CLEARINGHOUSE
FOR MILITARY FAMILY READINESS

Domestic Abuse and Child Abuse and Neglect: Barriers to Mandated Reporting

Rapid Literature Review (update)

Clearinghouse Technical Assistance Team

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Executive Summary

This report was developed in response to a request from Army Family Advocacy Program (FAP) headquarters for information on barriers to mandatory reporting of Domestic Abuse (DA) and Child Abuse and Neglect (CAN). Specifically, the Technical Assistance (TA) team at the Clearinghouse for Military Family Readiness at Penn State (Clearinghouse) was asked to focus on reasons a mandated reporter might not report incidences of DA or CAN. Due to limited military-specific research on reporting barriers, studies published on civilian providers' barriers are included in this literature review. Four military-specific reports are also included in this review. These reports present statistics, trends, and recommendations for improving screening and reporting DA and CAN in the military community. However, these reports do not address the question of why reporters might not file a report of DA or CAN.

DA and CAN are prominent health issues in the general population in our current society. Military families have added stressors that the civilian population may not experience, such as frequent moves, financial stress, or deployment concerns, that can potentially heighten the possibility of abuse in this population. Reoccurring moves due to permanent change of station can disrupt established support networks of healthcare providers, family, and friends. In addition, relocations may cause financial stress when military spouses have difficulty transferring their occupational license or finding work in their new location. Deployments add different types of stress, such as the at-home spouse is responsible for parenting alone and concerns for the Service member's safety (Defense Health Board, 2019).

Underreporting cases of CAN and DA throughout the United States continues to be a problem. This review intends to explore the barriers FAP providers may encounter that prohibit or discourage them from reporting suspected incidences of CAN and DA.

This report provides information on the following elements:

- DoD's definitions of abuse,
- Information on the role and procedures of the Military Health System (MHS) and Family Advocacy Program (FAP) in mandated reporting,
- Potential barriers to mandated reporting, and
- Additional resources.

Introduction

The Technical Assistance (TA) team at the Clearinghouse for Military Family Readiness at Penn State (Clearinghouse) conducted a brief rapid literature review on barriers to mandatory reporting of Domestic Abuse (DA) and Child Abuse and Neglect (CAN). Research that examines this topic was identified by searching peer-reviewed journal articles and grey literature, and an emphasis was placed on research published between 2015 and 2022. Seminal studies (i.e., those influencing more current research literature) before 2015 were also included in this search. Search queries included various combinations of the following terms: *barriers, service use, help-seeking, treatment use, mandatory reporting, domestic violence, child abuse, neglect, mandatory reporting barriers, stigma, service utilization, military, service member,* and *soldier*.

Department of Defense's Definitions of CAN and DA

This section provides definitions recognized by the Department of Defense (DoD) for CAN and DA. Throughout the research, the terms "Domestic Abuse," "Domestic Violence" (DV), and "Intimate Partner Violence" (IPV) were used interchangeably to refer to abuse of a spouse or intimate partner. In this report, for the purpose of clarity, DA will include the terms DV and IPV. The following definitions of DA and CAN are recognized by the DoD.

DA

"Domestic abuse, or a pattern of behavior resulting in emotional or psychological abuse, economic control, or interference with personal liberty that is directed toward a person who is one or more of the following: 1) Current or former spouse 2) Person with whom the alleged abuser shares a child in common 3) Current or former intimate partner with whom the alleged abuser shares or has shared a common domicile 4) Person who is or has been in a social relationship of a romantic or intimate nature with the accused and determined to be an intimate partner (as defined in this issuance)" (Under Secretary of Defense for Personnel and Readiness, 2022a, p.80) As with children, abuse may take many forms (e.g., physical, emotional, sexual abuse; neglect).

CAN

"The physical or sexual abuse, emotional abuse, or neglect of a child by a parent, guardian, foster parent, or by a caregiver, whether the caregiver is intrafamilial or

extrafamilial, 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" (United States Department of Defense, 2021, p.18). Child abuse may include **physical abuse** (e.g., pushing, slapping, burning), **emotional abuse** (e.g., intentional berating, disparaging, other verbally abusive behaviors), and **sexual abuse (e.g., sexual contact between an adult and child such as touching, exposure to pornography, rape, incest)** (Under Secretary of Defense for Personnel and Readiness, 2021).

Neglect is defined as "the negligent treatment of a person through acts or omissions by an individual responsible for the victim's welfare under circumstances indicating the victim's welfare is harmed or threatened" (Under Secretary of Defense for Personnel and Readiness, 2021, p.37). Neglect may include neglect of the child (e.g., depriving a child of necessary care such as food or clothing), educational neglect (e.g., knowingly allowing a child's absence from school), and medical neglect (e.g., failing to provide necessary medical care such as seeing a doctor or dentist).

The Role of the Military Health System and Family Advocacy Program in Mandated Reporting

The Military Health System (MHS) provides services to 9.5 million active duty personnel, their families, and retirees and is one of the most complex and largest healthcare institutions in the United States (Defense Health Board, 2019). The MHS is often the first point of contact for determining suspected abuse, and it is the most frequent identifier of CAN among children ages 0 to 3 – the most vulnerable population that experiences CAN (Defense Health Board, 2019).

Military-dependent children seen in an MHS facility are 2.4 times more likely to have a Family Advocacy Program (FAP) incident report generated than those seen at a civilian medical facility (Defense Health Board, 2019). This discrepancy between the reporting of CAN in civilian-service and military-service providers may be attributed to civilian-service providers being unaware of military reporting procedures or FAP reporting protocols (Defense Health Board, 2019).

Multiple reasons deter Service members or spouses from seeking help or filing a report of DA or CAN. These reasons include financial dependency on the perpetrator, sharing custody of children and desire to raise children together, fear of job repercussions, or potential negative stigma of treatment-seeking among military personnel associated

with such reports. Because of these concerns, the Office of the Secretary of Defense (OSD) created the FAP, which provides military families and professionals who work with military families guidance regarding DA and CAN on prevention, procedures, policy, training, education, and treatments. OSD FAP is available on every military installation, and this program recently created a FAP-prevention logic model for the military community based on evidence-informed approaches developed in 2020. Over 2,000 Domestic Abuse Victim Advocates, New Parent Support Program Home Visitors, credentialed/licensed clinical providers, and prevention staff are employed by FAP. All FAP staff are considered mandated reporters to state child welfare service agencies and are required to report instances of suspected CAN and DA to the DoD FAP Central Registry (United States Department of Defense, 2021).

In 2021, the U.S. Government Accountability Office (GAO) collected and analyzed DA data and made recommendations for actions that should be initiated to enhance DoD's prevention, response, and oversight of DA and CAN allegations. They found that, although there are continual efforts made to improve the reporting and response to DA cases, there are still challenges that prevent DA victims from getting the assistance they need. In 2016, the DoD standardized the Incident Determination Committee (IDC) process and stated that every reported incident must be presented to the IDC unless the incident had no possibility of meeting any of the DA criteria. Following this directive, several challenging problems arose, and these are listed below.

- The DoD met a statutory requirement to collect and report data for DA incidents that met its stated criteria, but the DoD failed to report data on all allegations received because multiple specific allegations may have been combined into one report.

    - Due to the different collection methods used across the Services, determining how many incidences of abuse occurred or what types of abuse occurred is impossible. Although the DoD's manual does provide procedures to each Service on the reporting of DA data, these procedures do not specifically indicate whether each DA allegation should be reported separately. Therefore, more than one abuse type may be combined into one report. This action would hinder the accurate collection of data on each singular incident.

    - There is no quality-control process that can be used to determine the reliability of allegations that did not meet DoD's criteria. Without a quality-control process in place, associated types of abuse or accurate or complete data may be missed.

- Military-service DA policies generally align with DoD requirements, but the number of Memorandums of Understanding (MOUs) provided to civilian organizations may be insufficient.

    - MOUs are generally consistent with the DoD's requirements; however, without a comprehensive formal MOU policy with civilian organizations, required elements may not be listed.

    - Although FAP policies address the key DoD requirements for military protective orders, the Army has not yet established required procedures for the violation of civilian protective orders. Army officials stated that an upcoming directive will require commanders to issue a military protective order if there is an existing civilian protective order.

- The DoD and the military Services have taken steps to implement and oversee DA prevention and response activities, but gaps remain in key areas (e.g., monitoring of the process for initial screening of reports, ensuring awareness of FAP among victims, overseeing IDC proceedings and command actions related to domestic violence incidents).

    - The initial screening for victims of DA is based on reasonable suspicion; however, there is no existing DoD policy that defines what constitutes reasonable suspicion. Without this definition, there is a lack of reasonable assurance that allegations are properly screened and that all qualified DA allegations are reported.

    - Although the military Services have developed risk-assessment tools, the implementation of these tools is inconsistent across installations.

    - Awareness of reporting options and resources for DA victims remains a challenge, especially for individuals who live off base, and evaluations of awareness efforts are not being assessed.

- Training for key personnel meets some DoD requirements, but required training completion data are incomplete.

    - According to Army commanders, lower-ranking Service members receive less DA information and may not always receive the installation-level

training. However, plans to make DA a common military training requirement with standard curricula are forthcoming.

- The Army does not provide standard training materials to their installations; rather, they use training materials developed at each instillation.

- There are incomplete data for commander and senior enlisted advisor training completion rates. Due to high turnover, the Army FAP indicated that identifying new personnel who need to be trained in DA can be challenging.

Based upon recommendations made in the 2021 U.S. GAO report, the DoD is updating policies and procedures to ensure the proper prevention, screening, and response for DA victims.

Potential Barriers to Mandated Reporting

The reasons why victims of DA and CAN do not report incidences to healthcare professionals and the barriers that victims encounter to reporting incidences have been widely studied in the research literature. However, there is limited research that examines why military-service providers (e.g., FAP personnel, MHS providers) may not report or properly screen for DA and CAN, even though screening is considered an essential tool for discovering and assisting with these occurrences. The following discussion presents the brief findings from this review of the literature on reasons why providers may not report incidences of DA and CA.

- **Education and lack of training** - Providers felt unprepared or unqualified to assess or determine cases of DA or CAN. Portnoy et al. (2020) interviewed providers at a large U.S. Veteran Health Administration (VHA) medical center and found their willingness to screen for DA was determined by their feelings of preparedness and knowledge in five domains: (1) knowing what questions to ask and how to ask them; (2) recognizing how to document DA in patients' electronic medical records; (3) understanding DA-related, mandated reporting requirements; (4) being aware of available referral options; and (5) realizing how to optimally follow up on positive screens. The concern providers had regarding their feelings of being unprepared or unqualified to identify or offer further assistance to possible victims of violence was a reoccurring concern throughout the research.

- **Lack of resources** – Providers are, sometimes, reluctant to report or address cases of DA and CAN, even though they may suspect the abuse, because they are unfamiliar with the available resources or next steps in their local area. Providers may feel they are unable to offer the patient appropriate resources or opportunities to address the situation (Ahmad et al., 2016).

- **Faith in Child Protective Services (CPS)** – Medical clinicians reported they often had little faith that CPS worked. They reported they did not receive communications or feedback from CPS after filing a report of CAN, and they were unsure of the status of those reports due to limited or no follow up from CPS (Kuruppu et al., 2020).

- **Gaze aversion** – Gaze aversion, or "turning our head away from unpleasant topics" (Runyan, 2018, p.1189), is a phenomenon that is familiar to clinicians (e.g., doctors, nurses) who work with CAN, and it may create a barrier to identifying abuse. In fact, gaze aversion may contribute to providers attributing signs of abuse to causes less difficult or emotional (e.g., accidental bruise).

- **Comfort level** – Ahmad et al. (2016) indicated that questions related to DA are difficult to address, and the healthcare professional's personal confidence and comfort level in tackling these situations may determine whether they screen appropriately for DA. Some providers indicated that damaging their provider/patient relationship by questioning patients about DA was a concern. In addition, some providers feared for their own safety if they broached questions regarding DA. These worries were cited as reasons some providers avoided inquiring about possible cases. Throughout the studies, providers agree that when patients are the initiators of the DA conversation, they are more likely to have an easier time discussing the situation and screening for potential abuse (Portnoy et al., 2020).

- **Provider bias** – Multiple factors contribute to provider bias (i.e., attitudes and subsequent behaviors by providers that limit client access to services) for reporting or not reporting cases of DA. Examples of provider bias include the following:

    - language barriers or cultural differences,
    - fear of offending victims or consequences that may occur due to a report being made (Alshammari et al., 2018),
    - desire to believe the caregiver (Tiyyagura et al., 2015),
    - relationship with the family (Kuruppu et al., 2020),
    - lack of empathy (Ahmad et al., 2016), and
    - personal history of abuse (Yonaka et al., 2007).

Alverez et al. (2017) noted that providers' fundamental feelings and beliefs about the screening process for DA influenced their decisions on whether to file a report. In addition, their thoughts about the patients who engage in DA may hinder the likelihood that they will screen for abuse (Portnoy et al., 2020).

- **Protocols and procedures** – The presence or absence of clinical-level protocol was a key influencing factor on how providers screen for DA. The absence of such a protocol that details providers' responsibilities and suggested responses to possible patients of DA is a barrier for screening practices (Erickson et al., 2001; Guillery et al., 2012) because providers may feel unprepared to screen and report the abuse (Glaister & Kesling, 2002). Portnoy et al. (2020) agree that the lack of diagnostic code for IPV can hinder a provider's ability to screen and report.

- **Time constraints** – Providers indicated that time constraints (i.e., limited visit times) were a barrier to screening and reporting incidences of DA. Without an adequate amount of time, providers found it difficult to assess and determine whether DA had occurred (Ahmad et al., 2016; Alshammari et al., 2018; Alvarez et al., 2017; Kuruppu et al., 2020; Portnoy et al., 2020).

- **Logistical concerns** - The space used by the clinic and its physical set-up can aid or hinder the use of DA screening (Portnoy et al., 2020). For example, patients at a clinic with limited space might feel concerned that someone could overhear their conversation with the clinician; consequently, a lack of privacy is a reoccurring concern throughout the research (Ahmad et al., 2016; Alshammari et al., 2018; Alvarez et al., 2017).

Additional Resources

- **Domestic Abuse: Actions Needed to Enhance DOD's Prevention, Response, and Oversight**

    - This report was given to Congressional Committees and was prepared by the U.S. GAO. It analyzed FAP program data, policies, and guidance; documents from 20 military installations; and interviews from 68 DA survivors and DoD, Service, and civilian officials. It examined the extent to which: (1) the DoD has met statutory requirements to collect and report complete data on reports of DA; (2) the DoD and the military Services have implemented and overseen DA prevention and response activities in accordance with DoD

policy; and (3) the military Services have developed DA training, which meets DoD requirements, for key personnel.
    - https://apps.dtic.mil/sti/pdfs/AD1174798.pdf

- **Child Welfare: Increased Guidance and Collaboration Needed to Improve DOD's Tracking and Response to Child Abuse**
    - This U.S. GAO report to Congressional requestors reviewed DoD policies, incidences, and guidance of reporting CAN that involved military dependents and interviewed parents and DoD, Service, and civilian officials to evaluate the following: (1) DoD's visibility regarding reported incidences, and (2) the DoD's developed and implemented policies and procedures to respond to and resolve CAN incidences.
    - https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:504eb596-f8f5-3082-b7e9-fc04a5f5dd4f

- **Report on Child Abuse and Neglect and Domestic Abuse in the Military for Fiscal Year 2020**
    - This DoD report offers data from the FAP Central Registry for fiscal year 2020. It encompasses an overall DoD description (including Army, Navy, Marine Corps, and Air Force) of the DA and CAN incidences reported to FAP. The report is intended to be used to improve prevention and response efforts and includes recommendations to the DoD for future efforts in screening and responding to DA incidences.
    - https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:c9fe19a9-0270-3896-90cf-83fc50015d8c

- **Healthy Military Family Systems: Examining Child Abuse and Neglect**
    - This report by the Defense Health Board was requested by the Acting Assistant Secretary of Defense for Health Affairs and it intended to examine the policies and practices of CAN for military families. The goal was to limit the stigma of reporting CAN incidences in the healthcare setting and improve efforts to prevent, detect, assess, and treat CAN victims. The four goals were as follows: (1) identify factors for military families that increase the risk of engaging in abusive and neglectful behavior towards children; (2) review existing support programs for victims of CAN in the MHS; (3) determine mechanisms to advocate treatment options in military healthcare settings, and 4) evaluate the training and educational opportunities available to military health providers to ensure they are aware of and utilize the best available practices and resources.

- **https://acrobat.adobe.com/link/review?uri=urn:aaid:scds:US:7d0a6c06-4764-3621-85fc-9800f59eed21**

Summary

This rapid literature review provides a brief, yet detailed, examination of the research published on DA and CAN and possible barriers to reporting abuse and neglect. Although all FAP personnel are considered mandated reporters, this literature review identified a list of potential reasons why medical providers or FAP personnel may choose not to report suspicions of abuse. Due to minimal military-specific research on this topic, further study is recommended to do the following: (1) understand the barriers related to reporting CAN and DA by military-connected service providers, and (2) remove these barriers to reporting to help ensure the well-being and health of military families.

Additional Assistance

The TA specialists at the Clearinghouse provide support to professionals as they examine and make informed decisions about which programs fit specific situations and are worth the investment. Whether connecting one with the resources and tools to conduct a needs assessment in a specific community, suggesting the best evidence-based program or practice for a certain situation, or developing an evaluation plan, the TA team of experts is a call or email away.

Please visit the Clearinghouse's website at www.militaryfamilies.psu.edu or call 1-877-382-9185 to speak with a TA specialist.

Suggested Citation

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