

The seal of the Defense Health Board is a circular emblem. It features a central figure of a caduceus (a staff with two snakes) superimposed on a globe. The globe is light blue and green, representing the Earth. The caduceus is dark grey. The entire emblem is set within a circular border that is light blue. The word "DEFENSE" is written in white, uppercase letters along the top arc of the border, and "HEALTH BOARD" is written along the bottom arc.

Decision Brief

Healthy Military Family Systems: Examining Child Abuse and Neglect

August 6, 2019
Defense Health Board



Overview

- Membership
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- Meetings
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- Findings and Recommendations



Membership

- Maj Gen (Ret.) George K. Anderson, MD, MPH
(Term Completed March 2019)
- Craig H. Blakely, PhD
- GEN (Ret.) Frederick Franks
(Term Completed June 2019)
- John Groopman, PhD
- Eve J. Higginbotham-Williams, SM, MD
(Term Completed June 2019)
- RADM (Ret.) H. Clifford Lane, MD
- Jeremy A. Lazarus, MD
- Vivian S. Lee, MD, PhD, MBA
- RADM (Ret.) Kathleen L. Martin, MS
- Gen (Ret.) Richard Myers



Tasking (1 of 2)

On June 15, 2018, the Acting Assistant Secretary of Defense for Health Affairs (ASD(HA)) requested 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.**



Tasking (2 of 2)

The DHB should examine 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:

- 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;
- 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.



Meetings Since Last Board Meeting

(1 of 2)

The CAN Work Group has gathered information through the following in-person briefings and teleconferences:

May 21, 2019	<ul style="list-style-type: none">▪ Meeting: Falls Church, VA<ul style="list-style-type: none">○ Report Development○ Integrating Assessment of Intimate Partner Violence into Routine Care○ American Academy of Pediatrics Clinical Guidelines○ Safe Environment for Every Kid (SEEK) Model
May 23, 2019	<ul style="list-style-type: none">▪ Teleconference:<ul style="list-style-type: none">○ Report Development○ The New Parent Support Program
June 4, 2019	<ul style="list-style-type: none">▪ Teleconference: Report Development
June 11, 2019	<ul style="list-style-type: none">▪ Teleconference: Report Development
June 13, 2019	<ul style="list-style-type: none">▪ Teleconference:<ul style="list-style-type: none">○ Report Development○ Child Abuse and Neglect: An Overview



Meetings Since Last Board Meeting

(2 of 2)

July 11-12, 2019	<ul style="list-style-type: none">▪ Meeting: Falls Church, VA<ul style="list-style-type: none">○ Public Session○ Report Development○ Child Protective Services, Onslow County, Camp Lejeune, NC○ Raising CAN Awareness
July 19, 2019	<ul style="list-style-type: none">▪ Teleconference: Report Development
July 29, 2019	<ul style="list-style-type: none">▪ Teleconference: Report Development



Putting a Face on CAN in the Military



Talia Williams, Age 5

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Bringing CAN Out of the Dark

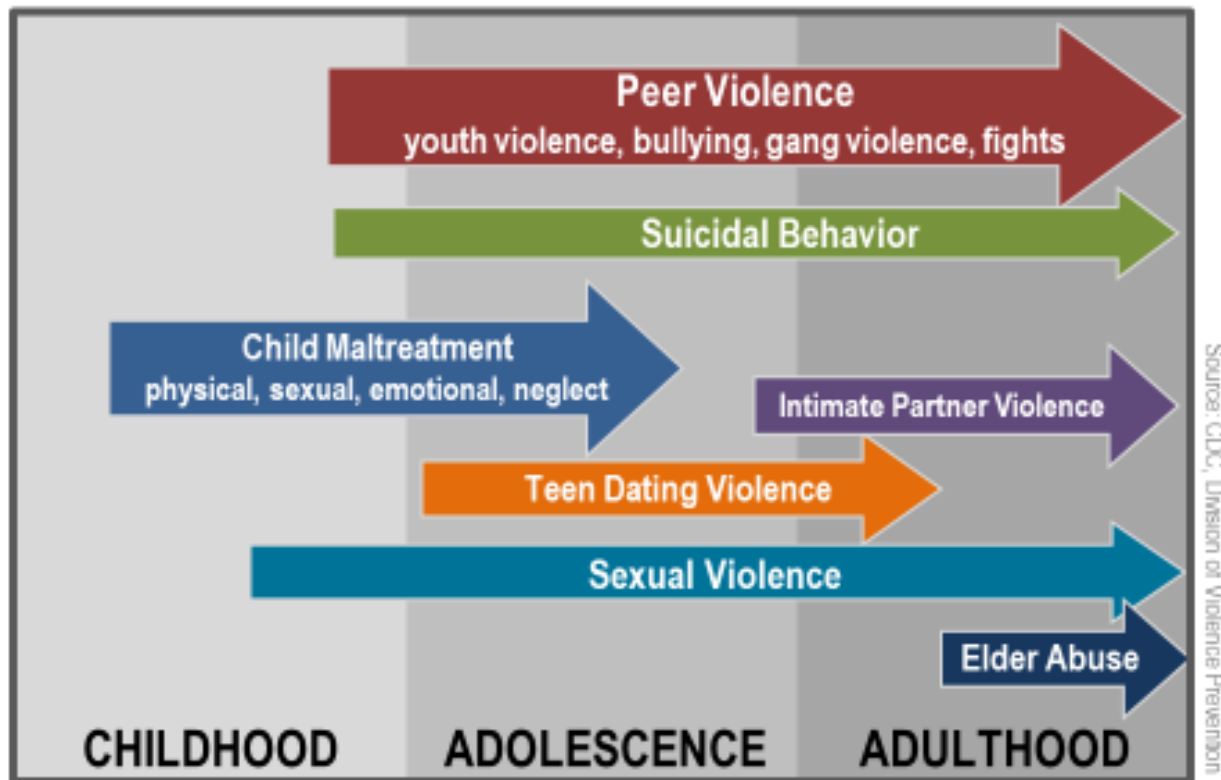
- CAN and other **forms of violence thrive on secrecy**. Secrecy is tied to stigma and fear of repercussions, among other factors.
- The phenomenon of **“gaze aversion”** can be a barrier to care.
 - May manifest as the failure to see child maltreatment when it has likely occurred, or to devote the necessary and appropriate resources to the problem at the systems level.





CAN in Context (1 of 2)

- Experts contend that various types of violence tend to co-occur within the lives of individuals and share similar risk and protective factors and solutions.

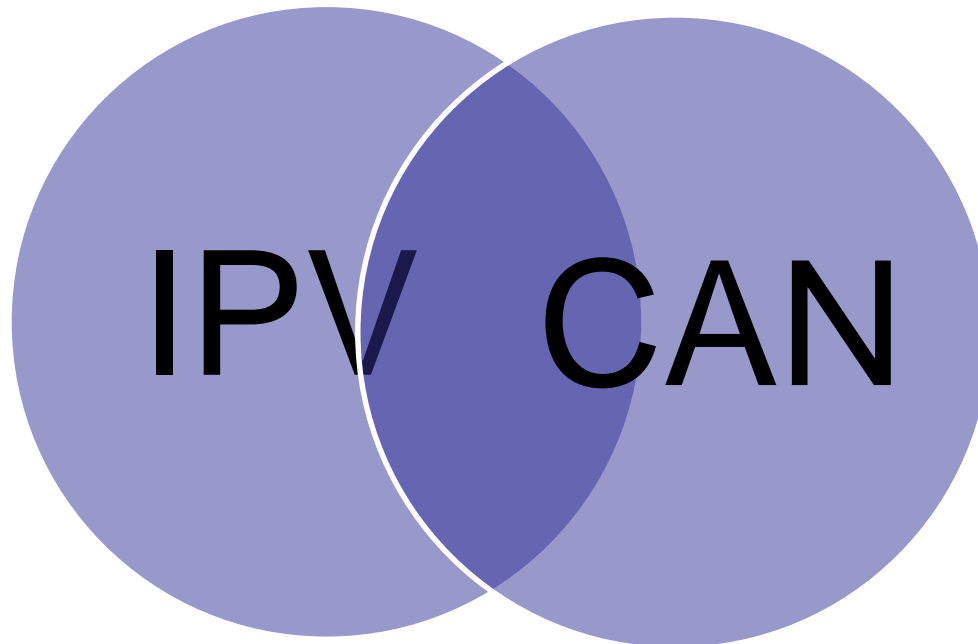


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CAN in Context (2 of 2)

- Example: CAN has been found to occur in approximately 34% of Intimate Partner Violence (IPV) cases.





Themes

*“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), April 12, 2019

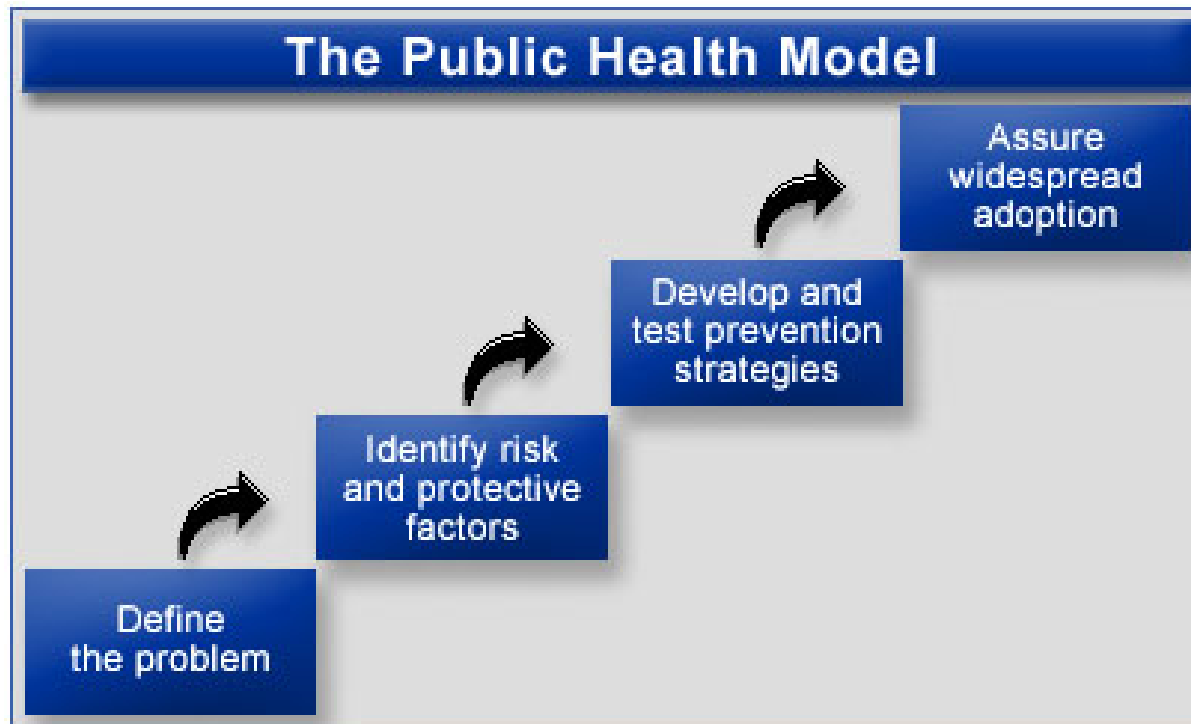
The Board conducted a comprehensive evaluation in response to its charge. Across a robust literature review, DoD and civilian expert briefings, review of existing policies and procedures in DoD, and public commentary, five themes emerged:

- A public health approach is essential to combatting CAN;
- The MHS is an essential and powerful partner in a public health approach to CAN in the Department of Defense (DoD);
- Coordination is essential – within DoD and between DoD and civilian partners;
- Surveillance and outcome metrics provide crucial information; and
- Military-unique factors must be considered in DoD’s anti-CAN efforts.



A Public Health Approach is Essential to Combatting CAN (1 of 3)

- A **public health approach** frames a problem as a health issue, relies on knowledge from a broad range of disciplines, and aims to provide maximum benefit for the largest number of people. Risk factors and symptoms are treated rather than stigmatized and punished.





A Public Health Approach is Essential to Combatting CAN (2 of 3)

*Global Campaign for
Violence Prevention*



**World Health
Organization**

Surveillance

- What is the problem?

Identification of Risk and Protective Factors

- What are the causes?

Development and Early Interventions

- What works and for whom?

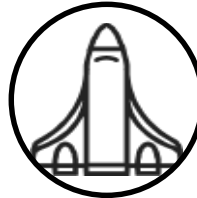
Implementation

- Scaling up effective policy and programs



A Public Health Approach is Essential to Combatting CAN (3 of 3)

Intimate Partner Violence Program



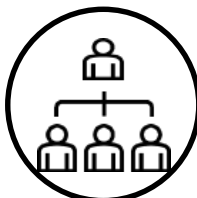
1 **Bold Goal**



2 **New Approach**



3 **Measuring Improvement**



4 **Designing for Spread**

A public health–informed systems approach to violence can be applied to the DoD

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The MHS is an Essential and Powerful Partner in a Public Health Approach to CAN in the DoD (1 of 3)

- The Family Advocacy Program (FAP) has the lead for anti-CAN efforts in the DoD. However, health care providers are integral to these efforts.
- Health care providers are typically the first point of contact outside the family; historically they're the most frequent identifiers of CAN within the most vulnerable population: children ages 0 to 3.
 - Regularly scheduled well child visits provide a routine opportunity to assess risk factors and suspected maltreatment in families.



The MHS is an Essential and Powerful Partner in a Public Health Approach to CAN in the DoD (2 of 3)

- Currently, there are variable CAN-related policies and training in place for health care providers.
 - A CAN-related Defense Health Agency Procedural Instruction (DHA-PI) is in progress. This DHA-PI addresses CAN reporting requirements and consultation options for providers. Additional standardization of policy and procedure is needed.
- CAN screening within routine care is complicated by several factors:
 - There are no validated, CAN-specific screening tools for use in health care.
 - CAN screening and management procedures are not currently standardized in the electronic health record (EHR) workflow.
 - CAN screening must compete with many other screening mandates for a provider's time and attention.



The MHS is an Essential and Powerful Partner in a Public Health Approach to CAN in the DoD (3 of 3)

- **Board-certified Child Abuse Pediatricians (CAPs) are an important source of expertise** for CAN cases. CAPs provide consultation, evaluation, case review, training, and testimony for CAN cases. There are **only five CAPs** to provide these services across the MHS; two of them have other job duties. Two CAPs are located at the Armed Forces Center for Child Protection (AFCCP).
- **The AFCCP is an important Enterprise resource for CAN training and response in the DoD and MHS.** The AFCCP includes two CAPs, a forensic nurse practitioner, a social worker/forensic interviewer, and administrative support. However, the AFCCP, an Enterprise-wide resource, is organizationally a division under the Department of Pediatrics at WRNMMC, and competes with other priorities at a hospital departmental level.



Coordination is Essential—within the DoD and Between DoD and Civilian Partners (1 of 2)

- The Family Advocacy Program (**FAP**) is **organized differently across Services**.
- There are **differing levels of coordination between FAP and the MHS** across Service FAP organizational models.
- **Inclusion of medical personnel** on case determination committees should be reexamined.



Coordination is Essential—within the DoD and Between DoD and Civilian Partners (2 of 2)

- There are many excellent DoD programs available to families at risk of CAN.
 - **Military OneSource** is a 24/7 call center and website that connects beneficiaries to information and support within the military community.
 - **The New Parent Support Program (NPSP)** is a prevention-based program designed to proactively address parenting concerns. NPSP falls under the auspices of FAP.
 - **HealthySteps** is an evidence-based, interdisciplinary pediatric primary care program designed to support positive parenting and healthy development of babies and toddlers. The MHS is currently piloting HealthySteps in several military medical treatment facilities (MTFs) and evaluating its potential for spread.
- CAN resources must be **coordinated and leveraged across the DoD.**



Coordination is Essential—within the DoD and Between DoD and Civilian Partners (3 of 3)

- Talia’s Law improves military-civilian coordination by requiring mandated military reporters to report suspected CAN to CPS. However, **civilian medical providers and CPS agencies are not required to report suspected CAN in military families to FAP.**
 - DoD agreements with some states and localities—known as memoranda of understanding or agreement (MOUs/ MOAs)—enable increased tracking and support for families affected by CAN.
- Civilian organizations can aid DoD’s anti-CAN efforts. **Child Advocacy Centers (CACs)** are one example. There are existing MOUs between CACs and military programs or installations.



Surveillance and Outcome Metrics Provide Crucial Information

- It is difficult to determine the true burden of child maltreatment in the civilian sector and in the DoD, due to definitional and data capture challenges and suspected under-reporting.
- This challenge is compounded within the DoD by variations in the populations served by FAP and the MHS. FAP serves active duty families only, while the MHS includes retirees and their beneficiaries. It is important to integrate FAP data with medical records to better serve families impacted by CAN.
- The DoD should support ongoing efforts, such as The Millennium Cohort Study, to track CAN and other health outcomes.



Military-Unique Factors Must be Considered in the DoD's Anti-CAN Efforts (1 of 2)

- Military life entails a unique combination of challenges and structural supports that can variously impact the likelihood of CAN.
 - Challenges include frequent and recurrent moves away from support networks, deployments leading to temporary single-parenting, and financial stress due to low pay or spousal employment difficulties secondary to moves.
 - Supports include a defined occupational structure and social network, shared emphasis on specific values, including honor, integrity, and accountability, and ongoing access to an integrated health system.



Military-Unique Factors Must be Considered in the DoD's Anti-CAN Efforts (2 of 2)

- Deployment periods are associated with higher odds of physical neglect, lack of supervision, and educational neglect. There are gender-specific considerations regarding this potential maladaptive response to deployment.
- The issue of career repercussions stemming from CAN has been raised as a barrier to seeking help. While sometimes indicated and necessary, particularly in light of 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.



Finding and Recommendation 1

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 and Recommendation 2

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).



Finding and Recommendation 3

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 and Recommendation 4

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

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 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

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 and Recommendation 6

Finding 6: There are no requirements or standardized ways to screen for CAN in the Direct or Purchased Care networks of the Military Health System (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 and Recommendation 7

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 and Recommendation 8

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.



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Finding and Recommendation 9

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 and Recommendation 10

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 and Recommendation 11

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 and Recommendation 12

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.



Finding and Recommendation 13

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 and Recommendation 14

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 and Recommendation 15

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 taken when significant findings emerge.



Finding and Recommendation 16

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

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

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 a tighter coordination between losing and receiving FAPs and commands during deployment or PCS of families with open FAP cases.



Finding and Recommendation 18

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 the underreporting of CAN cases.



Questions?