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Research article

Under-ascertainment from healthcare settings of child abuse events among children of soldiers by the U.S. Army Family Advocacy Program

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ABSTRACT

In cases of maltreatment involving children of U.S. Army service members, the U.S. Army Family Advocacy Program (FAP) is responsible for providing services to families and ensuring child safety. The percentage of cases of maltreatment that are known to FAP, however, is uncertain. Thus, the objective of this retrospective study was to estimate the percentage of U.S. Army dependent children with child maltreatment as diagnosed by a military or civilian medical provider who had a substantiated report with FAP from 2004 to 2007. Medical claims data were used to identify 0–17 year old child dependents of soldiers who received a medical diagnosis of child maltreatment. Linkage rates of maltreatment medical diagnoses with corresponding substantiated FAP reports were calculated. Bivariate and multivariable analyses examined the association of child, maltreatment episode, and soldier characteristics with linkage to substantiated FAP reports. Across 5945 medically diagnosed maltreatment episodes, 20.3% had a substantiated FAP report. Adjusting for covariates, the predicted probability of linkage to a substantiated FAP report was higher for physical abuse than for sexual abuse, 25.8%, 95% CI (23.4, 28.3) versus 14.5%, 95% CI (11.2, 17.9). Episodes in which early care was provided at civilian treatment facilities were less likely to have a FAP report than those treated at military facilities, 9.8%, 95% CI (7.3, 12.2) versus 23.6%, 95% CI (20.8, 26.4). The observed low rates of linkage of medically diagnosed child maltreatment to substantiated FAP reports may signal the need for further regulation of FAP reporting requirements, particularly for children treated at civilian facilities.

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1. Introduction

Established in 1981, the Army Family Advocacy Program (FAP) is responsible for the prevention, identification, reporting, investigation and treatment of spouse and child abuse in military families (“The Army Family Advocacy Program, Rapid Action Revision,” 2011; Rentz et al., 2006). Each year Army FAP investigates between 6000 to 9000 reports of alleged maltreatment involving children of military service members (R. Robichaux, personal communication, November 17, 2016). In the approximately 48% of reported cases in which Army FAP makes a determination that maltreatment has occurred and substantiates the report (R. Robichaux, personal communication, November 17, 2016), FAP is responsible for collaborating with local civilian child protection service (CPS) agencies in providing services to families and ensuring the safety of children (“The Army Family Advocacy Program, Rapid Action Revision,” 2011).

The unique stressors experienced by military families related to deployments and relocations have raised concern that military families may be at increased risk for child maltreatment, particularly during times of frequent and prolonged combat-related deployments (Gibbs, Martin, Kupper, & Johnson, 2007; Rentz et al., 2006; Rentz et al., 2007; Taylor et al., 2016). Rates of substantiated FAP reports of child maltreatment, however, have suggested that, on average, substantiated rates of child maltreatment in the U.S. military are half the rate of that for civilian children (McCarroll, Ursano, Fan, & Newby, 2004; Rentz et al., 2006; U.S. Department of Defense, 2015), raising speculation that some attributes of military families may be protective against abuse (Gumbs et al., 2013; Rentz et al., 2006; U.S. Department of Defense, 2015). Other studies have produced mixed results regarding the relative rates of child maltreatment in civilian and military populations (Gumbs et al., 2013; Rentz et al., 2006).

The reported number of substantiated cases served by FAP, however, almost certainly underestimates the number of child dependents of U.S. military service members who are victims of maltreatment. Numerous studies have demonstrated that many cases of child maltreatment in the U.S. are never reported to a CPS agency or are reported but not investigated or substantiated (Gilbert et al., 2009; Sedlak et al., 2010). Even severely maltreated children, requiring medical care due to abuse or neglect are not uniformly known to civilian CPS agencies. Among cases in which a diagnosis of child maltreatment is documented in the medical record and a diagnosis code for child maltreatment is assigned, the vast majority (90%) are reported to CPS (Schnitzer, Slusher, & Van Tuinen, 2004). In many cases, however, a diagnosis of child maltreatment is not documented and a report is not made because medical providers either failed to recognize the maltreatment or recognized the maltreatment but chose not to diagnose and report it (Flaherty et al., 2008; Jenny, Hymel, Ritzen, Reinert, & Hay, 1999; Oral, Blum, & Johnson, 2003; Ravichandiran et al., 2010; Taitz, Moran, & O’Meara, 2004; Thorpe, Zuckerbraun, Wolford, & Berger, 2014). Given the complexity of the reporting system for military families, there may be an even larger gap in reporting to FAP, as medical providers may not uniformly report to FAP even when they have made and documented a diagnosis of child maltreatment in a military family. Failures of reporting suspected child maltreatment to FAP could result in vulnerable children and families not receiving FAP services and contribute to undercounting of child maltreatment in the U.S. military.

The reporting system for suspected child maltreatment involving families in the U.S. Army, the largest branch of the military, is complex, with multiple possible routes for the communication of reports of suspected maltreatment to the U.S. Army FAP. These routes of communication may vary by medical care site. Children of Army service members with injuries from maltreatment may receive care at medical facilities associated with military installations or at non-military medical facilities. When medical providers at a military facility suspect a child is a victim of maltreatment, they are required per Army Regulation 608-18 (“The Army Family Advocacy Program, Rapid Action Revision,” 2011) to make an immediate report to the on-site Reporting Point of Contact (RPOC) designated by the installation commander. In most instances, the RPOC is the military treatment facility emergency room or Military Police desk (“The Army Family Advocacy Program, Rapid Action Revision,” 2011). Medical providers caring for a military family at non-military facilities, may be unfamiliar with the military system and make reports to civilian CPS agencies via centralized hotlines and not make an additional report to FAP. In some cases, military medical providers may choose to bypass the FAP RPOC and make reports to civilian CPS agencies. Thus, civilian CPS agencies may receive reports for children treated at military facilities as well as for children treated at non-military facilities. At military installations where a memorandum of agreement (MOA) exists between FAP and local civilian CPS agencies, each agency agrees to shared case management and is expected to provide case information on all known and suspected instances of child maltreatment involving soldiers and their families. This allows FAP to coordinate the case management and provision of services with civilian CPS as well as provide military-specific services when appropriate (United States Department of Army, 1995). It is unclear how many installations have the necessary MOAs in place to support an integrated response between civilian and FAP agencies. Furthermore, the extent to which these communications occur when MOAs are in place is also uncertain. Thus, there are multiple opportunities for lapses in communication of child maltreatment concerns to FAP.

Given the concern for possible under-reporting of child maltreatment to the U.S. Army FAP, the aim of this study was to estimate the proportion of medically diagnosed cases of child maltreatment that resulted in a substantiated U.S. Army FAP report, and to investigate how child, episode, and soldier characteristics influenced the linkage of a medically diagnosed child maltreatment episode to a substantiated FAP report. Although child maltreatment reports originating from medical providers represent a minority of all substantiated reports in both the civilian CPS and the FAP systems (Foster et al., 2010; Schnitzer et al., 2004; U.S. Department of Health and Human Services, 2015), we chose to focus on medically diagnosed cases of maltreatment for two reasons. First, the population of medically diagnosed cases of maltreatment includes the most severely injured and maltreated children, including those at highest risk for a fatality. Second, medical diagnosis codes

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