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I Serve 2: Identifying and caring for military-connected children in civilian primary care settings

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ABSTRACT

Military children make tremendous sacrifices in support of a parent(s) military service. More than two million children have a parent who is serving or has served in the Armed Forces. Research shows that military-connected children are at higher risk of physical, psychological, and behavioral health issues. While "resilient" is the word used to describe most military children, it is important to recognize the stresses/stressors of military life— that military children serve too—to support and care for them.

Keywords: Deployment; I Serve 2; military-connected children; military families.

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Introduction

Military service members and veterans have unique occupational, familial, and cultural contexts that have a real and lasting effect on health. Civilian providers may not have the background knowledge to thoroughly evaluate military-related health care needs. Although veterans, active duty service members, and national guardsmen/reservists come from every community in the country, approximately 19 million Americans have ever served in the military (U.S. Census Bureau, 2017). This creates a gap in civilian understanding of military-related populations and a lack of civilian health care professionals experienced in caring for the health of military-related populations. Nonidentification of service members, veterans, and their families in civilian clinical practices, coupled with a gap in understanding service-associated risks and comorbidities, puts these patients at risk of poor physical and psychological health outcomes.

It is critical to understand that service members do not serve alone. More than 50% of those currently serving in the military are married with families. Approximately 2.1 million children have experienced the deployment of a parent since the onset of the wars in Iraq and Afghanistan (White House, 2011). Research indicates that military-connected children are at higher risk of physical, psychological, and behavioral health issues than their civilian counterparts and could be at potential risk for toxic stress (Gorman & Hisle-Gorman, 2011; Gorman, Eide, & Hisle-Gorman, 2010). Military children make tremendous sacrifices in support of one or more parents. While "resilient" is the word used to describe most military children, it is important for health care providers to recognize that along with the benefits of military service that build resilience are risks of military life that place children at risk of physical and psychological comorbidities. Policies and initiatives focused on addressing the effect of parental military service must be addressed to minimize the physical, psychological, and behavioral health effect on military-connected children. The "I Serve 2: A Pocketcard for Healthcare Providers Caring for Military Children" attempts to fill the gap in knowledge and understanding

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of methods to support and strengthen military families and improve care in this population.

Background and significance

Historically, the physical and psychological health care needs of military-connected children have gone unrecognized outside military health care settings. Approximately 2.1 million military-connected children have had at least one parent deploy since the onset of the military action in Iraq and Afghanistan in 2001 and 2003, respectively (White House, 2011). It is important to note that there are two categories of military-connected children: one category is children of active duty servicemen and women. These children's parents serve full time on active duty and typically move every two to four years. The second category of military-connected children are children of servicemen and women who serve in the National Guard or Reserve Components. The parents of these children typically have two careers, one civilian and one military, and who rarely move because of their military career. National Guard and Reserve Component military-connected children are only able to access military-connected health and behavioral health resources when their parent has been mobilized on to active duty. When not mobilized, these children receive care in within the civilian health care system.

Military-connected children are subjected to unique stressors not experienced by their civilian counterparts. Military-connected children, both active duty and reserve, experience stress and anxiety when a parent deploys. If the parent is injured or dies, there are additional stressors, not only from grief but also from moving from a military culture into the civilian environment (Gorman & Hisle-Gorman, 2011; Gorman et al., 2010). The unique health care needs of military-connected children include higher risk of abuse and neglect, substance use, and suicide compared with non–military-connected children; stress and depression related to parental deployment or postdeployment physical/psychological injuries; behavior and academic issues secondary to emotional distress, frequents moves, or a parental deployment; and anxiety that can lead to changes in appetite, disrupted sleep patterns, and impaired immune response, which can affect overall physical and psychological health of military-connected children (Gilbreath et al., 2016; Gorman & Hisle-Gorman, 2011; Gorman et al., 2010; Gross, Beeber, DeSocio, & Brennaman, 2016).

Although these findings might suggest that most military-connected children experience adverse childhood experiences, the evidence to support this assumption is varied (Chandra, Burns, Tanielian, Jaycox, & Scott, 2008; McGuire, Kanesarahah, Runge, Ireland, Waller, & Dobson, 2016) and suggests that the outcome for children is highly dependent on the health of the at-home parent (McCubbin & McCubbin, 1993; McGuire, Kanesarahah, Runge, Ireland, Waller, & Dobson, 2016). For example, the RAND longitudinal study on deployment life recruited 2,724 primarily active duty families on military bases who were interviewed quarterly for 3 years (Meadows, Tanielian, Kareny, 2016). It is important to note that only 721 of these families were from Reserve Component families whose service member had been or was currently deployed. Forty outcomes for children and teens were examined, ranging from conduct, emotional state, and school performance as reported by the spouse remaining at home. The researchers found that most children did not experience major changes in conduct, emotional state, or school performance over the course of the deployment cycle. Some parents reported increased emotional problems during deployment, especially in children younger than 11 years compared with matched nondeployed families. The ability to gain peer support from other military children in school or on the military post provided a protective effect in teens and led to more positive outcomes (McCubbin & McCubbin, 1993). This study supports efforts by the Department of Defense (DoD) to emphasize and enhance family resilience efforts across the military, e.g., the United States Army "Stand To" Program, Strong Bonds, and the Yellow Ribbon Reintegration Program. One model suggested for use with military families is the Resiliency Model of Family Stress, Adjustment, and Adaptation (Meadows et al., 2015) as modified for military families (McCubbin & McCubbin, 1993) to reduce the "stress pileup" from military life and reduce the effects of chronic stress. It should be noted that military-connected children may be vulnerable because of barriers in access to care, knowledge deficit of health care providers, and/or inconsistencies in health care delivery (Meadows et al., 2015; Ohye et al., 2016).

Many of these barriers are very relevant to those children from National Guard and Reserve Component families who typically live in civilian communities where there is little understanding or appreciation for the uniqueness of military life. Lack of awareness/identification of military-connected children and knowledge deficits of health care providers in the civilian sector regarding the unique health care needs of military-connected children make this a vulnerable population (Fredricks & Nakazawa, 2015; Padden & Agazio, 2013; Rossiter, Dumas, Wilmoth, & Patrician, 2016). Although active duty military families may reside on military installations that provide a network of health and social services, the active duty lifestyle leads to disruptions in support networks, lack of continuity in education, social support, and health care services. Although fewer than 15% of military families live "on base" or "on post," many live in nearby military-connected communities and have unfettered access to all resources on base. Military health care providers are typically well versed in the military culture and are aware of the unique health care needs of

military-connected children, but even within military health systems, there are often disruptions in continuity of care because of deployments and frequent moves of the providers caring for children in military treatment facilities.

Conversely, family members of National Guard and Reserve Component forces tend to remain geographically stable; however, they are often isolated from military bases and military support networks. These children typically reside in communities that lack knowledge regarding the requirements and demands of military service. Civilian health care providers have little to no understanding of military culture or awareness of resources and referrals within the community (Fredricks & Nakazawa, 2015). Most civilian health care providers have minimal experience and expertise in recognizing the physical and psychological effect that parental military service can have on children and lack the knowledge to propose strategies to address the experiences of children and their families (Fredricks & Nakazawa, 2015; Padden & Agazio, 2013). It should be noted that in the RAND Deployment Life Study of the 2,724 families, only 721 or 26% were from the National Guard and Reserve Components, so very little is really understood about the effects of deployment on those families and their children (Meadows, Tanielian & Karney, 2016). This percentage is troubling, given that for the Army, the Army National Guard and Reserve forces provide 50% of the personnel for the Army, with the other 50% composed of those on active duty.

Upward of 33% of military-connected children are considered "at risk" or "high risk" of psychosocial morbidity or maltreatment, to include abuse, neglect, and psychosocial maladjustment, when a service member initially deploys and immediately following reunification—a percentage that has increased since the onset of military action in Iraq and Afghanistan (Johnson & Ling, 2013; Padden & Agazio, 2013; Ternus, 2010). A DoD report on military-connected children found that when a parent deploys, children tend to exhibit depressive symptoms, experience a decline in academic performance, and an increase in behavioral problems secondary to emotional distress (Department of Defense, 2010; Johnson & Ling, 2013). In addition, suicide ideation is higher in military-connected children than those with no connection to the military (Gilbreath et al., 2016). Although routine medical care for military-connected children decreases during the deployment of a parent, there is an increase in emergency, urgent, and specialist care, and often military-connected children present with somatic symptoms such as increase in blood pressure and heart rate, appetite changes, and disruptions in sleep secondary to nightmares and anxiety (Johnson & Ling, 2013). Identification of military-connected children in pediatric civilian health care settings, knowledge regarding the deployment cycle with associated risks, and vulnerabilities is critical to ensuring the health and well-being of military children (Padden & Agazio, 2013; Rossiter et al., 2016).

A resource for providers

Currently, there are no existing guidelines or resources for pediatric primary care providers, including advanced practice registered nurses (APRNs), to identify unique physical, psychological, and behavioral health care needs of military-connected children or to screen for physical, psychological, and behavioral comorbidities secondary to parental military service.

Clinical guidelines and pocketcards have been used successfully in clinical practice by health care providers to improve health care quality and are associated with improved outcomes (BootsMiller et al, 2004). BootsMiller et al. found that clinical guidelines have the potential to "reduce wide practice variations, improved quality of care, and control escalating medical costs" (page 248). Both the American Academy of Nursing and the Veterans Administration have developed pocketcards for use by health care providers caring for veterans in the civilian sector—the *"Have you ever served?" Campaign* and *Military Health history Pocket Card for health Professions Trainees & Clinicians* respectively.

Using the American Academy of Nursing and Veterans Administration pocketcards as models of successful tools for health care providers caring for veterans, APRNs who have worked with military families and military-connected children in both the DoD and civilian health care setting created the "I Serve 2: A Pocketcard for Healthcare Providers Caring for Military Children" by to be used as a resource for APRNs who care for military-connected children (**Figure 1**).

The I Serve 2

The "I Serve 2: A Pocketcard for Healthcare Providers Caring for Military Children" was created to provide guidance for APRNs to better identify physical, psychological, and behavioral health risk factors and comorbidities in military-connected children that they see in civilian practices. The utility of the pocketcard lies in use during assessment, diagnostic testing, and differential diagnosis formation. First, the pocketcard provides prompts for identification and assessment of military children along with resources for care. The card includes the ICARE (Identify, Correlate, Ask, Ready Resources, Encourage and Educate) Support Strategy discussed in greater detail below. Using the card, the APRN is armed with specific questions regarding parents' military service (active duty, National Guard, or Reserve Component). Parental service comes with military-specific milestones such as deployments and permanent changes of station (moves or permanent change of station). A copy of the

I SERVE 2: A POCKETCARD FOR HEALTHCARE PROVIDERS CARING FOR MILITARY CHILDREN©

I CARE Support Strategy for Military Children

- **Identify:**
  - Military children in your practice/community
  - Risk factors, mitigating aspects and patterns of coping
  - If the parent is Active Duty, Reservist, or National Guard in order to gauge services available
- **Correlate:**
  - Developmental stage, healthcare concerns in context of the individual child
  - Family and teacher concerns about child
- **Ask**
  - How the child is coping
  - Assess risks for physical, psychological, behavioral, social, and academic concerns
  - Conduct a vulnerability and safety assessment
  - How will the family ensure a smooth deployment and reintegration
  - What you can do to reduce unnecessary visits during deployment (e.g. medication refills, referrals, etc.)
- **Ready Resources**
  - Engage partnerships within the school system
  - Ready a list of local and national resources for military families
  - Encourage families to engage resources well in advance of deployment
  - Determine accessibility to military installation services
- **Encourage and educate**
  - Prevention strategies
  - Strong families and healthy problem solving
  - Early engagement with resources
  - Healthy expectations during and after deployment

I CARE created by Dr. Heather Johnson and Dr. Catherine G. Ling and adapted by Dr. Alicia Gill Rossiter DOI: 10.1111/1745-7599.12003

For additional information on I Serve 2 refer to: I Serve 2: Meeting the needs of military children in civilian practice—Dr. Alicia Gill Rossiter, Dr. Margaret C. Wilmoth, Dr. Patricia A. Patrician, and Dr. Mary Anne Dumas. DOI: 10.1016/j.outlook.2016.05.011

Questions that can be asked of parents and military children at well child/acute care visits:

Correlate/Ask

- Has anyone expressed any concerns about you (or your child?)
- Have you noticed any of the following?
  1. Increased stress
  2. Anxiety, sadness
  3. Emotional or physical outbursts
  4. Crying/ overly emotional
  5. Difficulty sleeping, nightmares
  6. Difficulty concentrating
  7. Change in academic performance or appetite
  8. Clingy or distant
  9. Increase in behavioral issues at home, school, with peers
  10. Increase in complaints of stomach aches, headaches, or other physical symptoms

Ready Resources

- Who do you turn to for support? Where is this person located?
- What resources are available to you in the:
  1. Military
  2. Community
  3. School/day care
  4. Religious affiliations
  5. Sports/ service organizations

Vulnerability/ risk assessment

- Where do you live? On or off a military instillation?
- Do you feel safe in your home?
- Are you concerned about your child?
- Tell me about the relationship with your parents.
- Tell me about a typical day at home/school
- How do you feel about your parent's job in the military?
- How have things been since your parent returned from deployment?

I SERVE 2: A POCKETCARD FOR HEALTHCARE PROVIDERS CARING FOR MILITARY CHILDREN©

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I SERVE 2

Ask your patients & their parents:

"Do you have a parent who has ever served in the military?"

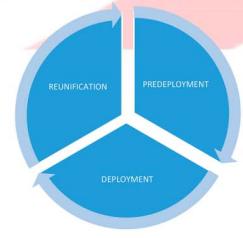
If the patient answers 'yes' ask:

- Is the military member:
  - Active duty?
  - Reservist?
  - National Guard?
  - Veteran?
- Has your parent deployed? Where? When?
- Where are you in the deployment cycle?
- What is your time for relocation (PCS)?

PREDEPLOYMENT (3 MONTHS BEFORE DEPARTURE): DENIAL, ANGER, SADNESS, FRUSTRATION

DEPLOYMENT (4 MONTHS TO 12 MONTHS): LONELINESS, FEAR, SLEEPLESSNESS, ANXIETY, ADJUSTING TO BEING ALONE, DETACHMENT, HIGH RISK FOR NEGLECT

REUNIFICATION (9 TO 12 MONTHS): APPREHENSION, ANTICIPATION, EXCITEMENT, EMOTIONAL READJUSTMENT, HIGH RISK FOR ABUSE



RESOURCES

BLUE STAR FAMILIES: WWW.BLUESTARFAM.ORG/RESOURCES/DEPLOYMENTS/DEPLOYMENT-RESOURCES/

CHILD MIND INSTITUTE: WWW.CHILDMIND.ORG/TOPICS/CONCERNS/MILITARY-FAMILIES/

MILITARY.COM: HTTP://WWW.MILITARY.COM/SPOUSE/MILITARY-LIFE/MILITARY-RESOURCES/FAMILY-SUPPORT-SERVICES.HTML

MILITARY ONE SOURCE: WWW.MILITARYONESOURCE.MIL

MILITARY CHILD EDUCATION COALITION: WWW.MILITARYCHILD.ORG

NATIONAL MILITARY FAMILY ASSOCIATION: WWW.MILITARYFAMILY.ORG

U.S DEPARTMENT OF EDUCATION: WWW.ED.GOV/VETERANS-AND-MILITARY-FAMILIES

Figure 1. Example of pocketcard.

Deployment Cycle model is included on the pocketcard to guide the APRN in assessment. This portion of the card also provides an explanation of potential positive and negative aspects and potential risks that could occur during each stage of deployment.

The ICARE Support Strategy for Military Children provides prompts for the APRN to identify a military-connected child and help correlate health concerns that individualize the child's needs based on the developmental stage and parent/teacher feedback. Asking targeted questions based on military-specific milestones will guide identification of at-risk patients at home and in social and academic settings. In addition, this is the time to work with the patient and family on being proactive to reduce unnecessary stressors. Helping the family identify resources within the military installation, community, and school system is critical to building positive support systems for the child. Finally, encouraging and educating the family unit to build resilience and develop healthy problem solving are critical to mitigating the effect of parental military service on military-connected children.

Conclusions

The "I Serve 2: A Pocketcard for Healthcare Providers Caring for Military Children" provides a foundation for civilian providers to join forces with military-connected children to build resilience and minimize physical and psychological risks, which is critical to the mission of building healthy military families. The pocketcard will serve as a valuable resource for APRNs who care for military-connected children and families.

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