the Choices Program.[198] When appropriate, sites may also use Couples Therapy for DV: Finding Safe Solutions.[198] Of note, Commander, Navy Incidents Command, (CNIC) does not endorse couple counseling or couple group if abuse is present in the relationship.[198] In met cases of domestic abuse, the offender should successfully complete an offender's DV group and meet all CCSM treatment recommendations related to the abuse prior to engaging in any couple work.[198] The DV Curriculum for Couples that is provided is intended for those low-risk, low-severity and/or "did not meet" allegations of abuse in which the program may be recommended in CCSM as a preventive resource for couples.[198] Victim support groups are also available.[198]

The Navy FAP allows for closed or open group sessions, based on the need of the installation.[198] Open sessions, with rolling admissions, provide the option of the client starting treatment at any time during the treatment process.[198] Other types of group treatment include conflict resolution

and anger management groups.[198] Conflict resolution focuses on two or more parties finding a peaceful solution to disagreements, without the use of violence.[198] Anger management focuses on understanding anger, coping with distress, and learning effective ways to communicate.[198]

FAP conducts periodic quarterly (monthly for child sexual abuse) case reviews of treatment through the CCSM, throughout the life of the case.[198] Case reviews allows for on-going risk management, evaluation of compliance, measuring treatment progress, and consultation on treatment recommendations.[198] The Navy tracks recidivism through queries from FAP historical records for civilian and military reported cases.[198]

Air Force: Treatment for Alleged/Potential offenders

The Air Force FAP is located within the MTF.[10] Available treatment programs are fairly consistent, however prevention services may vary depending on installation needs.[199] FAP offers psychoeducational interventions intended to be taken before an incident occurs.[199]

The Family Advocacy Strength-Based Therapy (FAST) program entails voluntary, short-term violence prevention therapy to address marital or parenting issues.[199] Love and Logic is a parenting class that teaches how to build relationships between parents and children and promotes healthy child development.[199] 1-2-3 Magic is another community-based program offered through FAP, which teaches positive discipline strategies to strengthen parent-child relationships.[199] Additionally, the Air Force is considering other initiatives such as a screening instrument for first sergeants' (E7-E9) who routinely interact with Airmen most at-risk for violent behavior and modifying the FAP treatment protocol based on evidence-based civilian clinical treatment programs for male and female victims of IPV and/or sexual assault.[199]

A challenge FAP faces is difficulty getting the community engaged.[10] The majority of the prevention curriculum is designed for groups but often only one or two Service members are enrolled at a time.[199] Additionally, a Service member's mission requirements or temporary duty assignments can conflict with scheduled interventions, making attendance difficult.[199] However, the greatest challenge for FAP is how Service members generally associate FAP with mandatory domestic violence treatment.[199] This stigma impacts effective large scale community prevention efforts.[10,199] Overall, secrecy is a major challenge of CAN.[10,199]

Marine Corps: Treatment for Alleged/Potential offenders

The U.S. Marine Corps (USMC) differs from the other Services in that it does not have its own medical department; it is serviced by the Navy.[28] If a Service member or other beneficiary requires medical attention, he/she is referred to an MTF or a Purchased Care provider.[28] FAP is housed under the USMC behavioral programs umbrella.[28] FAP provides services for alleged abusers and victims, which include evidence-informed counseling and rehabilitative services.[28] FAP offers counseling to children old enough to receive such services and refers children too young to receive such services to MTFs.[28] FAP is responsible for case and care coordination, even if they are not providing the actual counseling or rehabilitative services.[28]

Evidence-based prevention programs and universal curricula address anger management, parenting skills, work stress, and family stress management.[28] Of note, the USMC has the youngest population among the Services; more than half of active duty Marines are not married.

USMC FAP collects the DoD required metrics and additional performance and outcomes data. Re-offenses are tracked among alleged abusers who complete counseling or clinical services with FAP and have a subsequent met-criteria incident the following year. This information can be found within the aggregate data reported to the DoD. FAP is beginning to collect effectiveness data from their prevention programs. USMC tracks a range of risk factors, including rank.[28]

COAST GUARD: TREATMENT FOR ALLEGED/POTENTIAL OFFENDERS

The U.S. Coast Guard (USCG) FAP is unique; it is modeled on OSD FAP standards but is a Department of Homeland Security entity and not structurally aligned under the DoD.[29] Additionally, Family Advocacy Specialists (FASs) within USCG FAP provide a range of CAN services.[29] FAS personnel provide psychosocial assessments to the victim, offender, and family members to include safety and risk assessments and domestic violence counseling.[29] Health care providers report all CAN cases to FAP and CPS and collaborate with the FAS regarding CAN assessment and treatment services.[29]

Offenders may participate in USCG FAP or DoD FAP counseling services, parenting classes, stress management, anger management, batterer intervention groups, substance abuse screening, assessments, and referrals, DoD Behavioral Health, or TRICARE health services.[29] Referrals to other programs and resources can occur as needed.[29] However, if USCG offenders are convicted of a crime at a court-martial, USCG members are generally confined to a U.S. Navy Brig.[29]

E5. TREATMENT FOR CAN OFFENDERS WITHIN THE CORRECTIONAL SYSTEM

NAVAL CONSOLIDATED BRIG (NAVCONBRIG) MIRAMAR

The current population of Naval Consolidated Brig Miramar (NAVCONBRIG) Miramar ("Miramar") includes 157 men and women; 66% are child sex offenders.[46] Miramar also houses men serving 10 years or less.[46] Miramar houses all military female offenders including those on life without parole.[46] There are currently seven females.[46] One woman has been convicted of domestic violence.[46] Female Offender Programs address topics such as relationships, communication, children, dual diagnoses, and recovery.[46] Women are reported to be less disruptive and more apt to communal living at Miramar.[46]

General mental health services are offered to prisoners.[46] A health care provider and a social worker or psychologist provide screening, mental health medications, and post-treatment services for all prisoners.[46] Services provided include: evaluations such as screenings, appraisals, parole and clemency evaluations, suicide and assault risk assessments, and psychological assessments; weekly psychiatric clinic; individual therapy; consultation; and a Suicide Watch Companion Program Oversight.[46] A popular program is Dialectical Behavior

Therapy, designed to help individuals change behaviors, emotions, and thoughts that are linked to distress. Additionally, Drug Abuse Treatment and Transitions Skills/Relapse Prevention Programs are also available.[46] These programs discuss realistic expectations, healthy relationships, and time management.[46]

Miramar also offers specific Violent Offender Treatment Programs.[46] Innovative Skills Techniques Options and Plans for Better Relationships (STOP), is a 52-week group treatment program that teaches offenders how to improve relationships with family and partners.[46] The goal of treatment is to support transition of new skills to life outside of the facility in order to decrease the likelihood of reoffending.[46] Therapeutic Skills Training for General Offenders (GO) is a 26-week group program held once a week, developed specifically for the NAVCONBRIGs.[46] This program targets those convicted of a crime against a person with whom they do not have a domestic relationship.[46] The program addresses topics such as emotion management and empathy training.[46] General anger management classes are also offered.[46]

The vast majority of the population of men at Miramar are sex offenders, with specific treatment available.[46] There is a track for offenders with contact offenses (e.g., sexual assault) and a track for those without contact offenses (e.g., exposing to children, talking online to children).[46] There are a variety of assessments to understand needs and to determine the appropriate curriculum.[46] Sex Offense Education is mandatory for all convicted of an offense with a sexual component and these offenders remain in the same groups throughout treatment to establish a support network and to encourage accountability.[46] However, the Sex Offender Treatment Program is voluntary.[46]

Regardless of the prisoner Sex Offender Treatment Program track, the focus is to reduce sexual reoffending in the future through three phases, illustrated in Figure 26.[46] Phase I is active treatment, which is approximately 18 months.[46] Once the offender has lowered their risk of re-offending they move on to Phase II.[46] Phase II requires treatment maintenance until the offender is released from confinement.[46] Phase III entails release planning, which occurs during an offender's last 6 months in the Brig.[46] During this phase, offenders learn how to transition and still utilize skills learned within the program.[46] Of note, the facility did not have data on recidivism rates or on those who administratively separated after rehabilitation.[46] However, offenders are required to register in the national sex offender database and notify their jurisdiction; therefore, there may be an opportunity to determine recidivism.[47]

Figure 26. Phases for Sex Offender Treatment Program[46]

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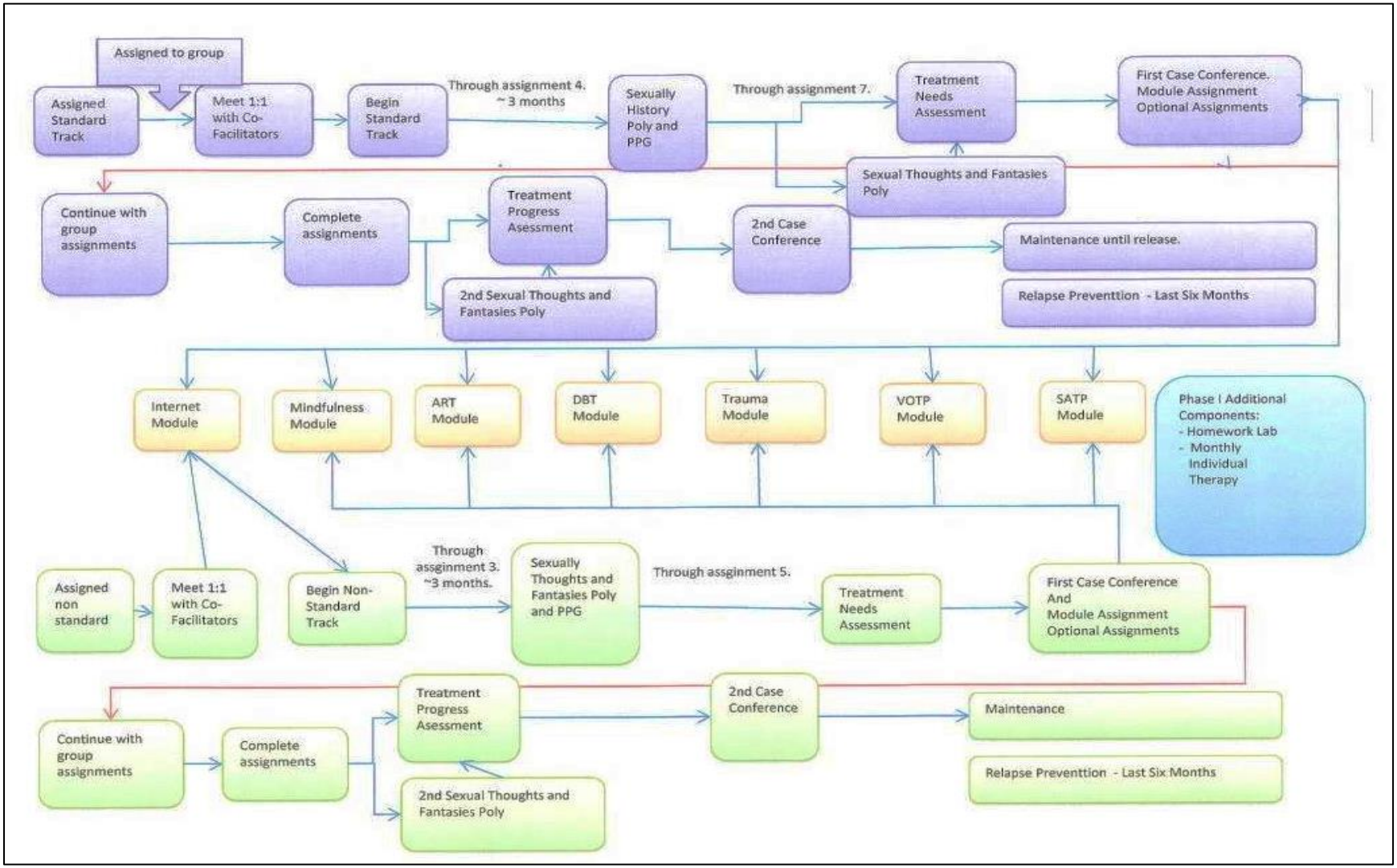


FORT LEAVENWORTH

The mission of U.S. Disciplinary Barracks (USDB) Leavenworth is to provide a comprehensive and evidence-based rehabilitation system that evaluates the risk an inmate presents to the facility and to society, provides effective medical and behavioral health treatment to reduce each inmate's risk, and supports the returning inmate's reintegration to society as a law abiding citizen.[47] The average USDB Leavenworth inmate is 37 years old, with a 23-year sentence.[47] As a level three facility, USDB Leavenworth houses inmates sentenced for more than 10 years.[47] All inmates are administered a Risk Assessment upon arrival to the USDB.[47] These Risk Assessments gauge each inmate's potential risk to the facility (internal risk) and risk for criminal recidivism (external risk). Various psychometric instruments are used to help determine risk. The Risk Assessments are updated at regular intervals throughout each inmate's term of confinement to reflect any changes, along with his progress in treatment. [47] All inmates are assigned an individual case manager for continuity of care.[47] Inmates with severe mental illnesses (SMI) or high-risk sex offenders are assigned to a licensed provider.[47] All inmates are required to complete Anger Management (AM), which focuses on personal anger histories and patterns of poor parenting.[47] This group is highly beneficial for child and spouse abusers.[47] Group facilitators use evidence-based treatment programs that include relationship and communication skills, sex offender preparatory group, parenting skills, transition/release planning, and grief and loss.[47] AM is a 12-week session that combines cognitive behavioral therapy and relaxation with cognitive and communication skills and interventions.[47] Leavenworth staff report that this is highly useful for CAN and IPV abusers.[47] The Cognitive Behavioral Therapy (CBT) group includes 20-sessions, divided into two segments: recognizing responsible behavior and practicing responsibility.[47] There are two Chemical Abuse and Addictions Programs (CAAP): intensive treatment track (for those inmates meeting at least American Society of Addiction Medicine [ASAM] 1 level of care) and the didactic/education track (for inmates meeting ASAM 0.5 level of care).[47] An Assaultive Offenders (AO) group helps inmates develop socially acceptable skills to deal with conflict.[47] This group is designed for inmates whose offenses include family violence.[47] Groups are the primary treatment modality, which benefits inmates by providing opportunities for support and confrontation.[47]

There are fewer than 20 inmates convicted of physical child abuse-related offenses.[47] However, there are a large number of child sex offenders.[47] The average demographic of a USDB Leavenworth sex offender is E-6, mid-30s, with the stepdaughter as the victim.[47] Approximately 46% of USDB Leavenworth inmates carry at least one conviction of sexual abuse against a child 8 years of age or younger. USDB Leavenworth assesses sex offenders using the Static 99-R, combined with STABLE-2007, which is a holistic structured interview.[47] All sex offenders must be registered in the National Sex Offender Database and notify their jurisdiction.[47] USDB Leavenworth uses a risk, need, and responsivity Sex Offender Treatment (SOT) model.[47] The Risk Principle states the treatment dosage should be proportional to the inmate's risk level.[47] The Needs Principle means treatment must address criminogenic factors.[47] The Responsivity Principle highlights the importance of flexibility in applying treatment to meet each client's personal style and needs.[47]

The SOT Program group modules include cognitive restructuring, emotional regulation, relationship skills, sexual regulation, and risk management planning.[47] Not all sex offenders will

need to complete all treatment modules.[47] The Therapeutic Rating Scale (TRS-2) is used halfway through the inmate's time in treatment and then again at the end of treatment; TRS-2 reports can inform the frequency and focus of treatment.[47] Post-SOT assessment of risk determines the maintenance treatment need while still incarcerated.[47] Recently, due to more inmates committing offenses related to child pornography, USDB Leavenworth developed an Internet Sex Offender Treatment Group.[47] In general, these inmates have poor social skills and impulsive behavior, so the group is tailored to address these deficits.[47]

USDB Leavenworth's goal is to have a 0% recidivism rate.[47] Since 2004, 17% of offenders on parole and 14.5% of offenders on Mandatory Supervised Release (MSR) have re-offended.[47] Opportunities for improving recidivism include tracking recidivism information by crime and enhancing communication with probation officers.[47] It should be noted that there is no standardized approach to determining recidivism rates. The Connecticut Criminal Justice Division recently presented multiple approaches to surveying recidivism; determining what is considered recidivism (e.g. a repeat sex crime vs theft charges) is unclear, leading to differences in recidivism rates, and difficulty comparing across offender populations and criminal justice systems. [200] As such, there is potential for university collaboration to research and evaluate recidivism approaches.[47]

APPENDIX F. FORGING A NEW APPROACH TO CHILD MALTREATMENT IN DOD: LEVERAGING CIVILIAN MODELS AND RESOURCES

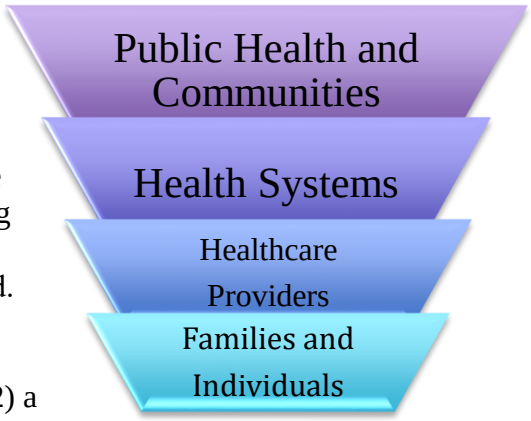
F1. INTRODUCTION

Child abuse and neglect (CAN) is a complex issue that not only requires medical engagement, but also requires an integrated, coordinated public health systems approach to monitor, detect, and mitigate risk factors and events. Therefore, Appendix F will address the following objectives in the Terms of Reference (ToR):

- Determine mechanisms to advocate treatment options in health care settings that address potential factors for increased risk of child abuse and neglect (i.e., mental health or relationship counseling, nonclinical counseling such as provided by Military OneSource, referral to programs focusing on socioeconomic factors such as food insecurity, etc.).
- Review the policies, protocols, and methods used by health providers and health care teams caring for military families to screen for child abuse and neglect, including recognizing symptoms of physical, emotional, and sexual abuse; identifying patterns indicative of child abuse and neglect; discussing child abuse and neglect; and reporting suspected child abuse and neglect to appropriate programs and authorities.
- Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.
- Review existing support programs for victims of child abuse and neglect in the MHS, as well as the continuity of care coordination with medical and social services to strengthen the interface between medical and non-medical communities (military and civilian).

F2. A Public Health / Systems Approach

Figure 27: Comprehensive Approach to Addressing Child Abuse and Neglect



Conceptualizing and addressing child maltreatment as a public health issue has significant potential impact. An additional rigorous and coordinated systems approach to violence – nested within and informed by the tenets of a public health framework – creates the standardized and interconnected structure necessary to combat a problem as complex as child maltreatment. Identifying and disseminating protocols, best practices, and referral resources for providers are an integral part of a successful anti-CAN effort. Finally, alerting families to resources that they can access outside of the provider's office may provide crucial assistance in times of need. This nested, interlocking approach is reflected in Figure 1 and described in the following Appendix, which is organized accordingly into four sections: 1) a Public Health Framework, 2) a Health Systems Approach, 3) Protocols, Care Pathways, and Diagnostic Tools for Healthcare Providers, and 4) Resources for Families and Individuals.

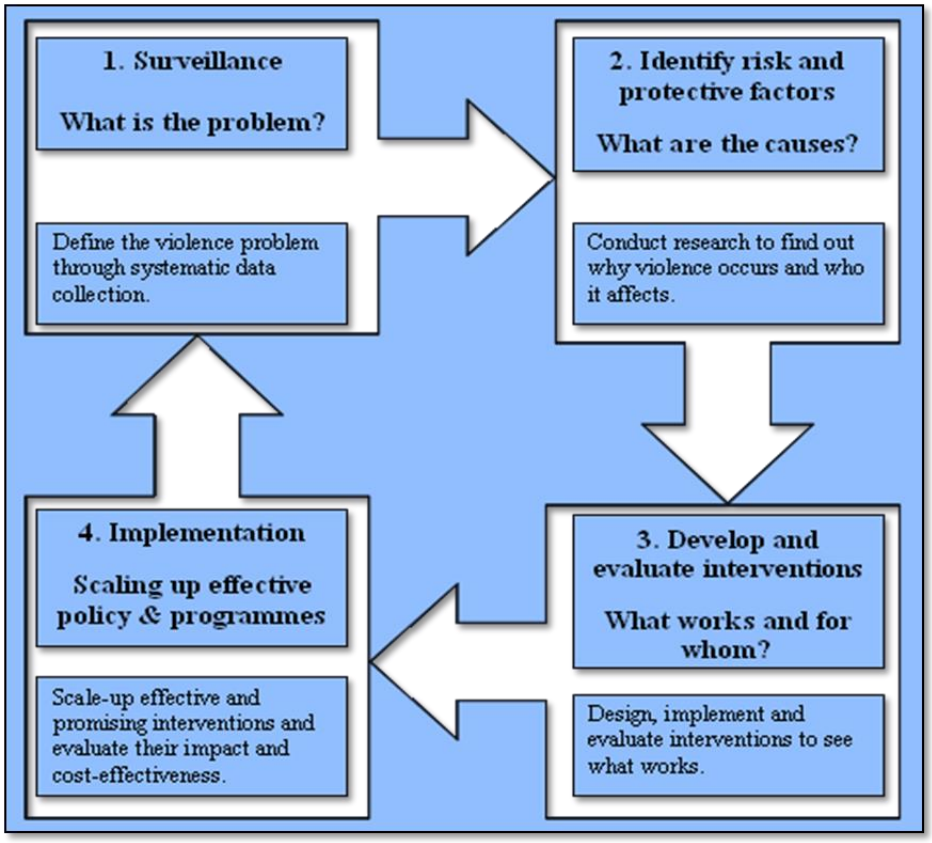
F3. A Public Health Framework

Interpersonal violence occurs across the lifespan in varied forms, including child abuse and neglect (CAN); in addition, those that experience one type of violence are more likely to experience other types of violence.[201] Organizations such as the National Foundation to End Child Abuse and Neglect (EndCAN) assert that viewing child maltreatment through a public health lens – such as the approach to substance use disorders (SUDs) and similar issues that were once stigmatized – is essential to its eradication and the resulting improvement in population health.[89] For example, the *Outcome Document of the 2016 United Nations General Assembly Special Session on Drugs* recognized that SUDs are preventable and treatable, further noting that the shift to approaching SUDs from a public health perspective, rather than a criminal justice perspective, is integral to advancing population health. Regarding this shift, Volkow and colleagues remarked, "The public health goal of reducing the world's drug problems cannot be achieved without addressing SUDs with the same scientific rigor, compassion, and commitment that other physical and mental health problems are addressed…access to affordable, quality health care for such disorders has been declared an inherent right for all United Nations Member State citizens."[202] Currently, the CAN approach is rooted in the criminal justice system;[89] however, a public health approach that integrates evidence-based interventions and empathy, like the SUDs approach, may prove to be a better and more cost effective long-term solution.

The World Health Organization's (WHO) Global Campaign for Violence Prevention outlines a public health approach with an emphasis on identifying and mitigating risk and protective factors (Figure).[203] This approach focuses on systematic data collection based on violence case definitions, victim and offender demographics, and outcomes.[203] These variables are then used to identify risk factors that could be mitigated through evidence-based interventions. Interventions and program strategies are then implemented in the target population and continuously monitored and evaluated to ensure their effectiveness and impact.[203] Examples of

interventions and strategies include media campaigns and crisis hotlines to address at-risk populations. Implementation also includes the scale-up of effective interventions and evaluation of cost-effectiveness. There are opportunities for health systems to adopt this framework for CAN to ensure scientific rigor, standardization, and spread.

Figure 2. The WHO's Public Health Approach to Violence Prevention[204]



Recognizing that child maltreatment is a major but preventable public health concern, the Centers for Disease Control and Prevention (CDC) developed a technical package in 2016 that includes a multi-level, multi-sector prevention approach rooted in public health.[205] Similar to the WHO model, the CDC approach relies on social programming such as parenting classes and early childhood education programs. The CDC approach further details changing social strategies by recommending economic and workforce support for families (e.g. family-friendly work policies and financial support), legislation on corporal punishment, improved professional training for care givers, and other focus areas related to family stress and support.

Figure 3. CDC's Strategies and Approaches to CAN[205]

Taken together, the WHO and CDC frameworks demonstrate a robust structure through which to address CAN risk factors, while ensuring regular program evaluation and quality monitoring.

Population Surveillance Tools

Monitoring CAN incidence and prevalence in the population is critical for informing prevention and intervention strategies. While the following tools are promising, they may be difficult to execute on a large scale. However, they could be used in some communities to signal surge campaigns based on events such as deployment and a recent history of violence.

Social Sentinel is a suite of tools that use language association classification algorithms to scan social media, emails, and/or user entries to identify and analyze entries for trends and topic frequency within a student population. Shareit™ is a tool that provides a platform for students to anonymously report safety or security concerns in their school.[206] This data is then used to inform wellness programs or policies that can mitigate identified risk factors. The social media scanning capabilities perform a similar function but scan social media sites for potential threats that may not be reported by students.[207] These programs provide an opportunity to not only quickly identify vulnerable students subjected to violence, but also to allow for data analysis that provides insight into gaps in policy and the environment. However, Social Sentinel suite requires a paid subscription based on level of service[207] and tools such as Shareit™ rely on crowd sourced input, which may be biased or incomplete. Also, neither addresses the stigma associated with family stress or asking for help.

It should be noted that PatientsLikeMe™, a patient engagement portal described later in this Appendix, could also be used as a surveillance tool for condition frequency and perceived

treatment efficacy; however, because their data is crowdsourced, use of this dataset may introduce bias into analyses.[208] These tools may supplement traditional surveillance strategies, such as monitoring case frequencies using Child Protective Services (CPS) data; this approach is described in further detail in Appendix C.

F4. A Health Systems Approach to Violence

System-wide coordination with specialists, social workers, law enforcement, and community resources is vital in the public health approach to CAN. A successful health systems plan for CAN includes validated quality measures that are both quantitative and qualitative, and the ability to scale the plan while still allowing for tailored approaches based on local risk factor prevalence. The Family Violence Prevention Model, described below, is an example of a best practice within the civilian sector that may be adapted for use in the DoD.

The Kaiser Permanente Family Violence Prevention Model

Figure 28: Systems Approach in the Family Violence Prevention Model[10]

Kaiser Permanente Northern California (KPNC), part of one of the nation's largest integrated health care delivery systems, developed a comprehensive public health approach to family violence that integrates Intimate Partner Violence (IPV) screening and intervention. Over the past 20 years, KPNC has sought to transform the health care response to IPV by integrating IPV assessment into routine care. Acute and chronical medical conditions are often the primary focus of large health care systems; thus a focus on IPV is uncommon. However, KPNC recognized that IPV, and family violence in general, is common, has devastating health effects, incurs substantial costs, and affects future generations.[5] While this model was developed to address IPV specifically, it has significant potential to address various forms of violence, including CAN, from a systems perspective.[5,209-211]

The KPNC approach has five key interdependent components (illustrated in Figure 4). Implementing this approach into clinical practice was achieved by (1) *Establishing a bold goal*; (2) *Taking a new approach*; (3) *Measuring improvement*; and (4) *Designing for Spread*.[10] A 'bold goal' was set to integrate IPV screening into routine care and was pursued through a 'new approach' to IPV: a multicomponent approach that includes staff training, clinical tools, development of workflows, quality improvement practices, and connection with social services. This systems approach centers around strong leadership and oversight and contains four other components: conducting inquiry and referral, creating a supportive environment, providing on-site services, and making community linkages.[5,212]

A supportive environment can be created in part through awareness campaigns and taking specific steps within the health care system to encourage patients to seek help for family violence. The approach is designed to create a welcoming environment, while ensuring that at-risk patients are connected to the proper resources.[5] A supportive environment spreads awareness and information through the use of posters and brochures, engaging and informing the workforce of available resources, and reaching patients throughout the health care system.[5] Private rooming is essential to allow patients to have open discussions with their physician regarding sensitive issues (e.g. relationship violence).

The inquiry and referral component is a variation on traditional screening. The clinician's job when using this method is to "ask, affirm, assess, document and refer";[5] this "clear and limited" role helps to "[make] the right thing easier to do."[5] Inquiry and referral considers both the patient and provider points of view: the patient's concerns about disclosing IPV and the provider's concerns about how to ask and how to respond in a caring and effective manner. Technology, such as intranet websites and online training, are incorporated throughout the system so that the clinician has resources readily available at point-of-contact.[5] Also, educational resource cards are used to prompt conversation about relationship stress and increase clinician identification of CAN/IPV.[5] In addition to clinically based resources, community advocacy linkages can be used to address resource gaps such as domestic violence advocacy (e.g., emergency shelters, counseling, safety planning, etc.), family justice centers, national hotlines, and online IPV chat resources.[5]

> "The clinician's job is to "ask, affirm, assess, document and refer." The inquiry and referral method establishes a "clear and limited" role for clinicians, "making the right thing easier to do."
>
> *-Dr. Brigid McCaw, Former Medical Director, Family Violence Prevention Program, Kaiser Permanente, 2019*

Defined evaluation measures that are actionable and make sense clinically are necessary for effective system evaluation. These measures should also include both qualitative and quantitative data types.[5] The electronic health record (EHR) should also be used when possible. Every medical center should have a multidisciplinary implementation team responsible for tracking progress.[5,210(p.2518)]

IPV identification is an integral component in overall IPV response. From the establishment of this systems-based approach in 2000 to 2015, IPV identification increased 18-fold within KPNC. In 2000, 1,022 patients were diagnosed with IPV, compared to 18,197 in 2015.[209] This increase reflects the importance of the health care provider/patient interaction. Indeed, research suggests that intervention uptake was four times greater for women who discussed abuse with their health care provider.[5]

An important part of transforming health care's response to family violence focuses on being able to broadly implement and disseminate change across the system. Tool kits alone are not sufficient; local leadership and engagement must be in place to implement and sustain successful models.[10] The "spread" process at Kaiser Permanente consisted of a pilot site with robust data collection, adoption by seven clinics, then all medical centers across 10 years.[10] Long term

sustainability of an improved health care response to IPV requires aligning this effort with other important priorities such improvement in patient safety and outcomes.

Research continues to demonstrate the long-term health and social effects of violence;[212] however, there is an opportunity to gain more insight into a systems approach by using I&D tools to not only eradicate CAN in the population, but address other family-related issues such as substance use disorders, post-traumatic stress, and IPV.[213]

F5. Protocols, Care Pathways, and Diagnostic Tools for Health Care Providers

Health care providers are in a unique position to identify, prevent, and mitigate child maltreatment. This is particularly true for the population of children under the age of three, as these patients have otherwise limited contact with other mandated reporters such as teachers, law enforcement, and counselors.[214] Also, health care providers play a significant role in the clinical management of maltreatment, including referral to the proper resources such as counseling and social services.

Training to gain and maintain these provider skills is essential. Providers must be appropriately prepared and resourced to address CAN within the context of routine care. Important elements include protocols for provider-patient/family interaction around risk factors and/or incidence of CAN, standardized care pathways with integrated decision making tools and referral sources, and assessment tools that enable differential diagnosis of potential CAN presentations.

Provider Protocols for CAN

Kaiser Permanente "Inquiry and Referral"

The "inquiry and referral" method utilized in the Kaiser Permanente Family Violence Prevention Model is one protocol for provider/patient interaction around the topic of family violence. As described above, the clinician's job in this approach is to "ask, affirm, assess, document and refer."[5(p.24)] The inquiry and referral method establishes a "clear and limited" role for clinicians, "making the right thing easier to do."[5(p.24)]

Safe Environment for Every Kid

The Safe Environment for Every Kid (SEEK) model was designed to go beyond CAN prevention to promotion of children's overall health, development, and safety.[215] The model is based on positive findings in two large federally-funded randomized controlled trials. SEEK aims to strengthen families, promote resilience, and improve the overall family environment by targeting families with children <5 years old.[215] By identifying risk factors for CAN such as depression, substance use disorders, and stress, the model encourages providers to leverage a network of social workers, behavioral health specialists, and other community resources and providers to address issues and support families.[215] SEEK is in a number of private and public settings across 18 states.[215] Some states have federal funding for implementation. In Virginia, for example, SEEK is being tested in clinics that serve children with developmental disabilities.[215] The model

is also used internationally and is available in multiple languages depending on the questionnaire.[215]

The SEEK model incorporates provider training on assessment and initial mitigation of family psychosocial issues. It includes education on empowering the family to use their strengths and resources to overcome stressors and other risk factors for CAN.[215] Providers are also trained in motivational interviewing as a method to engage parents and make them part of treatment plan development.[215,216] In motivational interviewing, the patient/parent is treated as a partner in the decision-making process versus a more prescriptive approach.[215] Parents are also provided with handouts developed for an average reader in easy to understand language.[215]

The SEEK Parent Questionnaire-R (PQ-R) is used for initial assessment of family issues that are risk factors for child maltreatment.[216] The SEEK PQ-R is an evidence-based, short, easy-to-read survey that utilizes yes/no questions and is both confidential and voluntary.[215] The questionnaire is administered before the patient encounter either in the exam room or online. Through 16 yes/no questions, the questionnaire screens for multiple CAN risk factors such as parental depression, substance abuse, family violence, and physical punishment, as well as environmental stressors such as food insecurity. The answers to these questions are used as "conversation starters" or cues for the provider to briefly discuss certain topics with the patient, while capitalizing on limited encounter time.[215] Motivational interviewing techniques are beneficial in determining the patient's/parent's perception of the problem and possible solutions.[216] SEEK has developed algorithms and responses to barriers to help providers efficiently assess and address identified problems.

It should be noted that the PQ-R is administered at selected checkups, such as the 2, 9, and 15 month well baby visits and annually when the child is 2-5 years old, rather than at every encounter. This strategy limits the questionnaire-related burden on the parent, while still collecting data that can be processed and analyzed in aggregate.[216] The screener is introduced in a non-accusatory and empathetic tone given the confidential and sensitive nature of the questions asked.[215,216] Similar to the Family Needs Screener (FNS) detailed in Appendix E, the success of this screener depends on the provider's ability to recommend resources that will benefit the patient's family and mitigate the identified risk factors. Also, the SEEK PQ-R, much like the FNS, depends on the parent responding honestly to the questionnaire, which could be negatively impacted by stigma, pressure to provide socially acceptable answers, or lack of awareness of family history or the practices of the other parent.[192,216] For several possible reasons, some parents may not disclose their problems. Experience has shown, however, that many do, thus offering a valuable opportunity to address issues and enhance the functioning of families and outcomes for their children.

Connected Parents, Connected Kids: Universal Education to Promote Family Resiliency

Futures without Violence's *Connected Parents, Connected Kids: Universal Education to Promote Family Resiliency* is a strengths-based, preventive approach to addressing CAN that assumes that parents want the best for their children. It focuses on CAN normalization, provider empowerment, and patient education about self-regulating skills and the connections between ACEs/trauma, health, and parenting.[6] This approach follows a model called "CUES"

(Confidentiality, Universal Education and Empowerment, and Support).[6] First, providers should see patients alone when possible and clearly explain the limits of provider/patient confidentiality.[6] Providers should be prepared for possible disclosure of CAN during an encounter.[6] *Connected Parents, Connected Kids* include provider resources for these cases such as online scripts for responses to disclosure.[6] In these cases, the provider is also encouraged to provide a warm handoff to a social worker.[6] This approach also includes universal education and empowerment. This approach assumes parents want a healthy, positive life for their children and removes potential accusatory connotations.[6] Also, providers educate the patient on positive techniques such as self-regulation and community support when needed[6]. Finally, resource cards are reviewed with the parent or family member. The provider should keep abreast of current community resources available for referral, such as 24/7 hotlines, thus "closing the gap" between identification of risk factors and mitigation.[6] Overall response to this methodology is positive; a focus group conducted by Futures without Violence with fathers in the Kaiser Permanente system showed that parents want to be informed of local resources. Participants found that reviewing these resources with providers was helpful to creating a positive, healthy environment for their families.[6]

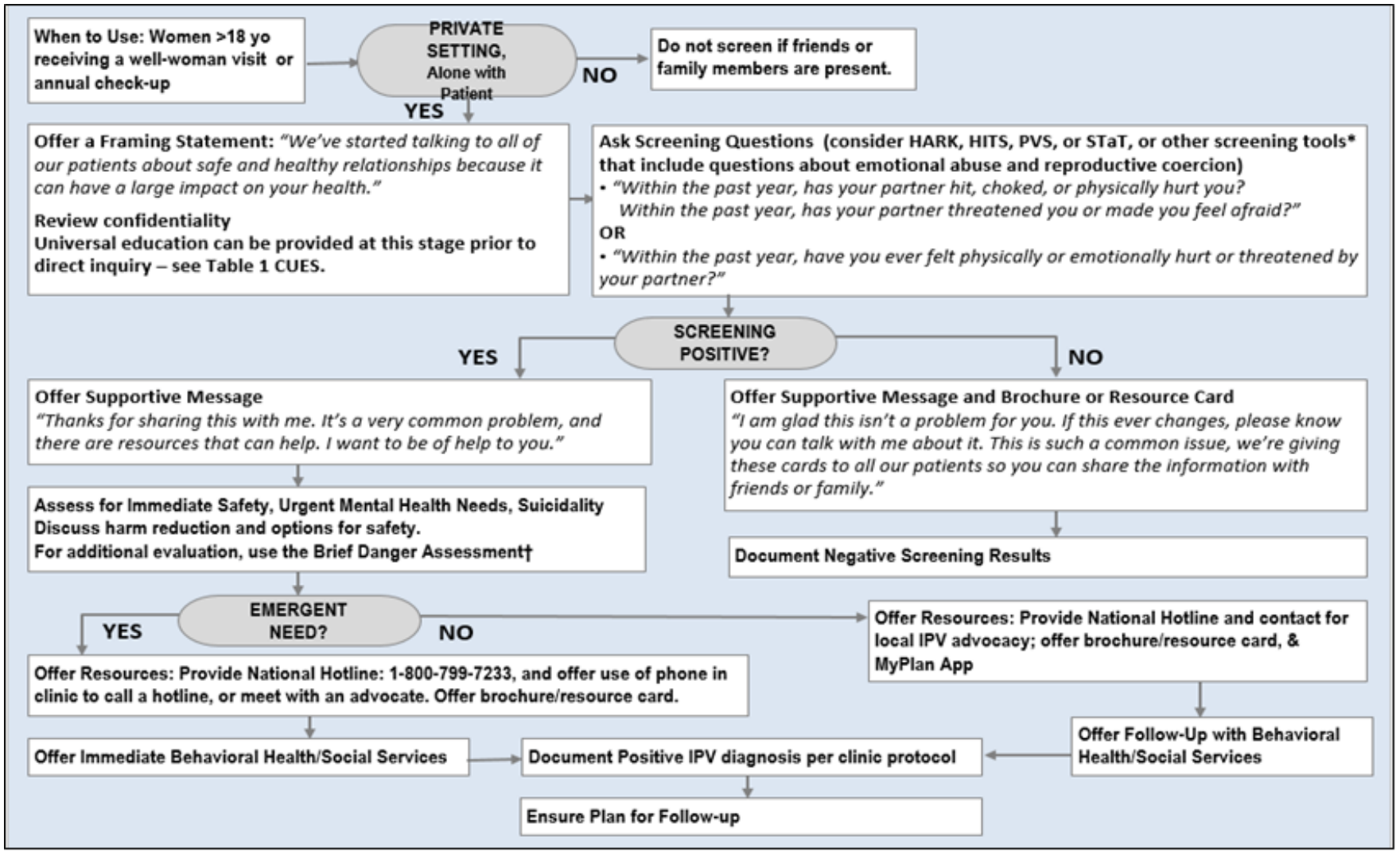
STANDARDIZED CARE PATHWAYS

Care pathways are guidelines intended to streamline and standardize practice for a specific problem, process, or incident in a defined population, while allowing for customization of care for the specific patient.[212,217] Examples include the KPNC "Workflow for Routine IPV Screening and Response" and the Children's Hospital of Philadelphia (CHOP) Clinical Pathways for Child Abuse and Neglect. [212] These examples are presented below.

A Standard Workflow for Intimate Partner Violence Screening and Response

A standard work flow for IPV screening and response, outlined in Figure 29, aims to provide guidance to the provider about how to inquire about IPV in a private, considerate, and confidential manner, and offer an appropriate intervention and referral.[10,212] Suggested questions and responses are provided to help the provider ensure that response to IPV disclosure includes assessment for immediate safety and referrals for resources.[10,212] Community referrals, educational materials, and follow up encounters are also encouraged to monitor the patient and family and to promote communication and support.[10,212] The standard IPV workflow includes provider awareness of current education materials and resources; in this way, it is similar to aspects of the SEEK model for addressing CAN.[11] Adapting this workflow to CAN cases would entail accounting for the role of the caregiver, both as potential cause of CAN and/or as the person responsible for ensuring[32] the child's attendance at follow up appointments.

Figure 29: Standard Workflow for Intimate Partner Violence Screening and Response[5,212]

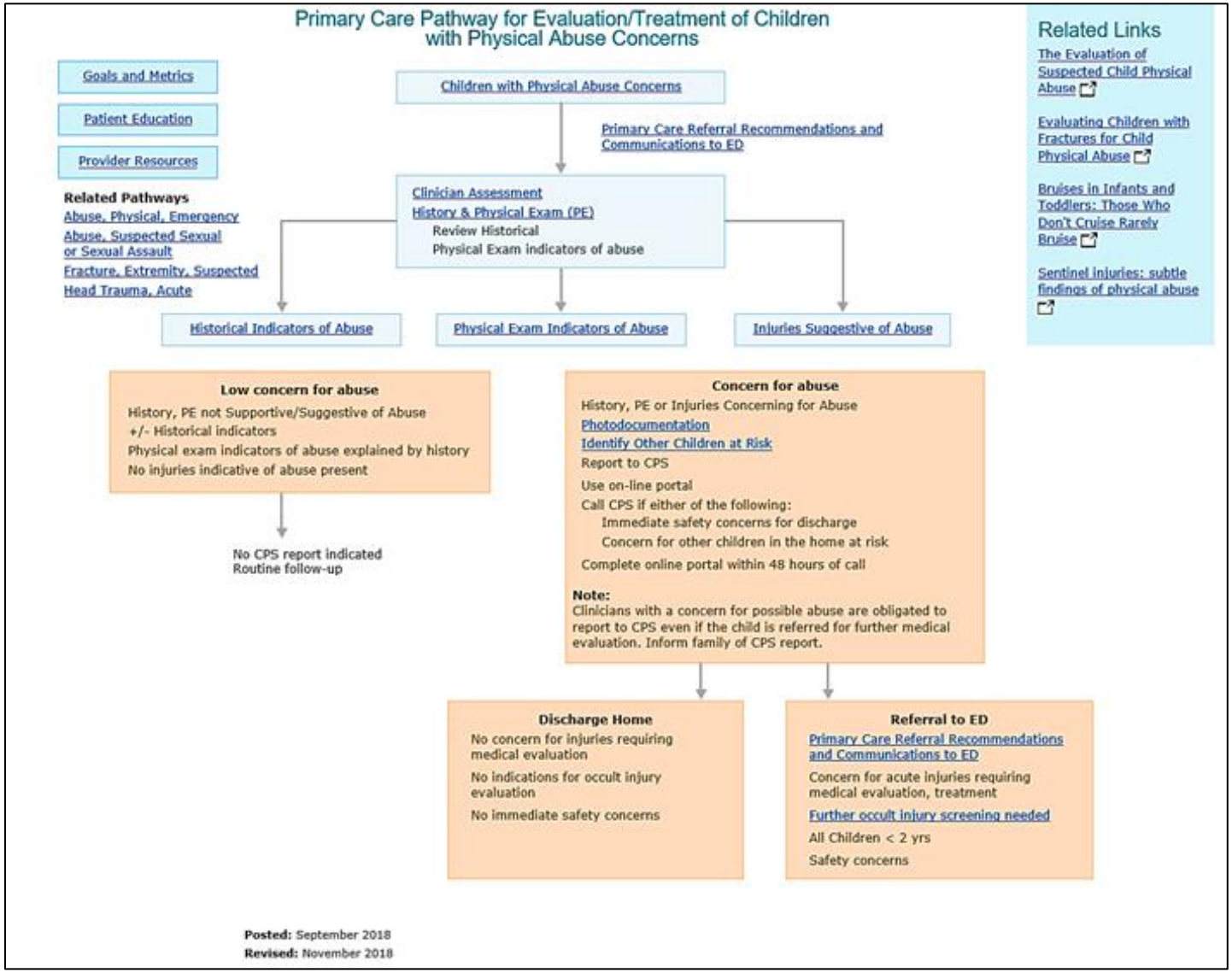


Children's Hospital of Philadelphia Clinical Pathways Program

The CHOP Clinical Pathways program allows providers to enter a specific condition into the CHOP database and find detailed algorithms and procedures that address the searched condition. The clinical pathway for CAN cases guides the providers through an algorithm with links to standardized diagnostic criteria and evaluation recommendations, patient education materials, and information on CPS reporting, local laws, and policies.[218] Figure 30 illustrates an example of this pathway for physical abuse.

The policies and laws referenced by the Clinical Pathways program are specific to eastern Pennsylvania and the greater Philadelphia metropolitan area; however, MHS and other providers practicing in areas with different laws and policies can still leverage aspects of the pathway, such as diagnostic and assessment best practices, forms, and patient education materials.[218] Also, the Clinical Pathway may be used as a template for other institutions wishing to develop a more tailored resource based on their unique location or patient population. Guidelines are regularly updated by clinical personnel, allowing incorporation of new evidence or best practices.

Figure 30. Clinical Pathway for Physical Abuse in a Primary Care Setting[218]



DIAGNOSTIC TOOLS FOR CAN

Clinical Guidelines for Physical and Sexual Abuse

Caregivers are typically responsible for recalling events or the conditions of pediatric patients, especially those too young to speak for themselves.[218] Astute differential diagnosis by the health care provider is crucial in child maltreatment cases, given that most injuries are non-specific and explanations or patient histories may be inaccurate.[218] The following section describes specific aspects of the comprehensive gold standard for differential diagnosis and medical management of child maltreatment as of 2019. The American Academy of Pediatrics (AAP) and other entities have published guidelines for CAN assessment and diagnostics. These guidelines provide decision support for providers evaluating potential CAN, and specify what to look for within the context of normal development, what tests or assessments are needed to provide essential information, and alternative conditions that can mimic maltreatment. A summary table of clinical best practices can be found in Attachment 1.

Skin and Soft Tissue Injury

Bruising is the most common injury sustained through physical abuse and is commonly the sentinel injury in later fatal or near-fatal abuse related injuries. Since the appearance of bruising varies, the time of the injury cannot be determined accurately;[111] however, bruising patterns often provide insight into the cause of injury. Negative imprints or images of the implement (e.g., extension cords, hands, belt buckles), bruise clustering, and defensive marks seen on physical examination should prompt an investigation for potential abuse.[111] Bruising is highly indicative of physical maltreatment in newborns and pre-ambulatory infants; "those who don't cruise, rarely bruise" is an easy-to-remember clinical saying disseminated by medical educators in child abuse pediatrics. [111] Bruised knees and shins are common in children but bruising on the torso, ear, or neck in children under 4 years old is unusual and is cause for concern.[111] The mnemonic "TEN 4" (Torso, Ears, Neck in children <4 years) was developed as a simple way to remember bruising criteria that suggest abuse.[111] When assessing for abuse, patient follow-up should occur 1-2 days after initial examination and include re-examination of any areas that were painful when palpated and any areas of swelling. Also, care should be taken during patient history and the development of a differential diagnostics to identify other causes associated with bruising, such as vasculitis and bleeding disorders.[111]

Bite marks can result from multiple sources such as animals, the patient, or another person. If the bite is fresh, swabbing for DNA to identify the source and collect additional evidence is also helpful, but not typically done.[111] The pattern of the mark is significant for determining the cause based on size, dentition characteristics, presence of skin punctures, and location.[111] Positive identification is based on a central area of erythema, ecchymosis, and indentation.[111] Comparison of marks with objects of known side and shape (e.g., a coin) can help determine the size, shape, and depth of the injury.[111] The American Board of Odontology has developed a scale (No. 2 scale) for measuring bite marks against a standard scale[111]. Consultation with a dental professional may be necessary to determine if a mark is from a bite.

Only a minority of burns are due to abuse; however, purposely inflicted burns tend to be more severe, partially because of delays in seeking medical care which can increase the risk of

infection.[111] Health care providers should note the age, history, number of burns, and pattern (especially the continuation over curved body parts) on the patient because these are key variables in determining whether a burn was inflicted.[111] Immersion burns have sharp demarcations and are often present on genitals and lower extremities in symmetric patterns.[111] These are often seen in toddlers who have had soiling accidents that require bathing or cleaning of the child. Burns from hot objects are patterned, usually deep, and have a clear imprint of the instrument. It is particularly difficult to differentiate between accidental and purposeful injuries by hot objects because both are patterned and leave imprints.[111] Although inflicted burns require the same type of treatment as accidental burns, children with burns due to abuse tend to have longer hospital stays and higher morbidity rates.[111] It should be noted that conditions such as impetigo and phytophotodermatitis have a similar appearance to burns;[111] therefore, the provider should consider these conditions in the differential diagnosis.

Skeletal Injury

Skeletal injuries, such as fractures, can also be sentinel injuries of CAN. While fractures are relatively common injuries among both abused and non-abused children, there are signs, often subtle or delayed in presentation, and patterns that warrant further investigation. Patients with fractures and broken bones usually show signs of injury such as crying, guarding the area, or swelling, but may not show bruising; obvious bruising within the first seven days is only present in about 10% of fracture cases.[111] "Grab marks" or erythematous areas that indicate restraint or twisting should be noted as possible causes of injury.[111] Unusual fractures, such as scapular, classic metaphyseal lesions of the long bones, sternum and/or vertebrae that are not explained by a verified history of severe accidental trauma are signs of possible abuse.[111] Also, infants and toddlers with midshaft humerus or femur fractures and children with rib fractures are atypical in non-abused children.[111] Finally, clusters of fractures, fractures in infants or pre-ambulatory toddlers, and/or unclear history of the injuries are cause for concern.[111]

Rib fractures are strong indicators of abuse and may be a result of forceful squeezing of the chest; multiple ribs are often affected.[111] These fractures can occur at any point along the rib's arc. Shallow breathing attributed to pain and splinting may be present; infants may display irritability when picked up or moved. Other symptoms include hemorrhagic effusions, pneumothorax from lacerations, and/or pulmonary edema due to suffocation.[111] Of note, infant rib fractures due to prematurity or metabolic bone disease can mimic rib fractures due to abuse.

A radiological skeletal survey is standard for assessing potential victims who are less than 2-years of age and determining otherwise undetected bone injury.[111] Radiographs of each region should be performed for all patients including infants[219,220]; a "babygram", or single radiograph of the entire body, is not appropriate in cases of suspected abuse.[220] Follow-up radiographs are recommended 2 to 3 weeks after initial presentation, particularly in infants, to improve sensitivity and specificity and assess for additional injuries.[220] Acute rib fractures can be difficult or impossible to detect radiographically and the follow-up skeletal survey, complemented by chest computed tomography (CT) or bone scintigraphy in selected cases, is especially valuable to detected developing callouses of rib fractures missed on initial radiographs.[111,219] Of note, prospective studies show that follow-up skeletal surveys increase the

number of identified bony injuries by 25% or more.[220] Finally, skeletal surveys may be indicated for a suspected victim's young siblings and household members.

It is important to augment skeletal surveys with screening for vitamin and mineral deficiencies and genetic or acute disease, as well as serum concentrations for calcium, phosphorus, and alkaline phosphatase.[219] Vitamin and mineral deficiencies, such severe Vitamin D deficiency or copper deficiency, and diseases like osteomyelitis or certain genetic conditions, can mimic skeletal injury and should be considered in the differential diagnosis.[111] Alkaline phosphatase may be elevated in the presence of healing fractures.[111]

Abusive Head Trauma

Abusive head trauma (AHT) is the leading cause of child abuse related fatality, especially among infants.[111] AHT in infants and young children includes a number of mechanisms, including blunt impact and shaking. [84] Diagnostic challenges include caretaker presentation of a false history of accidental trauma or presentation of nonspecific symptoms without an accompanying history of trauma. Common misdiagnoses include gastroenteritis, colic, accidental head injury, and otitis media. As with other non-accidental trauma, such as inflicted burns, AHT is associated with higher mortality, delayed medical attention, and longer hospital stays when compared to non-abused child populations.[111]

Victims of AHT may present with bruising or abrasion and possible scalp swelling. They may have sustained cerebral or spinal injuries as a result of blunt force trauma or shaking or have developing macrocephaly in more chronic cases.[111] Head and neck CT and/or MRI is recommended, although CT is preferred for identifying acute hemorrhage and skull fractures.[111] Of note, CT scans should be considered in infants with acute symptoms of intracranial injury and only if necessary;[111] health care providers may consider using the Pittsburgh Infant Brain Injury Score (PIBIS) to assist in determining if the infant should undergo CT.[221] However, this tool is supplemental to the overall diagnostic process and may not be appropriate in emergent cases where rapid neuroimaging is required.[221] An MRI is useful in cases where the victim is neurologically asymptomatic but needs to be assessed for intracranial injury. MRI is also indicated in all cases as a follow up to abnormal head CTs, and can best identify early cerebral hypoxia and ischemia.[111] In cases of young infants with open fontanelles, head ultrasound can be useful for detecting possible subdural collections leading to macrocephaly.[111] Ocular trauma, such as retinal hemorrhage may be present in cases of AHT and is seen in approximately 75% of AHT victims.[222] The role of the ophthalmologist in these cases is key in identifying CAN cases as they can provide a detailed description of the retinopathy.[111,222] Indirect ophthalmoscopy by an ophthalmologist with pediatric or retinal experience is recommended as well as a full view of the retina, characterizing the number, type, location, and patterns of hemorrhages.[222] In some cases, a slit lamp inspection can be useful when inspecting the anterior segment to determine signs of trauma. Optic nerve injury diagnosis is best done via a determination of an afferent pupillary defect.[222] This should be conducted before pupil dilation. Additionally, because of the need to monitor neurological status, short-acting mydriatics should be used.[222] Ideally, these exams would be performed within 72 hours as some retinal hemorrhages resolve quickly. In cases where this time limit is not met, ophthalmologic examination is still useful because it can

identify abnormalities like scarring, hemorrhages, and papilledema.[222] Ophthalmologists may have access to photo-documentation tools, which are helpful in overall documentation.[222]

Thoracoabdominal and Cardiovascular Injuries

Abdominal injury is a severe form of maltreatment and is the second leading cause of mortality due to physical abuse, with the highest rates seen in infants and toddlers.[111] When compared to pediatric populations with non-abusive abdominal injury, abuse victims with abdominal injury are younger, more likely to have injuries of the hollow viscera, have delays in seeking medical care, and have a higher mortality rate.[111] These injuries can be especially difficult to identify because patients do not usually display obvious signs and symptoms; abdominal bruising is often lacking, even in cases of severe abdominal trauma. Further, these injuries may be masked by others upon initial examination.[111] A surgical consult is encouraged in severe cases to determine if surgical intervention is needed.

In relative contrast to abdominal injuries, injuries to the heart are rare in abuse cases;[111] however, cardiac aneurysms, hemopericardium, and chylothorax due to thoracic duct shearing have been reported in abuse cases.[111] Health care providers should look for evidence of blows or crush injury (e.g., bruising, pain or sensitivity with chest palpation), and order laboratory tests for cardiac enzymes, troponin, and creatinine kinase with muscle and bone subunits (CK-MB) if heart injury is suspected.[111]

Liver injury is among the more common abdominal injuries related to abuse, but other solid organ injuries, such as those related to the pancreas, spleen, and kidney are rare.[111] In these uncommon cases, physical examination can be unreliable due to the patient's age, other injuries, or presence of head injury. Further, abuse-related liver injury may be comorbid with hollow viscus injury in abused children.[111] While some children with injury to intra-abdominal or retroperitoneal injuries may present with peritonitis or hemorrhage, abdominal bruising is rare, even in children with severe injuries;[111] therefore, screening laboratory tests for liver transaminases, pancreatic enzyme levels, and urinalysis are critical tools to detect these kinds of injuries..[111]

Sexual Abuse

Sexual abuse determination requires careful evidence collection, interviewing skills, and sensitivity. Health care providers should carefully document the caregiver's concerns, detail patient history, and review symptoms, especially urogenital and behavioral issues.[93] Providers should also note in the record the source of the information (e.g., "the father tells me the child said…," etc.). The provider should use developmentally appropriate language with the child.[93] It is helpful to ask the caregivers ahead of time which terms the family uses for bathroom activities, genitalia, breasts, and the anogenital region. When collecting information, the health care provider should ask open-ended questions.[93] Also, the child should not be rewarded after incident disclosure (e.g., "You can go back to your parents after you tell me what happened." etc.)[93]

In cases in which sexual abuse is suspected, the health care provider should conduct a medical interview with the goal of documenting and gathering enough information to make appropriate

decisions about reporting and treatment.[93] If possible, suspected victims of sexual abuse should be referred to clinics and/or advocacy centers with specially trained forensic interviewers and clinicians on staff.[93] If specialty facilities are not available, health care providers should be educated ahead of time about how to conduct childhood anal and genital examinations.[93] Evidence of infection, trauma, and/or bleeding should be documented in detail.[93] In the outpatient office, photographs and/or videos are not necessary unless they are a regular part of the practice; however, in specialty centers, examinations usually include photos and video.[93] All of these materials should be marked and treated as a confidential part of the medical record.[93] Clinical samples for sexually transmitted infections (STI) should be taken if the patient is symptomatic and sent for cultures and/or nucleic-acid-based assays.[93] Finally, evaluation for post-exposure prophylaxis for HIV or STIs, pregnancy screening, and counseling should be performed.[93] All examinations should be reviewed by an expert clinician.[93]

Of note, if a parent or caretaker is not available to be present in the exam room, a second health care professional must be present to reassure the child, act as a chaperone, and assist the health care provider.[93] An additional professional or caregiver may be present at the head of the exam table to provide support or comfort to the victim. The process and purpose of the examination should be explained to the child in age appropriate language. Appropriate gowns and drapes should be used to ensure modesty and limit feelings of vulnerability.[93]

Sometimes, caregivers are overly concerned about their child's normal sexual behavior.[93] In this case, reassuring and educating the parents on normal sexual behaviors is beneficial. A parent's concerns should be discussed without the child present, to avoid unintentionally influencing a child's perceptions by a parent's concerns of abuse.[93]

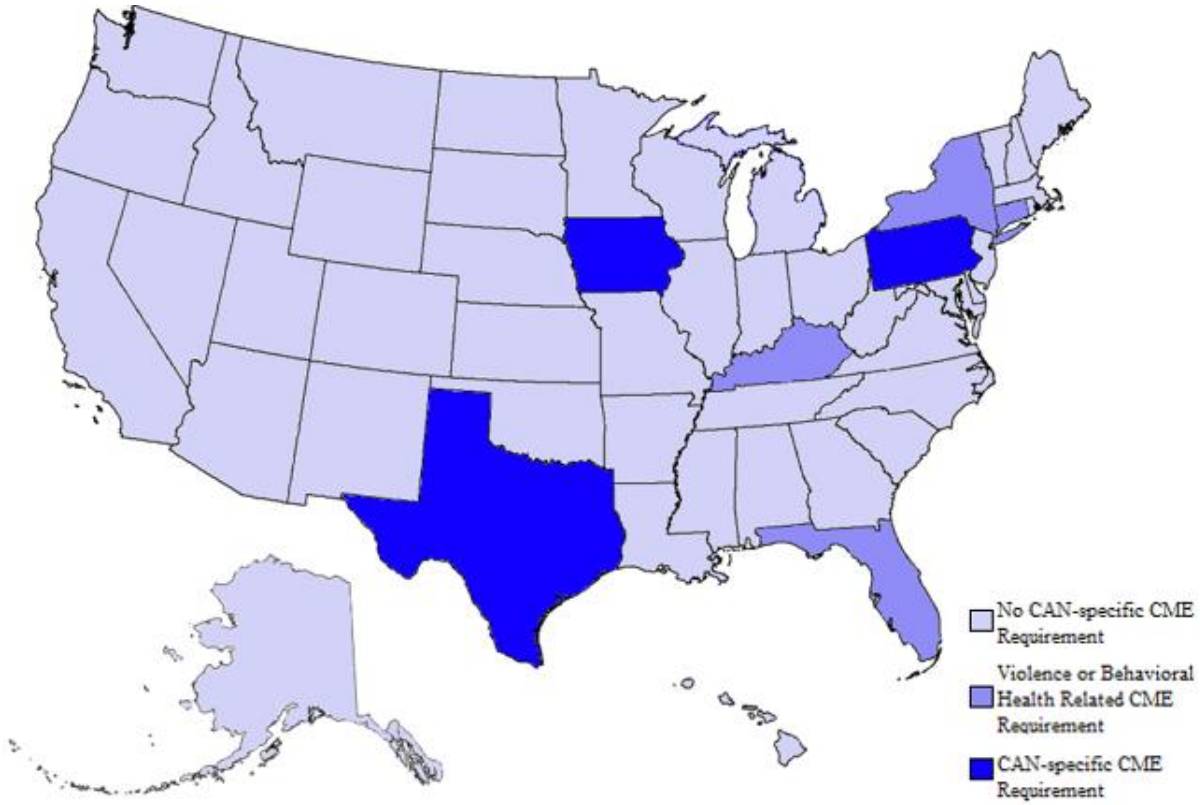
While clinical best practices are useful in guiding the health care provider through complex potential abuse cases, some institutions do not have the resources or infrastructure to support local CAN expertise and/or do not have the case volume to maintain CAN assessment proficiency. Thus, decision support tools that link providers to accessible resources and expertise are useful in these instances. Some of these resources are discussed in the next section.

Provider Training and Decision Support

Access to relevant training is key to maintaining health care provider competency in CAN identification and assessment. However, CAN specific training is not standardized across the United States. For example, CAN specific training is not required for state medical license renewal with the exception of Iowa, Pennsylvania, and Texas. [223] Requirements for nurses, psychologists, and other health care workers also vary by state.[224,225] Modality of training is a factor in access; conferences and in-person courses can be costly, requiring time away from patients and possible travel. In these cases, expenses may not always be covered. Online continuing medical education (CME) offerings are available and research on their effectiveness has been positive regarding ease of access and knowledge retention.[226-228] However, it should be noted that many of these studies rely on providers' self-reported outcomes. For information on CAN training within the Department of Defense, see Appendix D.

Where training opportunities are limited, decision support tools and other technology can be used to aid the health care provider in assessments.

Figure 31: Child Abuse and Neglect Continuing Medical Education Requirements for Allopathic Clinician Medical Licensing Renewal[223]



Child Protector Application

Child Protector is a mobile application ("app") developed by Children's Mercy and University of Texas Health Science Center in San Antonio for providers, law enforcement, and others who may be involved in cases of child maltreatment.[229] The app was designed to educate users on maltreatment identification and non-abusive causes of injury.[229] Through animations, clinical and diagnostic images, safety planning, and guides for patient history and assessment, users can better identify and collect information on CAN events. This app is particularly useful in areas of low case volume or if the user is unfamiliar with CAN events, identification, and processes.[229]

Training to Use Telehealth/Telemedicine in CAN Assessment or Treatment

Telehealth/telemedicine has been shown to be a force multiplier when expertise is not locally available. In CAN cases, this modality is most frequently used in child sexual abuse cases,[230] where time is of the essence for collecting evidence.[93] However, telehealth/telemedicine capabilities can mitigate the lack of expert access in a range of CAN presentations.[231] It may be

particularly useful for assessment and treatment of DoD beneficiaries who live in rural areas or outside the continental United States (OCONUS). It is important to note, however, that effective use of telehealth/telemedicine requires appropriate training to ensure provider effectiveness with this modality. This is particularly true in sensitive cases like child maltreatment.

F6. Resources for Families and Individuals

The stigma associated with child abuse and neglect, and with associated family stressors and dysfunction, can be a major barrier to help-seeking. This and other barriers to care are discussed in Appendix B. Publicly available options, such as anonymous internet chat and texting services that link users with mental health care providers and/or community support resources, may allow users to seek help with greater privacy. Such services have been shown to have positive results in addressing anxiety and depression.[232,233] Also, social media campaigns for these tools have demonstrated some success.[232] There are multiple tools available to families who are struggling with family difficulties or stress. Different modalities such as texting, websites, and videos are available, allowing access to support for those who may not feel comfortable with face-to-face interaction.

The Crisis Text Line is a free, anonymous 24/7 support service for those in crisis anywhere in the U.S. Crisis Text Line provides assistance for problems such as addiction, suicidal thoughts, eating disorders, and abuse by connecting users to a crisis counselor.[234] These counselors are not professionals; rather, they are volunteers trained to help individuals by validating their concerns and providing further local referrals, if needed.[234] Crisis Text Line was designed to provide users with a platform for expression, not to provide professional help; referrals are provided for family members, victims, or offenders to as indicated.[234]

PatientsLikeMe™ is a web-based resource that provides support via a database of similar individuals based on treatment, presenting concern, demographics, and military status.[208] This platform provides community support and information exchange either through direct patient-to-patient contact or through online forums. Also, this resource crowdsources data from users on conditions, treatments, and symptoms and displays user population frequencies and personal ratings on treatments.[208] PatientsLikeMe™ uses these datasets for research on patient perceptions and awareness regarding care, treatment, and comorbid conditions.[208]

As anonymous and voluntary services, neither the Crisis Text Line nor PatientsLikeMe™ directly connect military families within the larger support system that the Department of Defense and its community partners can provide. However, these services and others like them do encourage users to seek out professional help and are critical pieces in the overall community-coordinated response for issues that are often accompanied by stigma and social shame attached to them.

APPENDIX G. TERMS OF REFERENCE

These terms of reference establish the objectives for an independent review of the policies and practices in place to prevent, detect, and treat child abuse and neglect occurring in military families.

Mission Statement: The mission of the Defense Health Board (DHB) is to provide independent advice and recommendations to maximize the safety and quality of, as well as access to, health care for members of the Armed Forces and other Department of Defense (DoD) beneficiaries.

Issue Statement: The Military Health System (MHS) recognizes the importance of providing care and support to prevent, detect, assess, and treat child abuse and neglect occurring in military families. While many DoD programs exist to support military families coping with abuse and child maltreatment, real or perceived stigma as well as a lack of knowledge about resources can thwart efforts to seek mental health and relationship counseling, and may also adversely affect the reporting of incidents of abuse. This stigma and potential lack of knowledge, coupled with a slight upward trend in the rates of child abuse and neglect incidents in military children from fiscal year (FY) 2009 to FY 2014 (58% of the incidents are child neglect), indicates a need to review the existing policies and practices in place surrounding abuse.[1]

A comprehensive literature review conducted by the University of Minnesota found no direct correlation between deployments and increased incidence of child abuse and neglect.[2,3] Other studies have found that rates of abuse increase during and after deployments of Service members.[4] Researchers suggest that the increased stress associated with deployments and redeployments, combined with medical conditions such as post-traumatic stress disorder and traumatic brain injury, may contribute to abusive behaviors in Service members and their spouses, significant others, and families. Health providers caring for military personnel and their families, in collaboration with the larger community, can play an important role in recognizing risk factors and signs of abusive behavior. They can also play an important role in recognizing signs of abuse during patient examinations. Sections 574 and 575 of the National Defense Authorization Act (NDAA) for FY 2017 outline requirements for reporting allegations of child abuse in military families. In light of recent research, and given the increased incidence of child maltreatment within the military, there may be opportunities to improve the policies and practices currently in place for health providers caring for military personnel and their families to ensure that incidents of sexual, emotional, and physical abuse in children are detected, assessed, reported, and treated appropriately and in a timely manner. Additionally, these opportunities may help develop focused maltreatment prevention and intervention efforts at times of increased risk.[1]

Objectives and Scope: The Board should:

- Identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children, as well as demographic and socioeconomic factors that affect the risk of being abused, and evaluate/identify effective interventions and metrics such as Healthy Steps and Adverse Childhood Experiences (ACEs), intended to proactively prevent abuse and aggressive behavior, and promote healthy development.

- Determine mechanisms to advocate treatment options in health care settings that address potential factors for increased risk of child abuse and neglect (i.e., mental health or relationship counseling, nonclinical counseling such as provided by Military OneSource, referral to programs focusing on socioeconomic factors such as food insecurity, etc.).[5]

- Review the policies, protocols, and methods used by health providers and health care teams caring for military families to screen for child abuse and neglect, including recognizing symptoms of physical, emotional, and sexual abuse; identifying patterns indicative of child abuse and neglect; discussing child abuse and neglect; and reporting suspected child abuse and neglect to appropriate programs and authorities.[5]

- Review the policies related to TRICARE Network healthcare providers regarding identification of and appropriate intervention in cases of child abuse and neglect in Purchased Care. Assess how Network providers can be incentivized to work with military resources—clinical and nonclinical—to support victims of child abuse.

- Examine current reporting procedures outlined in Talia's Law and current military health providers' practices for reporting suspected child abuse and neglect to the appropriate authorities including Family Advocacy Program Offices and state child welfare services agencies[6], by noting and eliminating barriers and developing recommendations to track reporting compliance.

- Assess how child abuse and neglect victims are identified and treated in the military health care setting, with a focus on consistency within treatment protocols; record keeping; standardized treatments and protocols; medical and mental health treatment programs; and processes to connect victims to appropriate support programs within the MHS or civilian sector, and if there is overlap.

- Review existing support programs for victims of child abuse and neglect in the MHS, as well as the continuity of care coordination with medical and social services to strengthen the interface between medical and non-medical communities (military and civilian).

- Evaluate the training and educational opportunities available to military health providers to ensure that they are aware of and utilize the best available practices and resources, both before and after an event, and both inside and outside the MHS, to provide care to victims of child abuse and neglect.

- Assess the role and management of rehabilitative treatments/programs and wellness initiatives in place for abusers, including examining the accessibility of programs that provide support, such as mental health treatment programs, home visiting programs, social services such as family and parenting programs, and counseling.[6,7] This review should include programs provided to military personnel incarcerated for child abuse/neglect crimes in military disciplinary facilities.

- Note opportunities to track health outcomes of children who were abused or neglected, including parents' ACEs, within the Millennium Cohort Family Study to determine the full impact on the MHS.

Methodology:

1. The Board's assessment will be conducted in compliance with the Federal Advisory Committee Act, Department of Defense Instruction 5101.04, and the DHB Charter.

2. The Board's assessment should focus on improving the policies and practices currently in place for military health professionals to ensure that incidents of sexual, emotional, physical abuse, and neglect in children are assessed, detected, reported, and treated appropriately.

3. The Board may conduct interviews and site visits as appropriate.

4. As appropriate, the Board may seek input from other sources with pertinent knowledge or experience.

Deliverables: The Board will complete its work within one year of receiving the tasking and will deliberate on the report in a public forum. The DHB will, in accordance with its Charter, report to the Assistant Secretary of Defense for Health Affairs, who has been delegated the authority to evaluate the independent advice and recommendation received from the DHB and determine, in consultation with the USD(P&R), what actions or policy adjustments should be made by DoD in response. Progress updates will be provided at each DHB meeting.

Required Support:

1. The DHB office will provide any necessary research, analytical, administrative, and logistical support for the Board.

2. Funding for this review is included in the DHB operating budget.

References:

1. Department of Defense. Report on Child Abuse and Neglect and Domestic Abuse in the Military for Fiscal Year 2016. [online] pp. 1-2 Available at: http://download.militaryonesource.mil/12038/MOS/Reports/FAP_FY16_DoD_Report.pdf
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3. Moyer, V on behalf of the U.S. Preventive Services Task Force. Primary care interventions to prevent child maltreatment: U.S. Preventive Services Task Force. *Annals of Internal Medicine.* 2013;159:289-295.

4. Taylor, C.M., Ross, M.E., Wood, J.N., et al. Differential Child Maltreatment Risk Across Deployment Periods of US Army Soliders. *American Journal of Public Health.* 2016, 106(1): 153-158.
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6. Mogil C, Hajal N, Garcia E, et al. Focus for early childhood: A virtual home visiting program for military families with young children. *Contemporary Family Therapy*. 2015;37(3):199-208.
7. Turner S, Schechter DS, Cozza SJ. 41.0 My Family and me and posttraumatic stress disorder: Applications of evidence-based models to the treatment of military and civilian families with young children. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2016;55(10):S63.

APPENDIX H. MEETINGS AND PRESENTATIONS

October 24, 2018 – Work Group Teleconference

Members reviewed the tasking and discussed potential briefers, timeline, and report outline.

October 30, 2018 – Defense Health Board Meeting
Falls Church, VA

The Work Group Chair provided a tasking update to Board members.

October 31, 2018 – Work Group Meeting
Falls Church, VA

Members received an overview of the Department of Defense (DoD) Family Advocacy Program (FAP), the DoD New Parent Support Program (NPSP), and the DoD Partnering for Readiness (P4R) Initiative.

Subject matter experts (SMEs) in attendance included:
- Ms. Mary "Tib" Campise, Senior Program Analyst, Office of the Secretary of Defense (OSD) FAP
- CAPT Meghan Corso, United States Public Health Service, Chief, Behavioral Health Clinical Operations, Defense Health Agency (DHA)
- Mr. Bill Huleatt, Social Worker, OSD FAP
- Dr. Patricia Moseley, Military Child and Family Behavioral Health Senior Policy Analyst, DHA

November 28, 2018 – Work Group Teleconference

Members received an overview of FAP fiscal year 2017 data for child abuse and neglect and domestic abuse in the military.

The SME in attendance was Dr. Maia Hurley, Data Analyst, OSD FAP.

December 19, 2018 – Work Group Teleconference

Members received an overview of The Millennium Cohort Studies.

SMEs in attendance included:
- Dr. Rudy Rull, Research Epidemiologist, Naval Health Research Center (NHRC), and Principle Investigator (PI), Millennium Cohort Study
- Dr. Valerie Stander, Research Psychologist, NHRC, and PI, Millennium Cohort Family Study

January 10-11, 2019 – Work Group Meeting
Falls Church, VA

Members received an overview of the Military Community Support Programs, Armed Forces Center for Child Protection (AFCCP) and CAN family readiness in the Navy, Army, and Air Force.

SMEs in attendance included:
- Ms. Lolita Allen, Counseling, Advocacy, and Prevention Program Manager for Headquarters Navy Commander Navy Installation Command (CNIC)
- Dr. Barbara Craig, Senior Board Certified Child Abuse Pediatrician and AFCCP Director
- CAPT Amy Gavril, Assistant Chief of Pediatrics, Walter Reed National Military Medical Center (WRNMMC), and Certified Child Abuse Pediatrician/Rotation Director, AFCCP
- Ms. Lee Kelley, Director, Military Community Support Programs, Military Community and Family Policy, Office of the Deputy Assistant Secretary of Defense
- COL Steve Lewis, Chief, Family Programs Branch and Department of the Army FAP Manager, Office of the Assistant Child of Staff for Installation Management
- Lt Col Shelly Martin, Child Abuse Pediatrician, San Antonio Military Medical Center (SAMMC)
- Lt Col Patrick Pohle, Chief, Air Force FAP, Air Force Medical Operations Agency (AFMOA)

Members also reviewed sections of the draft report.

February 11-12, 2019 – Work Group Meeting
Falls Church, VA

Members received an overview of the Children's Hospital of Philadelphia's (CHOP) best practices for addressing CAN, the CHOP Child Abuse Training Program, DHA workflow protocols for family violence, and an over of recent research from the Center for the Study of Traumatic Stress (CSTS).

SMEs in attendance included:
- LTC Brian Brennan, Child Abuse Pediatrician
- CAPT Andrew Plummer, Senior Clinical Advisor for Quality Management, Medical Affairs, DHA
- Dr. David Rubin, Director of PolicyLab, CHOP, and Professor of Pediatrics at the Perelman School of Medicine at the University of Pennsylvania
- Dr. Twee Sim, Senior Medical Advisor, Medical Affairs, DHA
- Dr. Ronald Whalen, Research Assistant Professor, Uniformed Services University (USU)
- Dr. Joanne Wood, Director of the Child Abuse Pediatrics Fellowship Program, CHOP

February 28, 2019 – Work Group Teleconference

Members received an overview of CAN family readiness in the Marine Corps and offender treatment in the Army, Navy, and Air Force.

SMEs in attendance included:
- Ms. Lolita Allen, Counseling, Advocacy, and Prevention Program Manager for Headquarters Navy CNIC
- Ms. Shannon Best, FAP Manager, U.S. Marine Corps (USMC)
- Mr. Bill Huleatt, Social Worker, OSD FAP
- Ms. Lee Kelley, Director, Military Community Support Programs, Military Community and Family Policy, Office of the Deputy Assistant Secretary of Defense
- COL Steve Lewis, Chief, Family Programs Branch and Department of the Army FAP Manager, Office of the Assistant Child of Staff for Installation Management
- Lt Col Patrick Pohle, Chief, Air Force FAP, AFMOA
- Mr. Tony Robertson, Data Analyst, USMC FAP

March 19, 2019 – Work Group Teleconference

Members reviewed sections of the draft report. There were no briefings on this teleconference.

March 22, 2019 – Work Group Teleconference

Members received an overview of CAN in Purchased Care (TRICARE) and Air Force medical care.

SMEs in attendance included:
- Lt Col Shelly Martin, Child Abuse Pediatrician, SAMMC
- CAPT Ed Simmer, Chief Clinical Officer, TRICARE Health Plan, DHA

April 11-12, 2019 – Work Group Meeting
Falls Church, VA

Members received an overview of WRNMMC CAN standard operating procedures (SOP), Adverse Childhood Experiences (ACES) screening, the Futures without Violence organization, CAN treatment programs at the U.S. Disciplinary Barracks (USDB) Leavenworth and Naval Consolidated Brig (NAVCONBRIG) Miramar, pediatric clinical communities, the Strength at Home Program, development of the CAN terms of reference, and U.S. Coast Guard (USCG) medical care and family readiness.

SMEs in attendance included:
- Dr. Terry Adirim, Deputy Assistant Secretary of Defense, Health Services Policy and Oversight
- CAPT John Arnold, Specialty Leader, Pediatrics, Naval Medical Center San Diego (NMCSD)
- COL Tom Eccles, U.S. Army Human Resources Command
- CPT Christin Folker, Pediatrics Resident, WRNMMC
- Dr. Ellen Galloway, Chief, Mental Health Division, USDB Leavenworth
- Mr. William Gates, Chief, Assessment Division, USDB Leavenworth
- Lt Col David Hsieh, Maternal Child Consultant, Air Force Surgeon General, AFMOA

- Ms. Lisa James, Director of Health, Futures without Violence
- Ms. Rachel Jeter, Chief, Rehabilitation Division, USDB Leavenworth
- LTC Gordon Lyons, Director of Treatment Programs, USDB Leavenworth
- Ms. Johanna Macgillivray, FAP Manager, USCG
- Ms. JeanMarie Mangindin, Deputy Department Head, NAVCONBRIG Miramar
- Dr. Tina Marin, Director of Women's Programs, NAVCONBRIG Miramar
- LTC Michael McCown, Pediatric Pulmonologist, WRNMMC
- Dr. Nikole Nassen, Director for Sex Offender Treatment, NAVCONBRIG Miramar
- COL Thomas Newton, Chief, Department of Pediatrics, WRNMMC
- Ms. Deborah Owen, Clinical Services Department Head, Senior Clinician, NAVCONBRIG Miramar
- Dr. Abigayl Perelman, Director, General Mental Health, NAVCONBRIG Miramar
- Dr. Philip Rogers, Pediatric Hospital-Based Services, WRNMMC
- Mr. Anthony Simmons, Deputy Director of Treatment Programs, USDB
- Ms. Stacee Springer, Clinical Social Worker, WRNMMC
- CDR Shane Steiner, Chief of Preventive Medicine, USCG
- Dr. Casey Taft, Staff Psychologist at the National Center for posttraumatic stress disorder (PTSD) in the Department of Veterans Affairs (VA) Boston Healthcare System, and Professor of Psychiatry at Boston University School of Medicine
- Ms. Elena Terminiello, Clinical Social Worker, WRNMMC
- CDR Sarah Villarroel, Child Abuse Pediatrician, NMCSD

Members also reviewed sections of the draft report.

May 13, 2019 – Work Group Teleconference

Members reviewed sections of the draft report. There were no briefings on this teleconference.

May 20, 2019 – Defense Health Board Meeting
Falls Church, VA

The Work Group Chair provided a tasking update to Board members.

May 21, 2019 – Work Group Meeting
Falls Church, VA

Members received an overview of integrating assessment of intimate partner violence into routine care, the American Academy of Pediatrics Clinical Guidelines, and the Safe Environment for Every Kid (SEEK) model.

SMEs in attendance included:

- Dr. Cindy Christian, Endowed Chair, Prevention of Child Abuse and Neglect, CHOP; Professor of Pediatrics, Perelman School of Medicine, University of Pennsylvania; and Associate Dean of Admissions, Perelman School of Medicine

- Dr. Howard Dubowitz, Professor of Pediatrics and Director, Center for Families, University of Maryland School of Medicine
- Dr. Brigid McCaw, Former Medical Director, Family Violence Prevention Program, Kaiser Permanente Northern California Region; Senior Physician Internal Medicine, Kaiser Permanente

Members also reviewed sections of the draft report.

May 23, 2019 – Work Group Teleconference

Members received an overview of the NPSP.

The SME in attendance was Ms. Mary "Tib" Campise, Senior Program Analyst, OSD FAP.

Members also reviewed sections of the draft report.

June 4, 2019 – Work Group Teleconference

Members reviewed sections of the draft report. There were no briefings on this teleconference.

June 11, 2019 – Work Group Teleconference

Members reviewed sections of the draft report. There were no briefings on this teleconference.

June 13, 2019 – Work Group Teleconference

Members received an overview of child abuse and gaze aversion.

The SME in attendance was Dr. Richard Krugman, Distinguished Professor at the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado, and co-founder of the National Foundation to End Child Abuse and Neglect.

Members also reviewed sections of the draft report.

July 11-12, 2019 – Work Group Meeting
Falls Church, VA

Members held an open session and received public comments.

Public attendees included:
- Dr. Krystyna Bienia, Psychologist, Complex Pediatric Clinical Community, Medical Affairs, DHA
- MS. Renee Brown, Senior Analyst, Defense Capabilities and Management, U.S. Government Accountability Office (GAO)
- Dr. Barbara Craig, Senior Board Certified Child Abuse Pediatrician and AFCCP Director

- CAPT Amy Gavril, Assistant Chief of Pediatrics, WRNMMC, and Certified Child Abuse Pediatrician/Rotation Director, AFCCP
- Ms. Sara Guirrieri, Manager, Federal Affairs, CHOP
- Ms. Lisa Howard, Public Advocate, Barry Robinson Center
- Ms. Eileen Huck, Deputy Director, Government Relations, National Military Family Association
- Ms. Patricia Moseley, Associate Editor, Military.com
- CAPT Ed Simmer, Chief Clinical Officer, TRICARE Health Plan, DHA
- Ms. Kristen Webb, Child/Adolescent Forensic Interview, AFCCP, WRNMMC

Public comments were provided by:
- Ms. Denise Edwards, Director of Government Affairs, National Children's Alliance
- Mr. Douglas Strane, Research Project Manager, PolicyLab, CHOP

Members also received an overview of Child Protective Services (CPS) in Onslow County, NC and raising CAN awareness during the closed session.

SMEs in attendance included:
- Ms. Kim Bailey, CPS, Onslow County, NC
- Ms. Lori Poland, Founding Executive Director, The National Foundation to End Child Abuse and Neglect
- Ms. Kim Winston, CPS, Onslow County, NC

Members also reviewed the draft report.

July 19, 2019 – Work Group Teleconference

Members the draft report. There were no briefings on this teleconference.

July 29, 2019 – Work Group Teleconference

Members the draft report. There were no briefings on this teleconference.

August 6, 2019 – Defense Health Board Meeting
Falls Church, VA

The Work Group Chair provided a decision brief to Board members. Board members voted to approve the report and its findings and recommendations.

APPENDIX I. ACRONYMS

AAP: American Academy of Pediatrics
ACE: Adverse Childhood Experience
ACGME: Accreditation Council for Graduate Medical Education
AFCCP: Armed Forces Center for Child Protection
ADAPT: After Deployment: Adaptive Parenting Tools
AHLTA: Armed Forces Health Longitudinal Technology Application
AHT: Abusive Head Trauma
APSAC: American Professional Society on the Abuse of Children
ASAM: American Society of Addiction Medicine
ASAP: Army Substance Abuse Program
BAH: Basic Allowance for Housing
BAMC: Brooke Army Medical Center
BHCC: Behavioral Health Clinical Community
CAC: Child Advocacy Center
CAN: Child Abuse and Neglect
CAP: Child Abuse Pediatrician
CAPTA: Child Abuse Prevention and Treatment Act
CC: Clinical Communities
CCR: Coordinated Community Response
CCSM: Clinical Case Staff Meeting
CDC: Centers for Disease Control and Prevention
CHOP: Children's Hospital of Philadelphia
CO: Commanding Officer
CPS: Child Protective Services
CT: Computed Tomography
CUES: Confidentiality, Universal Education and Empowerment, and Support
DHA: Defense Health Agency
DHA-PI: Defense Health Agency Procedural Instruction
DMDC: Defense Manpower Data Center
DoD: Department of Defense
DoDD: Department of Defense Directive
DoDEA: Department of Defense Education Activity
DoDI: Department of Defense Instruction
DoDM: Department of Defense Manual
DV: Domestic Violence
EA: Enterprise Activity
ECHO: Extension for Community Healthcare Outcomes
EHR: Electronic Health Record
EMDR: Eye Movement Desensitization and Reprocessing
eMSM: Enhanced Multi-Service Market
FAP: Family Advocacy Program
FAS: Family Advocacy Specialist
FAST: Family Advocacy Strength-Based Therapy
FBI: Federal Bureau of Investigation

FFSP: Fleet and Family Support Program
FNS: Family Needs Screener
FOCUS: Families OverComing Under Stress
FOCUS-EC: Families OverComing Under Stress for Early Childhood
FY: Fiscal Year
GAO: Government Accountability Office
GME: Graduate Medical Education
HEADSSS: Home, Education/Employment, Activities, Drugs, Sexuality/Sexual Activity, Suicide/Depression, Safety
HESD: Hospital Education and Staff Development
HHS: Department of Health and Human Services
HIPAA: Health Insurance Portability and Accountability Act
HMO: Health Maintenance Organization
HN: High Needs
HSWLSC: Health, Safety, and Work-Life Service Center
I&D: Implementation and Dissemination
IDC: Incident Determination Committee
IPV: Intimate Partner Violence
KPNC: Kaiser Permanente Northern California
LRMC: Landstuhl Regional Medical Center
LCSW: Licensed Clinical Social Worker
LN: Low Needs
MAMC: Madigan Army Medical Center
MC&FP: Military Community and Family Policy
MCSC: Managed Care Support Contractor
MEDCEN: Medical Center
MFLC: Military and Family Life Counseling
MHS: Military Health System
MOA: Memorandum of Agreement
MOU: Memorandum of Understanding
MTF: Military Medical Treatment Facility
MWR: Morale Welfare & Recreation/Resale
NAT: Non-Accidental Trauma
NatSCEV II: Second National Survey of Children Exposed to Violence
NAVCONBRIG: Naval Consolidated Brig
NCA: National Children's Alliance
NCANDS: National Child Abuse and Neglect Data System
NDAA: National Defense Authorization Act
NIS-4: National Incidence Study of Child Abuse and Neglect 4
NMCP: Naval Medical Center Portsmouth
NMCSD: Naval Medical Center San Diego
NPSP: New Parent Support Program
OSD: Office of the Secretary of Defense
PCM: Primary Care Manager
PCS: Permanent Change of Station
PIBIS: Pittsburgh Infant Brain Injury Score

PMO: Program Management Office
PMTO™: Parent Management Training-Oregon
POS: Point-of-Service
PQ-R: Parent Questionnaire-Revised
PTS: Posttraumatic Stress
PTSD: Posttraumatic Stress Disorder
RMC: Regular Military Compensation
SAMHSA: Substance Abuse and Mental Health Services Administration
SAMMC: San Antonio Military Medical Center
SCAN: Suspected Child Abuse and Neglect
SEEK: Safe Environment for Every Kid
SHARP: Sexual Harassment Assault Response Prevention
SIDS: Sudden Infant Death Syndrome
SJA: Staff Judge Advocate
SME: Subject Matter Expert
SMI: Severe Mental Illness
SUD: Substance Use Disorder
SOP: Standard Operating Procedure
SOT: Sex Offender Treatment
STI: Sexually Transmitted Infection
STOP: Skills Techniques Options and Plans for Better Relationships
TAMC: Tripler Army Medical Center
TBI: Traumatic Brain Injury
TFL: TRICARE for Life
TOM: TRICARE Operations Manual
TOR: Terms of Reference
TPM: TRICARE Policy Manual
TRS-2: Therapeutic Rating Scale
TSWF: Tri-Service Workflow
TYA: TRICARE Young Adult
U.S.: United States
USCG: United States Coast Guard
USDB: United States Disciplinary Barracks
USD(P&R): Under Secretary of Defense for Personnel and Readiness
USFHP: Uniformed Services Family Health Plan
USMC: United States Marine Corps
USPSTF: United States Preventative Services Task Force
USUHS: Uniformed Services University of the Health Sciences
VA: Victim Advocate
WAMC: Womack Army Medical Center
WHO: World Health Organization
WRNMMC: Walter Reed National Military Medical Center

APPENDIX J. DEFENSE HEALTH BOARD SUPPORT STAFF

Juliann Althoff, CAPT, MC (FS), USN
Executive Director and Designated Federal Officer (DFO), Defense Health Board
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Management Analyst, Knowesis, Inc.
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ATTACHMENT ONE. CLINICAL GUIDELINES FOR CHILD PHYSICAL AND SEXUAL ABUSE

	Clinical Guideline Notes	Physical Examination Findings consistent with non-accidental trauma	Diagnostics	Follow up
Skin Injuries				
Bruising	• Most common sites for accidental, non-abuse related bruises in preschool and school aged children are knees and shins. A majority of normal bruises are over bony prominences.[1] • Bruises are rare in pre-ambulatory infants.[1] • Diseases associated with bruising, such as coagulopathies and vasculitides, should be part of the differential diagnosis.[1] • Bruises may not appear immediately, but may take a few hours or days.[1]	• Bruising patterns on head and face.[1] • Higher number of bruises found at time of diagnosis and/or clustering of bruises.[1] • Negative imprint or image of an implement, such as an extension cord or hand.[1] • In children under 4 years of age: bruising on torso, ear, or neck.[1] • Soft tissue swelling.[1]	N/A	• Areas that are painful when palpated should be rechecked for bruising in 1-2 days.[1] • Soft tissue swelling may persist for several days.[1]
Bite Marks	• Perpetrator identification is determined by size, dentition characteristics, location, and presence of punctures.[1] • Medical photography and dental professionals are valuable in evaluation.[1]	• Central area of ecchymoses due to positive pressure from teeth closing with erythema or negative pressure from tongue thrusting or suction.[1]	• American board of Odontology No. 2 scale or using known size and shape items (e.g. quarter) to determine size, shape, etc. of mark.[1] • Swabs of a fresh bite can be taken for DNA analysis.[1]	
Burns	• Only a minority of burns are associated with abuse. Burns associated with abuse are more common in young patients.[1] • Inflicted burns tend to be more severe, partially because of delays in seeking medical care.[1] • The history, number of burns, and pattern continuity over curved body	• Immersion burns have sharp demarcations and are often present on genitals and lower extremities in symmetric patterns. These are often seen in toddlers and with soiling accidents that require cleaning the child.[1] • Burns from hot objects are patterned, usually deep, and have a clear imprint of the instrument.[1]	N/A	• Inflicted burns require the same type of treatment as accidental burns. However, children with inflicted burns tend to have longer hospital stays and higher morbidity rates.[1]

	surfaces can inform the probability of inflicted injury.[1] • Note that dermatological diseases such as impetigo and phytophotodermatitis can mimic burn injuries.[1]	• Continuity of the burn over curved body surfaces may indicate a higher probability of intentional burns.[1]		
Skeletal Injuries	• Fractures/skeletal injury may be the sentinel injury for an abused child.[1] • Fractures in non-ambulatory infants should prompt further investigation for abuse.[1] • Infants and toddlers with midshaft humerus or femur fractures and children with rib fractures are atypical in non-abused children.[1] • Unusual fractures, such as scapular, classic metaphyseal lesions of the long bones, sternum, and/or vertebrae that are not explained by a verified history of severe trauma, are signs of possible abuse.[1] • Vitamin and mineral deficiencies such as copper deficiency, as well as diseases like osteomyelitis and genetic diseases such as osteogenesis imperfecta should be considered in the differential diagnosis as these can mimic traumatic skeletal injury.[1]	• Children with recent fractures are usually symptomatic, with crying, swelling, and/or refusal to use affected area.[1] • "Grab marks" or erythema on skin surface may indicate restraint or areas that were twisted or pulled.[1] • Note that bruising is not always observed.[1]	• Radiological skeletal survey is standard.[1] • Screenings for vitamin and mineral deficiencies as well as genetic or acute disease.[1] • Results of testing for serum calcium, phosphorus, and alkaline phosphatase should be reviewed (although alkaline phosphatase may be elevated in the presence of healing fractures.)[2] • Consider checking parathyroid hormone and 25-hydroxyvitamin D serum concentrations and the ratio of urinary calcium excretion to urine creatinine.[2]	• Repeat skeletal surveys 2 to 3 weeks after initial presentation to better date injuries, clarify equivocal findings, and identify fractures that may not have been visible on initial presentation.[1] • Skeletal surveys of young siblings and household contacts should be conducted as well.[1]
Thoraco-abdominal Injuries	• Abdominal injury is a severe form of maltreatment and is the second leading cause of mortality due to physical abuse.[1]			
Cardio-vascular	• Injuries to the heart, including dysrhythmias and direct cardiac trauma, are rare in abuse cases.[1] • Cardiac aneurysms, hemopericardium, and chylothorax	• Evidence of blows or crush injury such as bruising, sensitivity, etc.[1]	• Laboratory tests for cardiac enzymes, troponin, and creatinine kinase with muscle and bone subunits (CK-MB).[1]	

	due to thoracic duct shearing have been reported in abuse cases.[1]			
Pulmonary	• Pulmonary edema due to suffocation.[1] • Pneumothorax from lacerations.[1] • Hemorrhagic effusions could be observed.[1] • Contusions could be seen.[1] • Rib fractures are strong indicators of abuse and may be a result of forceful squeezing of the chest, and are often multiple.[1] • Note that rib fractures in infants could be attributed to prematurity or metabolic bone disease.[1]	• Pulmonary edema.[1] • Shallow breathing attributed to pain and splinting.[1] • In infants, irritability when picked up or moved.[1]	• Skeletal survey and computed tomography (CT) of chest.[1] • Bone scintigraphy could be used to complement skeletal surveys as it has a higher sensitivity rate for detecting rib fractures which can be difficult to identify.[2]	• Repeat skeletal survey 2-3 weeks after initial incident if child abuse is strongly suspected. [1.2]
Other Solid Organ (e.g. liver, pancreas, kidney)	• These injuries are rare, but usually involve the liver.[1] • Abused children are more likely to have hollow viscus injury along with liver injury.[1] • Physical examination can be unreliable due to the patient's age, other injuries, or presence of head injury.[1]	• Abdominal bruising is usually not seen, even in severe organ injury.[1] • Some children may present with peritonitis or hemorrhage.[1]	• Screening laboratory tests for liver and pancreatic enzyme levels, even for children who present without any visible trauma.[1] • Urinalysis to identify trauma to urinary tract or kidneys.[1] • CT is helpful in determining intra-abdominal trauma.[1]	
Head Trauma (General)	• Leading cause of child physical abuse fatality.[1] • Victims may present with a false history of accidental medical trauma or with nonspecific symptoms related to their injuries.[1] • May also have cerebral or spinal injuries as a result of blunt force trauma or shaking.[1] • Common misdiagnoses given include gastroenteritis, colic, accidental head injury, and otitis media.[1]	• Possible bruising or abrasions as well as scalp swelling.[1] • Developing macrocephaly.[1] • Retinal and/or subdural hemorrhage.[1] • May have ocular trauma as well.[1]	• Cranial CT and/or MRI, although CT is preferred for identifying acute hemorrhage and skull fractures.[1] • MRI is useful to assess for intracranial injury, including cerebral hypoxia and ischemia.[1] • Ultrasound can be used to evaluate macrocephaly in young infants.[1] • Indirect ophthalmoscopy by an ophthalmologist with pediatric or retinal experience.[1]	• Possible surgical intervention in the event of severe trauma.[1]

			• Consider using the Pittsburgh Infant Brain Injury Score (PIBIS) to assist in determining if the infant should undergo CT. [4]	
Sexual Abuse	• When the parent brings up possible sexual abuse, the child should immediately be removed from the conversation because they might be influenced by their parent's concerns of abuse.[5] • Sometimes parents are overly concerned about their child's normal sexual behavior. In this case, reassuring and educating the parents on normal sexual behaviors is beneficial.[5] • Pediatricians should remember that, when conducting an interview, they are conducting a medical interview with the goal of documenting and gathering enough information to make appropriate decisions about reporting and treatment. Specially trained forensic interviewers will conduct a more in-depth interview.[5] • In all cases, physicians should carefully document the parent's concerns, detail patient history, and review symptoms, especially urogenital and behavioral issues. Also, they should note in the record the source of the information (e.g. "the mother tells me the child said…) The physician should use developmentally appropriate language with the child. It is helpful to ask the parents ahead of time which terms the family uses	• If a parent is not available, a second medical professional should be present in the room to reassure the child, act as a chaperone, and assist the physician.[5] • Use of appropriate gowns and drapes protects the child's modesty and make them feel less vulnerable.[5] • *Females*: Genitalia examination does not usually require instruments in these cases. The patient should be supine in "frog leg" position (knees bent with hip abduction) and the labia gently separated. Speculum examinations are contraindicated in prepubuteral children. In adolescents, intravaginal examination is usually not needed in the absence of concerning signs or symptoms, but may be required for forensic evidence collection in acute vaginal sexual assault. For virginal adolescents or those who cannot relax their muscles, a Hoffmann speculum can be used, as it is narrower[6]. A pediatric/infant speculum should never be used. If intravaginal trauma is suspected, or the adolescent has a physical, behavioral, or developmental disability, examination or vaginoscopy should be performed under anesthesia. Forcing the	• Children who present with recent sexual contact with the exchange of body fluids should be referred to a specialty clinic which can collect samples for forensic processing.[5] • Clinical samples for sexually transmitted infections (STIs) should be taken if the patient is symptomatic, and sent for cultures and/or nucleic acid based assays.[5]	• Patients should be referred to specialty clinics/centers for further treatment or exam, if deemed necessary.[5] • Evaluation for post-exposure prophylaxis for HIV or STIs as well as pregnancy screening and counseling.[5]

	for bathroom activities and genitalia and breasts. [5] • When collecting information, the pediatrician should ask open-ended questions. Also, the child should not be rewarded after incident disclosure (e.g. "If you tell me what happened, you can go back to your Mom…")[5] • If available, the physician should refer the patient to specialized clinics and/or advocacy centers that can provide specially trained forensic interviewers and clinicians. If the facilities are not available, the pediatrician must educate themselves about childhood anal and genital examinations.[5]	patient to undergo pelvic examination is always contraindicated.[6] • Males: Genital examination consists of inspection of the penis and scrotum for abnormalities such as scarring, trauma, or lesions.[5] • Examination of the anus is performed by the patient lying supine with their knees to their chest and applying gentle traction of the buttocks to expose the anal sphincter. Anoscopy and or digital rectal examination is not routinely indicated.[5] • Evidence of infection, trauma, and/or bleeding should be documented in detail. In the pediatric office, photographs and/or videos are not necessary unless they are a regular part of the practice. In specialty centers, examinations usually include photos and video. All these materials should be marked and treated as a confidential part of the medical record.[5] • All examinations should be reviewed by an expert clinician.[5]		

INSIDE BACK

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