Availability of Family Violence Services for Military Service Members and Their Families

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Preface

Family violence occurs in the U.S. military as it does in the civilian population, but unique stresses of military life may contribute to the risk for child abuse and neglect and domestic abuse among service members. Multiple deployments, family separation and reintegration, combat-related brain injuries, frequent relocations, financial strains, higher rates of substance abuse, and military cultural norms around authority and hierarchy may all contribute to child abuse and neglect and domestic abuse among service members. Moreover, there are multiple circumstances that may inhibit reporting and prevent victims and perpetrators from seeking help for child abuse and neglect and domestic abuse, including potential reduction in rank; limitations in promotion; loss of income, housing, insurance, and retirement benefits; community stigma or disbelief; and fear of retribution from a dangerous partner.

Given these substantial challenges, it is unclear to what extent military programs are available to meet the needs of military victims and offenders of child abuse and neglect and domestic abuse. At the request of the Department of Defense (DoD) Office of the Under Secretary of Defense for Personnel and Readiness, RAND Corporation conducted a multimethod research study to review current resources and programs available to military families, and provided recommendations for both improving services and increasing access to services when needed.

This research was sponsored by the DoD Office of the Under Secretary of Defense for Personnel and Readiness and conducted within the Forces and Resources Policy Center of the RAND National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense, the Joint Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense Intelligence Community.

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Summary

Family violence occurs in the U.S. military as it does in the civilian population, but unique stresses of military life may contribute to the risk of child abuse or and domestic abuse among service members. The Department of Defense (DoD) holds itself accountable for preventing and addressing child abuse and neglect and domestic abuse and does so primarily through the congressionally mandated Family Advocacy Program (FAP), but also in coordination with other military and civilian services. At the request of the Under Secretary of Defense for Personnel and Readiness, RAND Corporation conducted a multimethod study to review current resources available to military-affiliated victims and perpetrators of child abuse and neglect and domestic abuse, describe the barriers to utilization, document the challenges faced by military service providers working to prevent and respond to child abuse and neglect and domestic abuse, and provide recommendations to improve services. Surveys and interviews with FAP leadership and providers suggest that FAP offers a wide range of important services to military-affiliated families. However, additional targeted resources and stronger leadership support could improve the program, particularly in improving the balance between prevention and response.

Family Advocacy Program

The FAP mission centers on the safety and well-being of military families. FAP offices at military installations partner with other entities within DoD's coordinated community response system, including law enforcement, legal, command, medical, child and youth services, chaplains, as well as with civilian agencies, to deliver child abuse and neglect and domestic abuse prevention and response services. To accomplish its goals, FAP provides a variety of prevention and intervention services related to child abuse and neglect and domestic abuse for both victims and offenders. FAP offers prevention programs such as the New Parent Support Program; preventative counseling services for individuals, couples, and parents; and life skills classes in anger management, stress management, and parenting. FAP also provides treatment and response services that address incidents of child abuse and neglect or domestic abuse through a network of providers offering, advocacy, clinical counseling for victims requesting support, and intervention services for offenders.

Study Methods

To investigate the availability and sufficiency of family advocacy services for military populations, RAND employed diverse methods, including literature review, interviews with key informants—including FAP leadership, FAP providers at military installations, and state domestic violence coalition leaders—and a survey of FAP office directors. We examined not only the family advocacy services provided by FAP but the wider range of services that military families may access, including other relevant military services and services available in the civilian community.

This design omitted some stakeholders. To protect their privacy, service members and their families who utilize FAP services were not included in the study, and therefore, we are unable to provide their unique perspective. Of the installation FAP offices invited to complete a survey, 36 percent submitted a completed survey. It is possible that the offices that participated differ in important, but unmeasured, ways from the offices that did not submit a survey. Finally, the key informants for this study have considerable, but likely imperfect, expertise about the system of services for military families in crisis. The information provided in the report should be treated as representing the best understanding of a given informant at the time the data were collected.

Family Advocacy Program Prevention and Treatment Services

The pathways by which service members and their dependents access FAP services appear to be broadly similar across installations and service branches. According to the survey of FAP office directors, most FAP cases are initiated after a victim calls law enforcement for help, and the case is then referred directly or indirectly to FAP. The next most common referral source was a referral by another provider such as a therapist or a substance abuse counselor. A small number of service members or family members self-refer for FAP services—most providers whom we interviewed regarded self-referrals as rare.

Once an incident is referred to FAP, an intake is performed. If the incident is found to meet the DoD definition of child abuse and neglect or domestic abuse, a standardized assessment is conducted with the offender. Each service branch relies on a multidisciplinary team to determine whether a case meets DoD criteria for child abuse and neglect or domestic abuse. For cases that meet the criteria, FAP provides a recommended treatment plan for the offender and suggests services for the victim. Civilian offenders and all victims are offered FAP services, and/or referrals to other installation or civilian support services, but are free to decide whether to engage. According to survey responses from FAP offices, families typically use FAP services for about six months, though the victim advocates and clinicians whom we spoke with were clear that there is significant variation that depends primarily on the unique needs of each case. Across all FAP offices that completed an installation survey, the average annual caseload was 194 cases. A staff of about 11 members on average per installation provided response services for these cases, supported voluntary clients, and provided outreach and prevention services to the installation.

Public awareness and outreach activities to increase knowledge about FAP and family violence in general are not a strong emphasis of programming. About one-half of responding FAP offices reported that they did not host a public meeting, update their website, or update their

Facebook or other social media page in the past year. However, sending email announcements and distributing hard-copy brochures occurred more frequently; more than half of the FAP offices we surveyed sent email announcements monthly or more often, and about 70 percent of offices distributed brochures monthly or more often.

Other Support Available on Military Installations

Some cases of child abuse and neglect or domestic abuse are associated with other types of problems such as substance abuse, mental health issues, or other life stresses. Military installations may offer support services targeted toward these other problems, and coordination between these services and FAP may improve outcomes in child abuse and neglect or domestic abuse cases. Thus, we examined the co-occurring needs common among child abuse and neglect or domestic abuse cases, referrals to non-FAP services, and the perceived quality of coordination between FAP and other service providers on the military installation.

According to the FAP office director survey, directors indicated that most domestic abuse cases are related to communication skills and anger management issues, and responded that most child abuse and neglect cases are associated with lack of parenting skills or understanding of child development, or anger management issues. FAP offices were also surveyed about the availability of services on installations that address these concerns. Mental health treatment was the most available behavioral health service offered, followed by alcohol use disorder treatment and substance use disorder treatment. Nearly all FAP offices also indicated that financial planning or education and financial advice in response to current financial stress were available on their installation.

FAP offices most commonly referred child abuse and neglect or domestic abuse cases for counseling and legal assistance, and were more likely to refer cases to on-installation services than those available in the civilian community. With respect to coordination between FAP and other services on installation, respondents most commonly reported weekly communication, either formal or informal, between FAP staff members and behavioral health providers, and most reported that coordination works well. According to the FAP office director survey, the most pressing barrier to coordinating between FAP and behavioral health services was other providers' lack of understanding of FAP concerns.

Violence Services Available in the Civilian Community

In addition to family advocacy services provided by FAP and other military service providers, family advocacy services are often supplied in the communities surrounding installations. We were interested in the availability of such services, agreements and coordination between FAP and civilian agencies, and FAP satisfaction with the quality of services provided.

The majority of FAP offices reported that there were civilian social services for both domestic abuse cases and child abuse/neglect cases in the surrounding community, but that availability varies by the type of service. FAP offices that completed a survey were most likely to list civilian victim advocacy and emergency shelter services as available in their surrounding community, relative to other service types. Among installations that had access to a particular type of service, typically more than half had a formal agreement with an agency offering that

service type. In our interviews with FAP providers, they noted that these formal agreements can be challenging and time intensive to secure due to military service administrative requirements and delays.

While civilian social services are accessible from many installations and sometimes even formally coordinated with FAP, the FAP offices typically indicated feeling only neutral or satisfied with these services and their coordination with FAP. Respondents to the FAP director survey believed that the most important reasons why some clients use civilian resources are to ensure their privacy and to avoid reporting the violence to military authorities or the military legal system. This perception was shared by both the FAP providers and providers in the civilian community, who clarified that some families are afraid that negative impact to the military member's career could accompany military involvement.

Our interviews with domestic violence state coalition leaders provided a unique perspective that largely corroborated the perspective of FAP service providers. They also perceived challenges in coordinating military and civilian resources and saw the value of maintaining professional relationships. Coalition leaders noted that military members seek out civilian services not due to scarcity of services in the military system, but instead when they are motivated to protect their privacy and avoid the risks they perceive as accompanying military involvement. Coalition leaders saw relative strengths and weaknesses across the two systems and pointed to strong collaborative relationships as an opportunity to improve services to military families.

Challenges to Providing Comprehensive Family Violence Services

According to FAP offices and service providers, the primary barriers that prevent families from accessing FAP services include

- the threat (real or perceived) of career consequences
- a desire for privacy
- the shame and embarrassment associated with child abuse and neglect or domestic abuse.

FAP office director survey respondents also identified outreach—both outreach overall and the use of social media for outreach—as important strategies for reaching perpetrators and victims who might not otherwise know about FAP services. The logistical factors perceived as limiting FAP's efforts to provide family violence service to the greatest degree were the number of available FAP professional staff and staff turnover. Of greatest concern in these areas were staffing challenges related to licensed social workers followed by administrative staff.

FAP directors also noted that child abuse and neglect and domestic abuse do not have the same visibility or public attention as other problem behaviors, such as sexual assault, suicide, or substance abuse. They believed that child abuse and neglect and domestic abuse are not topics that service members feel comfortable talking about, and the lack of credible leadership support on their installation inhibits efforts to draw greater attention to these problems. FAP service providers echoed this theme in their varied perception of the role of leadership. While some providers saw their relationship with installation leadership as a key to the success of the FAP mission, other installation providers reported a lack of command buy-in as a major challenge.

Despite these barriers, FAP office directors and service providers also believe that FAP has a positive impact within the military community on helping families overcome family violence. They cited as a contributing factor to success the skills and dedication of the professional staff, despite perceived staff shortages.

Recommendations

FAP directors and service providers offered many recommendations to improve FAP services. Six recommendations were mentioned by multiple key informants and were supported by both survey and interview findings.

- **Reconsider staffing levels.** Staffing shortages were repeatedly mentioned as a key barrier to providing comprehensive services. FAP providers believed they were meeting the minimum standards for required response services, but additional outreach or prevention services could not be supported, nor were offices able to support proactive, exploratory programming. A formal staffing study to determine ideal manning may be necessary. Many of the subsequent recommendations may be addressed, at least partially, by a staff size well matched to the breadth of the FAP mission.
- **Assess outreach efforts across the portfolio of problem behavior prevention.** FAP providers believe that the threat to mission readiness is similar for service members experiencing child abuse and neglect or domestic abuse as it would be for those who had experienced military sexual assault (for example). They recommended that DoD consider strategies to provide comprehensive prevention programming applicable to a wide range of problem behaviors (which share some common risk factors) and advocated for additional resources to deliver child abuse and neglect and domestic abuse prevention services to their installation.
- **Identify lessons learned from installations with strong leadership support and community coordination.** Leadership support for child abuse and neglect and domestic abuse programs varies widely, as do relationships between installations and providers of community resources. The variation suggests an opportunity to probe for lessons learned from offices with strong leadership and a strong support network for child abuse and neglect and domestic abuse prevention and response. Strengthening these connections may lead to a better response to incidents.
- **Explore strategies to reduce prominent barriers to care.** Fear of career harm to the military member (and possible subsequent family harm) and loss of privacy were perceived by FAP office directors and service providers as key barriers that prevent families in crisis from seeking FAP support. Strategies to reduce privacy concerns, such as anonymous initial entry points, online support groups or chat rooms, text-based support, or smartphone apps, could be explored.
- **Explore strategies to support and speed establishment of memoranda of understanding (MOUs) with community resources.** FAP providers noted that MOUs with community resources were challenging and time intensive to secure, typically due to military service delays. Individual installation FAP offices may need support from headquarters or influential supporters to speed the process. Ensuring that MOUs are established and

maintained allows FAP to leverage community resources to substitute for and expand the reach of their available resources.

- **Consider the balance of prevention and response.** Many FAP office directors and service providers believed that additional attention should be focused on prevention. Family violence is a serious problem with linkages to sexual assault, suicide, harassment and discrimination, and substance abuse. Leveraging the combined expertise and resources of the distinct programs that address these issues to attack shared risk factors or to deliver one-stop information services should be considered.

FAP is tasked with a broad mission of preventing child abuse and neglect and domestic abuse and responding to the incidents. As in the civilian sector, not all families in crisis will seek out services or otherwise garner the attention of FAP. However, those who do are offered comprehensive family advocacy services, typically delivered by FAP, and referrals to supportive services to address co-occurring risk factors for violence and the consequences of violence. Despite this broad mandate, and despite perceived staffing shortages, FAP service providers were proud of their work and their teams. Based on their collective experience, the recommendations we offer could help improve the services provided by FAP and provide the resources that would support increased emphasis on prevention.

Acknowledgments

Many people contributed to the completion of this work. First and foremost, we thank FAP staff members who gave generously of their time, including the many FAP office directors who completed a comprehensive survey of FAP services and coordination with other providers. In addition, we are grateful to the FAP service providers who talked with us about their experience delivering family advocacy services, and FAP service branch representatives who provided critical support to coordinate and communicate with installation staff.

We wish to thank the state domestic violence coalition leaders who met with us to discuss coordination with military FAP services from a civilian perspective.

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Finally, we thank our sponsor, Ms. Julie Blanks, Principal Director of Military and Community and Family Policy, and our DoD FAP project monitors, whose support was critical to completion of the research: Maia Hurley, William Huleatt, and Katherine Robertson.

Abbreviations

CDC	Centers for Disease Control and Prevention
CPS	Child Protective Services
DoD	Department of Defense
FAP	Family Advocacy Program
MOU	memorandum of understanding
OSD	Office of the Secretary of Defense

CHAPTER ONE

Introduction

Domestic violence is a substantial public health risk faced by the military community. In the most recent representative survey of military-affiliated women, the Centers for Disease Control and Prevention (CDC) estimated that, in 2010, 4.7 percent of active duty service women and 4.6 percent of women married to active duty service men had been physically assaulted, raped, or stalked by an intimate partner in the past 12 months (Black and Merrick, 2013). Although the annual risk faced by military-affiliated women is significantly lower than it is for demographically similar civilian women (Black and Merrick, 2013), the Department of Defense (DoD) still holds itself accountable for prevention and making services available (DoD, 2015b) to the roughly 41,000 military-affiliated women who are physically assaulted, raped, or stalked by an intimate partner each year (Black and Merrick, 2013). In addition, military family advocacy services are also available to other military-affiliated women and men not included in the CDC estimate, including victims of psychological abuse and unmarried romantic or sexual partners who share a residence or child. Thus, the number of military-affiliated victims eligible for services is likely even higher than 41,000.

Taking 41,000 as the lower bound for the number of military-affiliated victims who were physically, sexually, or psychologically abused by an intimate partner in 2010, the DoD reports of family advocacy services provide a rough benchmark for the proportion of the total population that seeks services (DoD, 2018). In fiscal year 2010, DoD recorded 20,304 reported incidents, of which 9,134 met DoD criteria as an incident of domestic abuse corresponding to 8,206 unique victims. Compared with the lower bound of 41,000 unique victims in the population, this suggests that the majority of victims of domestic abuse were not identified for services (DoD, 2018).

Child abuse and neglect also occurs in some military families. As of 2018, no high-quality estimates of the percentage of military children who are abused or neglected are available. Reporting laws that require disclosure when child abuse is detected make it difficult to conduct surveys on the topic, as many parents are reluctant to disclose child abuse and neglect. Of the total unknown number of children who are abused or neglected each year, some incidents are reported to DoD. In fiscal year 2017, DoD substantiated reports of abuse or neglect of 4,667 military-affiliated children (5.0 victims of abuse or neglect per 1,000 military-affiliated children; DoD, 2018).[1]

[1] A total of 12,849 incidents of possible child abuse and neglect were reported to DoD in fiscal year 2017. Of those, 6,450 were substantiated through the DoD incident substantiation process as meeting the definition of child abuse or neglect (DoD, 2018). The 6,450 substantiated reports corresponded to 4,667 unique child victims (i.e., some victims had more than one substantiated report of abuse or neglect).

The DoD Family Advocacy Program (FAP) is a congressionally mandated program tasked with preventing and responding to child abuse and neglect and domestic abuse in military families (DoD, 2015b). Offices are located at every installation with command-sponsored families (Robertson, 2014). Together with other installation support services (e.g., mental health services, substance abuse treatment, parenting support) and with civilian service organizations in the surrounding community, FAP provides coordinated response and support for military families in crisis (Robertson, 2014). This is a challenging task given the many logistical, social, cultural, and environmental factors that prevent military-affiliated victims and perpetrators of child abuse and neglect and domestic abuse from seeking help. Multiple deployments, family separation and reintegration, traumatic brain injuries, frequent relocations, financial strains, substance abuse, and mental illness may all contribute to risk for child abuse and neglect and domestic abuse and subsequently also become barriers to seeking help (Marshall, Panuzio, and Taft, 2005). Additional considerations that may inhibit reporting and help-seeking include potential reduction in rank; limitations in promotion; loss of income, housing, insurance, and retirement benefits; community stigma or disbelief; and fear of retribution from a dangerous partner.

Given these substantial challenges, it is unclear to what extent military programs are available to meet the needs of military victims and perpetrators of child abuse and neglect and domestic abuse. At the request of the DoD Office of the Under Secretary of Defense for Personnel and Readiness, we conducted a multimethod research study to review current resources available to military-affiliated victims and perpetrators of child abuse and neglect and domestic abuse, describe perceived barriers to utilization from the perspective of FAP service providers, document the challenges faced by military service providers working to prevent and respond to child abuse and neglect and domestic abuse, and provide recommendations to improve services.

Definitions

In this report, we use the umbrella term *family violence* to include domestic abuse, domestic violence, child abuse, and child neglect. DoD policy documents define these terms as follows:

- *Domestic abuse* is a "pattern of behavior resulting in emotional/psychological abuse, economic control, and/or interference with personal liberty that is directed to a person who is a current or former spouse, a person with whom the abuser shares a child in common, or a current or former intimate partner with whom the abuser shares or has shared a common domicile" (DoD, 2015a).
- *Domestic violence* is the "use, attempted use, or threatened use of force or violence against a person, or a violation of a lawful order issued for the protection of a person who is a current or former spouse, a person with whom the abuser shares a child in common, or a current or former intimate partner with whom the abuser shares or has shared a common domicile" (DoD, 2015a). Sexual abuse is included as a form of domestic violence.
- *Child abuse* is "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 interfamilial 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" (DoD, 2015a).

- *Child neglect* is "the negligent treatment of a child through acts or omissions by an individual responsible for the child's welfare under circumstances indicating the child's welfare is harmed or threatened" and includes abandonment, medical neglect, and/or non-organic failure to thrive (DoD, 2015a).

Research Approach

To investigate the availability and sufficiency of family advocacy services for military populations, we employed diverse methods, including literature review, interviews with key informants, and a survey of FAP office directors. The research was reviewed and approved by the RAND Corporation Human Subjects Protection Committee and Washington Headquarters Services (Record Control Symbol DD-P&R(OT)2662).

Review of the Literature

We reviewed the published literature and key unpublished reports to document the prevalence of child abuse and neglect and domestic abuse in military populations, the general structure of the FAP program and the services it provides, and risk factors (usually studied in civilian populations), which informed the development of our interview protocol and survey instrument.

To review the academic literature, we searched research databases including Web of Science, PubMed, PsycINFO, and Google Scholar, from 2002 to 2017, focusing on review articles. Search terms included ("violence," "abuse," "maltreatment," OR "neglect"); AND ("domestic," "child," "partner," OR "family"); AND ("military," "armed forces," "Army," "Navy," "Air Force," "Marines," OR "veterans"). The search to identify risk factors for child abuse and neglect and domestic abuse excluded the military-related search terms and added terms such as "risk factor," "protective factor," and "correlate." We also reviewed relevant articles referenced in the review articles identified through this literature search, as well as articles identified by informed colleagues.

To identify relevant nonpublished reports, we reviewed OSD (Office of the Secretary of Defense) FAP annual reports and Military OneSource (www.militaryonesource.mil) to document resource availability and service provision processes in the military setting. We additionally conducted web searches to review services and reporting processes in civilian settings. An expert on family violence in civilian settings provided documentation of state-level coalitions for review.

Interviews with Key Informants

FAP Leadership

We conducted 11 open-ended, informational interviews with leadership in the headquarter offices of Air Force, Army, and Navy FAP. Our goal in these initial interviews was to develop a broad understanding of the structure of military and civilian offerings to address child abuse and neglect and domestic abuse, and the nature of any partnerships across military and civilian settings. The interviews served to inform the data-collection protocols for a survey of each installation FAP office and the interview protocols to be used with a sample of FAP victim advocates and clinicians. Interviews with FAP Air Force, Army, and Navy leadership were

conducted by telephone from November to December 2016 with detailed notes taken for each interview. Leaders at the headquarters office of Marine Corps FAP were invited to participate in the interviews; they declined to do so.

State Domestic Violence Coalition Leaders

We also conducted seven open-ended, informational interviews with leaders of state domestic violence coalitions. Because of their statewide role, coalitions appeared to be a good starting point for understanding domestic violence service delivery in civilian communities. To identify respondents who would have expertise on the interface with military installations, we asked contacts at the National Network to End Domestic Violence to recommend state coalitions known for their capacity working on military issues and their proximity to major installations. Based on these recommendations, we interviewed coalition leaders in Guam, Kansas, Kentucky, Hawaii, North Carolina, Texas, and Virginia. The purpose of the interviews was to become familiar with available services in each state and to identify local domestic violence providers that work closely with military installations. Telephone interviews with state coalition leaders were conducted in February and March of 2017.

FAP Service Providers

To learn more about the services offered to child abuse and neglect and domestic abuse victims and perpetrators who access FAP services, we reached out directly to the providers who deliver those services. We conducted 52 qualitative interviews with a sample of FAP service providers on military installations. Our goal was to add insight into the findings of the quantitative survey (described below). The interviews assessed the types of services offered by each installation, types of cases, ways in which families access FAP services, typical intake and treatment services, availability and coordination with off-installation services in the surrounding community, and the main strengths and challenges facing the FAP office. Appendix A contains the full interview guide.

From a complete list of all 190 FAP installation offices, we randomly selected 50 and emailed the FAP office director at each of the sampled installations to request that he or she nominate an experienced clinician or victim advocate who might be willing to be interviewed about FAP services. Office directors who had not replied within a week were sent one reminder email.

Our goal was to interview 12 to 15 FAP service providers from each military service. Based on the response rate in this first set of 50 FAP offices, we randomly selected the number of additional FAP offices within each service that we inferred would be required to obtain 15 clinician nominations. Because the Marine Corps has a small number of offices, we invited all 16 (100 percent) to submit nominations.

In total, we contacted the directors of 103 FAP offices and received 57 service provider nominations (55 percent response rate overall). Of 42 randomly selected Air Force FAP offices, 15 directors (36 percent) nominated a service provider for the interviews. Of 21 randomly selected Army FAP offices, 13 directors (62 percent) nominated a service provider for the interviews. Of 24 randomly selected Navy FAP offices, 15 directors (63 percent) provided a nomination for the interviews. The Marine Corps has 16 FAP offices, 15 of which (94 percent) provided a nomination for the interviews.

A RAND interviewer contacted 55 of the 57 nominated providers to invite them to participate in a one-hour, semistructured interview about FAP services. Two nominated providers

were never contacted due to a RAND data entry error. Of the 55 providers who were invited, 52 (95 percent) completed an interview. The remaining three (5 percent) originally agreed to participate, but were unable to talk with the interviewer during the study period. The final sample included 52 FAP providers (14 Air Force, 12 Army, 13 Marine Corps, and 13 Navy).

Our original request was for FAP office directors to nominate an experienced and knowledgeable victim advocate or clinician. However, some directors had staffing vacancies or an extremely small staff. Thus, in some cases, the director nominated a middle manager or him- or herself to complete the interview (either because they served as the primary clinician in addition to their leadership role, or because their current staff was overburdened due to staffing shortages). Thus, we interviewed a total of 13 victim advocates, 22 clinicians, and 17 staff members in leadership roles (e.g., treatment manager, family advocacy officer, area coordinator). Table 1.1 details the characteristics of the FAP offices that participated in interviews relative to the composition of all FAP offices. With the exception of service branch, which we deliberately sampled for equal cell sizes, the characteristics of the sample appear to be similar to the characteristics of all FAP offices. Interviews were conducted between May and July of 2018.

Survey of Installation Family Advocacy Program Offices

We also fielded a survey of installation FAP offices (Appendix B). Our goal was to document the provision, utilization, and sufficiency of resources addressing reported violence in military families, across installations. The survey aimed to assess FAP services, other installation resources, and non-DoD resources available in the surrounding community.

We contacted all 190 installation FAP offices across the Air Force (71), Army (47), Marine Corps (16), and Navy (56) and invited them to complete the survey. Invitations and reminders were sent by email. The lists of service FAP offices serving an installation were obtained from FAP representatives from each military service and cross-checked with Military OneSource FAP listings.

Of the installation FAP offices invited to participate (190), we received completed surveys from 69 (36 percent), including surveys from 20 Air Force (28 percent response rate), 12 Army (26 percent), 9 Marine Corps (56 percent), and 28 Navy (50 percent) installation FAP offices. Table 1.1 summarizes the characteristics of installations that submitted a survey compared to the full set of installation-level FAP offices. In the final sample of surveys, it appears that Air Force and Army FAP offices may be underrepresented and Marine Corps and Navy may be overrepresented. The remaining characteristics summarized in Table 1.1 appear to be similar for the sample compared to the full set of installation offices. Although we have no reason to suspect that nonresponse is not random, we caution that the nonrandom responses could bias results.

We conducted power analyses to determine whether the sample would support inferential statistics. For the surveys, the sample size would only allow detection of extremely large effect sizes. For this reason, we were unable to analyze differences by service, population (installation, surrounding community), or urban-rural location. Although the report narrative presents results aggregated across services, we have provided survey results by service branch in Appendix C. When survey results are presented in the main report, we describe the results descriptively in keeping with the poor power to explore group differences.

Table 1.1
Characteristics of Installation FAP Offices That Participated in the Clinician/Victim Advocate Interview and the Survey Relative to All FAP Offices

FAP Office Characteristic	FAP Service Provider Participated in Interview (*N* = 52)	Installation Director Submitted Survey (*N* = 69)	All FAP Offices (*N* = 190)
Service Branch			
Air Force	14 (27%)	20 (29%)	71 (37%)
Army	12 (23%)	12 (17%)	47 (25%)
Marine Corps	13 (25%)	9 (13%)	16 (8%)
Navy	13 (25%)	28 (41%)	56 (30%)
Location			
CONUS	45 (87%)	53 (77%)	145 (76%)
OCONUS, United States	3 (6%)	5 (7%)	10 (5%)
OCONUS, foreign	4 (8%)	11 (16%)	35 (18%)
Installation Active Duty Population			
<2,000	13 (25%)	23 (33%)	63 (33%)
2,001–4,000	12 (23%)	14 (20%)	43 (23%)
4,001–10,000	17 (33%)	22 (32%)	57 (30%)
10,000+	10 (19%)	10 (14%)	27 (14%)
Population of Surrounding County (U.S. locations only)			
<100,000	12 (25%)	15 (26%)	39 (25%)
100,000–250,000	12 (25%)	15 (26%)	43 (28%)
250,001–1 million	18 (38%)	21 (36%)	53 (34%)
1 million+	6 (13%)	7 (12%)	20 (13%)

NOTE: CONUS = continental United States; OCONUS = outside the continental United States.

Study Limitations

To provide a comprehensive picture of FAP services across diverse installations, we relied on a multimethod, multi-informant design. However, this design omitted some stakeholders. To protect their privacy, service members and their families who utilize FAP services were not included in the study, and therefore, we are unable to provide their unique perspective on the benefits and challenges in accessing and utilizing FAP services. The installation-level service providers whom we interviewed were able to share their perceptions of the challenges faced by their clients; however, this not the same as obtaining client perspectives directly and likely misses important details. In addition, we did not speak with civilian service providers. The nonmilitary agencies in the communities surrounding installations offer services to families who may be reticent to access military services, and thus they would have a unique perspective on the barriers families face in using FAP services. However, the interviews we conducted with state domestic violence coalitions provided a high-level perspective on civilian service provid-

ers. Finally, many military families in crisis choose not to access support from any source. Very little is known about these families, and this study does not offer any additional information about them. Future research that outlines the needs of all military families in crisis, and the effectiveness of services to meet those needs, will be critical to designing an aspirational system that can serve every family in crisis.

Of the installation FAP offices that were invited to complete a survey, only 36 percent submitted a completed survey. It is possible that the offices that participated differ in important but unmeasured ways from the offices that did not submit a survey. For example, if only offices with available staff time completed the surveys, the results may not represent the characteristics of FAP offices with higher staffing burdens. For this reason, all survey results should be interpreted as estimates from the FAP offices *that participated* and should not be generalized to *all* installation FAP offices.

The key informants for this study have considerable, but likely imperfect, expertise about the system of services for military families in crisis. In this report, we treated the information they shared with us as good-faith reports. That said, it is possible that some informants provided information that was outdated, imperfectly estimated, incorrect, or out of alignment with DoD or service policy. The information provided in the report should be treated as representing the best understanding of a given informant at the time the data were collected.

Organization of This Report

In this report, we first provide an analysis of the availability of family advocacy services in the U.S. military and an overview of the FAP (Chapter Two). We then describe findings on FAP services (Chapter Three), other child abuse and neglect– and domestic abuse–related services available on the installation (Chapter Four), and civilian services available in the surrounding community (Chapter Five) from our interviews with FAP service providers and survey of installation FAP offices. In Chapter Six, we provide a system map of these services and conclude with recommendations. Appendixes contain our interview protocol and survey, detailed tables of survey results by service branch, and an overview of key family violence risk factors.

CHAPTER TWO

Family Violence in the Military and the Family Advocacy Program

Family violence is a significant public health problem across the U.S. population, including in the U.S. military (Black and Merrick, 2013). As context for the findings presented in the remainder of this report, in this chapter we discuss the prevalence of family violence in military populations, focusing on child abuse and neglect and domestic abuse. We also provide an overview of the FAP—a congressionally mandated program designed to prevent and respond to child abuse and neglect and domestic abuse—including the services offered by FAP, and we discuss coordination between FAP programs, other military resources relevant to child abuse and neglect and domestic abuse, and civilian resources.

Prevalence of Family Violence in Military Populations

In the military there are unique demographic, psychological, social, and environmental factors that may affect patterns of child abuse and neglect or domestic abuse and the way that individuals respond to observing or experiencing such violence. For example, deployments, relocations, combat experiences, substance use, posttraumatic stress, the separation and reintegration of families, and social norms regarding authority and use of force may increase the risk of child abuse and neglect or domestic abuse among service members (e.g., Bell et al., 2004; Cesur and Sabia, 2016; Hahn et al., 2015; Hoyt et al., 2014; Kelley et al., 2015; Martin et al., 2010; Taylor et al., 2016). At the same time, meaningful work, quickly forming social support networks, and a stable family income may decrease risk for domestic abuse and child abuse and neglect.

Moreover, differences in policies and practices across military services and civilian institutions, such as in the classification of cases, make it difficult to draw strong conclusions about whether child abuse and neglect and domestic abuse are more prevalent in military or civilian populations (Rentz et al., 2006). Measures of child abuse and neglect and domestic abuse vary in their sensitivity to reporting biases, treatment of repeat occurrences, and in the span of time assessed for incidents of child abuse and neglect and domestic abuse. Studies in this literature also vary in their rigor and in the representativeness of their sampling.

Domestic Abuse

In FY 2017, FAP received 15,657 reports of spouse abuse (24.5 per 1,000 married couples), with 7,153 incidents involving 5,781 victims that met the DoD-defined criteria for abuse

(DoD, 2018). In addition, there were 1,519 reports of intimate-partner[1] violence, with 916 incidents involving 756 victims that met the DoD-defined criteria for abuse (DoD, 2018). To determine which incidents of reported abuse meet criteria, installations rely on a decision-making committee and a "standardized research-based decision tree algorithm" (DoD, 2017, p. 6) (see Chapter One for the basic DoD definitions of domestic abuse and domestic violence). The majority of spouse and intimate-partner incidents that met criteria in FY 2017 were physical abuse cases (74 percent), followed by emotional (22 percent) and sexual (4 percent) abuse (DoD, 2018). Nine fatalities were related to domestic abuse in FY 2017 (DoD, 2018).

Incidents reported to authorities do not capture the full extent of domestic abuse in a population. To understand the prevalence of domestic abuse in the military, a number of survey-based studies have estimated the rates of domestic violence using responses to self-reported domestic violence scales, such as the Conflict Tactics Scale (Straus, 1979). In these studies, estimates of the rate of domestic violence in the past year have varied based on differences in the characteristics of each study sample and have focused primarily on male-to-female domestic violence perpetration (Marshall et al., 2005). As described in Chapter One, recent CDC estimates from a large, nationally representative sample have provided evidence that annual risk of experiencing physical violence perpetrated by an intimate partner is lower among military-affiliated women than among demographically similar civilian women (Black and Merrick, 2013). In contrast, smaller studies, varying in quality, have found evidence of higher rates of physical domestic violence perpetration in military populations compared to civilian populations (Heyman and Neidig, 1999; Marshall et al., 2005; Rentz et al., 2006). Possible explanations for the disparity include the CDC focus on married spouses, higher rates in studies that recruit based on mental illness (e.g., clinic samples; see Marshall et al., 2005 for analysis), or historical changes in prevalence.

Child Abuse and Neglect

In FY 2017, FAP received 12,849 reports of suspected child abuse and neglect (13.7 per 1,000 children), with 6,450 incidents involving 4,667 unduplicated victims that met the DoD-defined criteria for child abuse and neglect (DoD, 2018).[2] The majority of child abuse and neglect cases that met criteria in FY 2017 were cases of neglect (57 percent), followed by emotional (19 percent), physical (20 percent), and sexual (4 percent) abuse (DoD, 2018). There were 17 fatalities related to child abuse in FY 2017 (DoD, 2018).

Studies comparing rates of child abuse and neglect in military and civilian populations have offered inconsistent conclusions. Effects have been documented in opposing directions, and some studies show lower and higher rates depending on the form of maltreatment analyzed (Rentz et al., 2006). Rates of child maltreatment have historically been higher in civilian samples compared to military samples; the pattern appears to be driven by higher rates of neglect in civilian samples compared to military samples, rather than differences in the rates of physical abuse across civilian and military samples (Dubanoski and McIntosh, 1984;

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[1] Intimate partners exclude current spouses (statistics regarding whom are summarized in the prior sentence) and include former spouses, individuals with whom the abuser shares a child, and current and former romantic or sexual partners who share or have shared a domicile.

[2] As with domestic abuse, a decisionmaking committee employs a "standardized research-based decision tree algorithm" to make a determination of whether the incident meets criteria for abuse or neglect (DoD, 2017, p. 6) (see Chapter One for the DoD definitions of child abuse and child neglect).

McCarroll et al., 2004b). Among children who are abused, children in military families may be subjected to more severe physical abuse than children in civilian families (McCarroll et al., 2004a).

The Family Advocacy Program to Prevent and Respond to Family Violence

FAP, a congressionally mandated program (full name: Office of the Secretary of Defense Family Advocacy Program, or OSD FAP), is central to DoD's efforts to address child abuse and neglect and domestic abuse (DoD, 2017). FAP offices at military installations partner with other entities within DoD's coordinated community response system (e.g., law enforcement, chaplains, command, medical and legal services), as well as with civilian agencies, to deliver child abuse and neglect and domestic abuse prevention and response services. FAP provides services for both victims and offenders.

FAP also manages the Central Registry, a database of incidents of domestic abuse and child abuse and neglect. The Central Registry includes data on incidents reported to FAP from each of the military services.

The FAP mission focuses on the safety and well-being of military families. Its goals are to

- promote prevention, early identification, reporting, and treatment of child and spouse abuse
- strengthen family functioning in a manner that increases the competency and efficacy of military families
- preserve families in which abuse has occurred, if possible, without compromising the health, welfare, and safety of victims
- provide effective treatment for all family members when appropriate
- effectively collaborate with state and local civilian social services, law enforcement, and medical agencies
- support victims with trained domestic abuse victim advocates to include a full range of support services, such as safety planning, court accompaniment, and information on civilian and military protective orders
- collaborate with state and local civilian social services and law enforcement agencies to provide a coordinated community response and support for service members and their families (Robertson, 2014).

To accomplish these goals, FAP provides a variety of prevention and intervention services related to child abuse and neglect and domestic abuse. For example, one prevention service is the New Parent Support Program, designed as a secondary prevention program which promotes protective factors in military families to decrease the risk for child abuse and neglect. The program provides one-on-one support for new and expectant parents via home visits, parenting classes, playgroups, and resource materials. The program works to help parents build strong, healthy bonds with their children, manage the demands of parenting, build a support network, and respond to infant and toddler behavior appropriately (Military OneSource, 2018c). FAP also offers a variety of preventative counseling services for individuals, couples, and parents, and life skills classes in anger management, stress management, and parenting.

Response services address incidents of child abuse and neglect and domestic abuse when they occur. Over 900 licensed providers are available to deliver intervention services, such as advocacy, and clinical counseling for victims, and intervention services for offenders. Additional, domestic abuse victim advocates are employed in response to domestic abuse. Services are voluntary for all victims (military or civilian) and for civilian offenders, but commanders may mandate treatment for active-duty offenders. FAP services are also available for child witnesses to domestic violence and for children who are abused or neglected; families may also be referred to specialized treatment or community services as appropriate.

Victims who self-refer for domestic abuse services have the option of making a restricted or unrestricted report, both of which provide access to victim advocacy services, medical care, and counseling (Military OneSource, 2018b). Unlike unrestricted reports, restricted reports do not require notification of command or law enforcement, allowing the victim to confidentially disclose an incident without triggering an official investigation. Unrestricted reports will begin a law enforcement investigation of the incident of abuse, coordination with the victim's and/or alleged offender's commander (to provide support and protection as well as potential administrative action against the offender), the sharing of information on legal rights, and assistance in applying for transitional compensation (DoD, 2015b; Military OneSource, 2018b).

Our interviews with FAP service-level leadership revealed variation across service branches in the organization of FAP services provided to military families. Differences in service FAP organizational structure, position, and coordination with both military and civilian organizations have implications for how FAP resources are accessed and provided, the level of integration between FAP resources and other service providers, and the involvement of command. In the next section, we summarize FAP services and their relation to other military resources by service branch (from the leadership perspective), and highlight notable differences. We then summarize the background provided by service leadership during interviews on potential variation in FAP services by installation characteristics and coordination between FAP and civilian resources.

Family Advocacy Program Services and Relationship to Other Military Resources

Army FAP leadership reported that the Army FAP operates out of the Army Community Service (ACS). The clinical intervention and prevention arms of Army FAP are located separately; the clinical arm is based out of the military medical treatment facility, and prevention resources are based out of ACS. The clinical arm of Army FAP is housed within the Behavioral Health Department of the military medical treatment facility, which allows for coordination between family advocacy services and mental health services. The Army Behavioral Health tracking system, Behavioral Health Data Portal, includes child abuse and neglect and domestic abuse screeners and tracks clinical assessments over time.

Navy FAP leadership indicated that the Navy FAP operates out of Fleet and Family Services. Unlike the Army FAP, the Navy FAP is not medically aligned, but rather is under the command line. All counselors are considered generalists, meaning they do both family advocacy work and clinical counseling. The counselors may also participate in prevention efforts, in addition to delivering counseling services (e.g., marital counseling) to families that may be at risk for, but have not experienced, violence. Navy commanders are involved in conducting risk assessments, and they work directly with a group that makes administrative decisions about cases. Navy FAP coordinates with other military resources to ensure provision of services for long-term medical issues or mental illness via a medical facility.

Air Force FAP leadership noted that the Air Force FAP is medically aligned; FAP clinics are assigned to medical groups, and FAP locations often share waiting rooms with the mental health and substance abuse programs in a military treatment facility. To coordinate with other military resources, Air Force FAP participates in a quarterly meeting of service providers on the installation. Together, the group identifies clients' needs and trends across the installation, and uses this information to create promotional programming. In addition, the Air Force FAP works with other organizations (e.g., Child Development Center, and Airmen and Family Readiness) to reach families that live off base. Active duty Air Force members can access all FAP services (regardless of whether they live on base); civilian partners of Air Force service members can access the preventative classes available but cannot receive treatment.

Marine Corps FAP leadership declined to participate in interviews about their organizational structure.

Variation in Family Advocacy Program Services by Installation Characteristics

Leadership from the Air Force, Army, and Navy described variation in FAP services across installations. For example, Army FAP leadership mentioned that smaller installations may lack some of the programs and resources (e.g., New Parent Support Program, clinical resources available for intervention) present at larger installations. Navy FAP leadership noted that while services are generally consistent across installations, there may be some variation. In rural areas, where availability of services is low, Navy FAP works with the community to share resources. However, Navy FAP offices located in more urban areas require more coordination, as there is potential for more partnership with multiple community resources. According to Air Force FAP leadership, the programs and services offered by FAP are generally uniform across bases; however, larger installations are likely to have more FAP staff on site.

Coordination with Civilian Resources

Air Force, Army, and Navy HQ FAP leadership described several ways that FAP may coordinate with civilian resources. Army FAP leadership described having a memorandum of understanding (MOU) with Child Protective Services (CPS), but it does not require that CPS share information about military-affiliated cases with FAP. Army FAP has coordinated with civilian services for cases of domestic abuse via MOUs with shelters and law enforcement. Navy FAP leadership similarly described having MOUs with civilian shelters and agencies to respond to incidents of domestic abuse, and also described being a mandated reporter to CPS, while the reverse is not true. If cases of child abuse and neglect or domestic abuse happen outside the base, the Naval Criminal Investigative Service will work with civilian law enforcement to determine who should handle the case. Air Force FAP leadership also described coordinating with civilian resources, and noted that smaller installations are more likely to rely on civilian resources for support. The Air Force HQ FAP described MOUs with civilian shelters and CPS, and the organization offers clients a list of civilian individuals who provide marriage counseling.

Conclusions

While FAP serves as a focal point for support services addressing child abuse and neglect and domestic abuse across the military branches, other resources also are available to military

families that can be used in conjunction with FAP or on their own. Whether military families choose to seek support through FAP or through other military or civilian resources varies based on a wide variety of circumstances. Understanding the availability of this set of resources for military families is the focus of the remainder of this report. In the next three chapters, we describe the findings of the mixed-method data collection that we employed to assess the availability of military and civilian resources addressing child abuse and neglect and domestic abuse: resources provided by FAP to address child abuse and neglect and domestic abuse, other resources available on military installations, and services available in the community surrounding military installations that supplement FAP services or respond to co-occurring needs.

CHAPTER THREE

Family Advocacy Program Family Violence Services

In this chapter, we describe in further detail the child abuse and neglect and domestic abuse services provided by FAP, including a summary of FAP caseloads, staffing, response services, and prevention and outreach efforts. To gain insight into potential areas of improvement, we examined barriers to using FAP services by families, logistical and staffing issues at FAP offices, the balance between prevention and response services, and overall successes and challenges of FAP efforts. The information presented here combines results of the surveys submitted by the directors of installation FAP offices with the interview notes from our discussions with FAP service providers.

Caseload

According to survey data, annual caseload for the entire office varied considerably across installations (Table 3.1). The installation FAP offices that responded to the RAND survey estimated that they were responsible for providing services for an average of 194 cases per year. On average, they reported staffing 99 domestic violence[1] cases, 75 child abuse and/or neglect cases,

Table 3.1
Average 12-Month Installation Caseload by Case Type

Case Type	Average Number of Cases in Past 12 Months
Domestic violence *only*	99 (55–142)
Child abuse and/or neglect *only*	75 (44–106)
Both domestic violence and child abuse and/or neglect *in the same family*	42 (14–69)
TOTAL	194* (113–275)

NOTE: Data cells contain the mean response across installations, followed by the 95% confidence interval in parentheses. *N* = 57–58.

* The three types of cases do not precisely sum to the total, because they are estimates, rather than precise case counts, provided by installation directors.

[1] Officially, FAP is responsible for providing services for domestic abuse cases, of which only a subset are domestic violence cases. Despite the precision of language in policy documentation, in common parlance, including among the clinician and advocates whom we interviewed, the terms *domestic violence* and *domestic abuse* are used interchangeably to describe romantic/sexual relationships that include psychological, physical, or sexual abuse. In the survey that was completed by

and 42 families with combined domestic violence and child abuse and/or neglect. Nearly all the victim advocates and clinicians whom we interviewed indicated that they were assigned both types of cases: domestic violence and child abuse and/or neglect.

Pathways to the Family Advocacy Program

FAP offices were asked to estimate the percentage of cases in the past 12 months that were received through different types of referrals (Table 3.2). These numbers should be interpreted with caution, given that they are estimates; some FAP offices noted explicitly that this information is not tracked.

Respondents to the FAP office director survey estimated that about half of all FAP domestic violence cases (53 percent) were referred to FAP by an authority (e.g., commander, police, CPS), after which the service member may be required to engage with FAP services. Similarly, about half of child abuse and neglect cases (50 percent) were received as referrals from an authority. In the interview protocol, we asked victim advocates and clinicians to describe the "typical path that someone on your installation would take to seek help" for domestic violence or child abuse/neglect. Providers echoed the survey data by indicating that most cases begin with an incident that involves law enforcement. As one Air Force clinician described: "The vast majority of cases are initiated by the victim. This occurs either though a 911 call to the civilian police or through a call to security services." In some cases, law enforcement directly refers to FAP. For example, an Army clinician indicated that "typically, we will receive a call from law enforcement after they have been called about an incident. We are supposed to be notified within 24 hours, but in many cases, we are not." In other cases, law enforcement notifies command, which in turn notifies FAP:

Table 3.2
Referral Types by Case Type

Referral Type	FAP-Estimated Percentage of DV Cases	FAP-Estimated Percentage of CAN Cases
The incident was reported to FAP by an authority	53% (46%, 59%)	50% (43%, 57%)
Service member or family was referred to FAP by another provider	19% (15%, 24%)	33% (26%, 39%)
Service member or family self-referred for domestic violence or child abuse/neglect	18% (14%, 21%)	7% (4%, 10%)
Service member or family self-referred for a different issue	7% (5%, 10%)	6% (4%, 8%)
Other	4% (0%, 7%)	6% (2%, 9%)

NOTE: DV = domestic violence; CAN = child abuse and neglect. Data cells contain the mean estimated percentage response across installations, followed by the 95% confidence interval in parentheses. *N* = 55–64.

installation FAP offices, the term *domestic violence* was used. Thus, when describing results that were drawn from a survey question, we replicated the usage in the item.

> The typical pathway is that the victim will call and report an event, the police will notify the first sergeant within a week and deliver a copy of the police report to them, and they will bring the client to us (Air Force clinician).

Many Army providers described a reliance on the police blotter to identify cases:

> Usually we'll get a referral from the MP [military police] blotter, or command will notify us, or medical will send us a referral, or a walk-in, but most of the cases we get [a referral] from an MP blotter (Army clinician).

According to FAP office directors, the next most common referral source was another provider (Table 3.2). According to victim advocates and clinicians, provider referrals—though less common than law enforcement or command referrals—arrived from a variety of provider types and offices including: emergency rooms, Military OneSource, schools, CPS, the Airmen and Family Readiness Center, the Sexual Assault Prevention and Response program, pediatric clinics, behavioral health clinics, OB/GYN offices, primary care offices, the new-parent support program, the chaplain's office, and child development centers. For domestic violence cases, about one out of five (19 percent) referrals were estimated to come from other service providers, and about one-third of child abuse/neglect cases (33 percent) were estimated to arrive via referrals from other providers.

Some service members or family members self-refer for FAP services, seeking assistance for violence, abuse, or neglect in the family. According to survey responses, approximately 18 percent of domestic violence cases and 7 percent of child abuse/neglect cases were received as self-referrals. Others may present with a different primary complaint, such as relationship problems, and domestic violence or child abuse/neglect is revealed afterward. FAP receives an estimated 7 percent of domestic violence and 6 percent of child abuse/neglect cases in this way.

Individuals may self-refer for FAP services, but most of the providers whom we interviewed perceived self-referrals as rare. A Marine Corps victim advocate said: "It is rare that someone will come in voluntarily and file a restricted report so that they can access services without notifying command, but it does happen." A Navy clinician echoed:

> It is uncommon, but if they walk in and tell us about an incident that we do not already know about, they would get screened and a case is assigned. As long as there is not an imminent threat, and there are no children involved, they can . . . receive services without having to notify command at our discretion.

There was strong consensus among the providers with whom we spoke that self-referrals were almost always cases where the domestic abuse victim or the nonoffending parent was seeking assistance. A Navy counselor said: "I have never had an offender call," and a Marine Corps victim advocate explained that "it is almost always the victim, although I have seen cases where the offender will come forward and admit that they need help with anger management or a situation within the marriage."

As mentioned, a self-referral can be categorized as either an unrestricted or a restricted report. Most unrestricted reports involve communication between the FAP office and the victim's and/or perpetrator's commander. Among FAP office directors who responded to the survey, four in five (81 percent, $N = 67$) reported that all unrestricted cases are discussed with

the individual's commanding officer. Most installations (82 percent, *N* = 67) indicated that discussions with the commanding officer were helpful or very helpful.

Self-referred domestic abuse victims may opt to file a restricted report provided command or law enforcement has not already been notified. A restricted report allows the victim to access advocacy and response services without involving law enforcement or command. The FAP office directors in our sample estimated that 12.9 percent of their office's domestic abuse cases in the past 12 months were restricted reports (95 percent confidence interval: 10.1, 15.8; *N* = 55). Child abuse/neglect cases are not eligible for restricted reporting.

Response Services

Active duty service members[2] and their families are eligible for all FAP services. Eligible family members include current and former spouses, current or former intimate partners who cohabitate or have cohabitated, current or former partners who share a child or children in common, and dependent children. Technically, FAP services are not required to extend to retirees, non-activated Reservists, civilian employees, contractors, extended family members, and dating partners who do not cohabitate or share a child in common. However, providers across the four services indicated that victim advocacy, referrals, and warm handoffs are typically provided to victims in these categories if caseloads allow. As one advocate explained: "I will assess and complete safety plans with anyone who comes in for assistance, and then refer them out [to the community] if needed" (victim advocate, Marine Corps). In-person meetings are limited to those with base access, but phone consultations can be provided more broadly. Service providers told us that, typically, retirees are referred to community resources, but in cases when the violence is severe, FAP provides services directly.

Intake Process

There is some variation in the intake process across the service branches, but the general structure follows a similar path. When a child abuse and neglect or domestic abuse report is filed, FAP providers reach out to both the offender and the victim (in domestic violence cases), or to the offending parent and nonoffending parent (in child abuse/neglect cases) to schedule intake assessments. An exception is made for restricted domestic abuse reports, in which case the offender is not contacted. Intake sessions typically occur in person at the FAP office and occasionally in the home, are scheduled separately for the domestic abuse victim and offender and the child abuse and neglect offender and victim/nonoffending parent. The intake includes an assessment of the incident, family history, and safety planning with the victim. There was variation in how interviews with child victims and child witnesses to violence were handled across installations. Some larger installations had trained staff in child interviewing and conducted interviews; others relied on transcripts or reports of child interviews conducted by trained interviewers in civilian settings (e.g., CPS interviewers) or by law enforcement (e.g., FBI interviewers).

[2] Active duty includes active component service members and currently activated Reservists and Guard members.

After all assessments are complete and documented, and within 30–60 days of the incident,[3] a FAP representative presents the assessment to a review board for a determination. While waiting for a meeting date and determination, FAP providers often recommend that the offender begin engaging in services, may provide victim advocacy services as appropriate, and offer referrals for co-occurring needs (e.g., behavioral health services).

Each service branch relies on a review board to determine whether the case meets DoD criteria for child abuse and neglect or domestic abuse, but the membership on the board varies slightly across branches. The group or board typically includes a representative from the FAP office, and may also include representatives from the legal office, law enforcement or military criminal investigation office; the chaplain; medical providers; the senior noncommissioned officer of the offender (and victim, if applicable); and a commander. Board members use an evidence-based, formal algorithm to make an individual determination of whether the case does or does not meet criteria, and a majority vote across board members determines the final case classification.

For cases determined to meet criteria, FAP provides a recommended treatment plan for the offender and may also suggest services for the victim. When the offender is a service member, FAP remains in communication with the offender's commander and notifies them when the case has been resolved (i.e., closed because the offender has completed the treatment recommendations) or has been closed as unresolved (i.e., the offender never engaged in or completed the treatment plan).

For cases that do not meet criteria, the offender and victim are notified that the maltreatment case has been closed because it does not meet criteria for domestic abuse or child abuse and neglect. However, the family is invited to continue to use FAP services voluntarily. A clinical treatment manager with the Air Force estimated that "80 percent say yes" to continued FAP services.

Treatment Plans

Once a case has been determined to meet criteria, a treatment plan is developed. For domestic abuse offenders, FAP service providers indicated that they typically recommend a 26-week, offender intervention program modeled on the Duluth model for offender treatment (Pence and Paymar, 1993), but translated for military populations. Some large installations have the caseload to support group interventions for female offenders, but this was less commonly mentioned. Some installations provide offenders' intervention groups within the FAP program, while smaller installations referred to similar groups offered at nearby installations or in the civilian community. Treatment plans for offenders may also include anger management classes (six to eight weeks), individual therapy (12 weeks), and couples counseling or groups (variable). Couples counseling is recommended only after the offender has successfully completed individual treatment.

For child abuse/neglect cases, offender treatment plans may include parenting classes, the New Parent Support Program (available to parents of children age three or younger[4]), individual counseling (parent and child), family counseling, couples counseling, and home visits. While nearly every installation FAP office offers individual counseling and one-on-one parent-

[3] Varies by branch.

[4] The Marine Corps offers the program for children up to age five.

ing support, some installations with smaller staff and smaller caseloads reported that they were unable to also offer parenting groups, classes, or home visits.

When an offender has completed all recommendations in the treatment plan, and no further support services are required by the treatment plan or requested by the offender, the case is closed as “resolved.” If an offender does not engage in the treatment plan, most providers indicated that they would reach out for support from the offender’s commander. Some commanders will encourage or mandate their service member to engage, and then treatment continues. In other cases, a commander may not intervene, and then the case is closed as “unresolved.” Unresolved cases refer to cases in which the criteria for domestic abuse or child abuse and neglect were met, a treatment plan was developed, but the offender never completed the plan.

Treatment can be similar for clients in domestic abuse incidents who have restricted reports and clients who remain engaged in domestic abuse or child abuse and neglect services even after the review board closes the case. Although these clients are under no obligation to continue to use FAP services, victim advocates and clinicians make available support services, individual counseling, groups, and parenting supports as appropriate. Victims, particularly civilian intimate partners, may or may not decide to engage in services offered by the military installation. They are offered the full range of available support and referrals to community resources, if preferred. There was significant variation across providers in their perception of how engaged victims are in services. An Army leader said: “Civilian spouses are very good about coming in for services. I can only think of two in the past years that said no.” Whereas other providers indicated that civilian victims were unlikely to engage: “In my experience, the civilian family members rarely participate in any therapy or groups, and we can’t force them to” (Army clinical supervisor).

Duration of Participation

Six months seemed to be a typical length of engagement, but the victim advocates and clinicians whom we spoke with were clear that there is significant variation that depends primarily on the unique needs of each case. A Marine Corps clinician explained that “it depends on the severity of the case. If we have someone referred to the offender group, they are here for a longer time, otherwise, three to four months.” A Navy clinician noted that “child cases, particularly when a child is placed in foster care, may extend longer than a year.” Providers across service branches noted that cases may be extended if a deployment or temporary duty assignment occurs in the middle of treatment, and also noted that individuals involved in cases that are closed due to not meeting criteria may complete voluntary services in less than six months.

Types of Response Services Offered

The overview of response services provided to perpetrators and victims of child abuse and neglect and domestic abuse was drawn from interviews with FAP service providers. Data from the installation surveys provided a snapshot of what proportion of installation FAP offices offer specific response services and specialized groups (Table 3.3). Nearly all FAP offices that completed the survey indicated that they offered case management (94 percent) and individual counseling (99 percent), and most offered group counseling (77 percent) and victim advocacy services (83 percent).

To provide a more detailed accounting of the group counseling and prevention activities offered, FAP offices also indicated whether they offered specific types of classes or groups (Table 3.4). The most common service offered was anger management and/or stress manage-

Table 3.3
FAP Response Services and Supporting Staff

Activity	Percentage of Installation FAP Offices Offering Activity	If Offered, Average Number of FAP Staff Supporting Activity
Response Services		
Case management	94% (88%, 100%)	5.2 (3.8, 6.5)
Counseling—individual	99% (97%, 100%)	5.3 (3.2, 7.4)
Counseling—group	77% (67%, 87%)	4.2 (3, 5.3)
Victim advocacy/legal assistance	83% (74%, 92%)	2.1 (1.6, 2.5)
Other Services		
Outreach and prevention activities	93% (87%, 99%)	4.5 (2.8, 6.3)
New-parent support	75% (65%, 85%)	2.2 (1.7, 2.7)
Financial education	31% (20%, 42%)	0.9 (0.5, 1.3)

NOTE: The second column contains the percentages of installations indicating that FAP offers the activity, followed by the 95% confidence interval in parentheses. The third column contains the mean response across installations, followed by the 95% confidence interval in parentheses. *N* = 52–69.

Table 3.4
Classes, Workshops, and Seminars

Type	Percentage of Installations Offering Activity in the Last 12 Months
Anger management, stress management	92% (85%, 99%)
Effective parenting	86% (78%, 94%)
Couples communication	78% (68%, 88%)
Education programs for leaders	73% (62%, 84%)
Conflict resolution	59% (47%, 71%)
Parent-child interactive groups	38% (26%, 50%)

NOTE: Data cells contain the mean response across installations, followed by the 95% confidence interval in parentheses. *N* = 61–66.

ment services (92 percent), followed by effective parenting classes (86 percent), and couples' communication groups (78 percent).

We also examined the availability of offenders' intervention services. These services are provided for those who have been identified as having committed domestic abuse, not for individuals who are at risk of becoming an offender. We found that 75 percent of installations offer groups or classes for offenders (95% confidence interval = [65%, 85%]), and 96 percent offer individual counseling for offenders (95% confidence interval = [91%, 100%]).

Variation in Response Services

During the interviews with FAP service providers, we asked about how much discretion they have when providing services and about any unique services provided at their installation. Our goal was to document innovative programming. The providers with whom we spoke explained that the programs and services offered are largely determined by service headquarters with little discretion at the installation level. A Navy counseling and advocacy supervisor noted: "We are heavily evaluated on how we follow processes so [there is] not a lot of room for variation in how we deliver the program." Similarly, a Marine Corps victim advocate explained: "The programs that we offer are typically a global decision based on standards handed down from headquarters." A Marine Corps clinical counselor perceived this standardization to be driven by an emphasis by headquarters on delivering evidence-based programs linked to positive outcomes:

> There is a huge move toward evidence-based programs, so we can no longer [innovate]. Now, we have to use evidence-based programs, and they have to be approved by headquarters. So, no, I don't have discretion. I'm told what I can do.

We did not note variation across service branches on the degree of emphasis on standardization.

In response to questions about unique approaches at their installation, many providers explained that innovation was limited due to resource or staffing constraints. As a Navy supervisor summarized:

> Our FAP program participates in everything that we are mandated to participate in, but [we] don't have the liberty to go too far off the checklist, because we don't have the manpower to handle the cases we have.

Offices serving small installations indicated that they do not have the caseloads necessary to offer services in a group format. For example, there may not be enough offenders mandated to receive treatment at any given time to support a group format. An area coordinator with the Navy told us:

> We are a very small place, and we don't have a lot of resources, so I can offer individual counseling and that's about it. We don't ever have enough offenders to do a DV [domestic violence] group, so I have to do this one on one. We don't have any support groups and no support groups in the community. We are very limited in the types of services we can offer.

Offices serving larger installations typically did not describe the same types of constraints. Only two providers indicated that their installation offered unique response services relative to other installations. An Air Force treatment manager noted that they were able to offer a

marriage class with support from external grant funding. A Navy FAP manager indicated that s/he had developed a life skills group.

Although providers consistently indicated that the programs and services offered were largely directed by service headquarters, many service providers indicated that they did have the ability to “customize the services to fit the needs of each individual family” (Navy victim advocate). An Air Force clinical treatment manager explained that while they offer individual, marital, and family counseling, “we tailor it to what they need. So, a lot of flexibility that way.” A victim advocate with the Air Force explained: “I have to meet the victim where they’re at. As long as it’s within the realm of AFI [Air Force Instruction] or standards, then it’s okay. I can meet with the victim where . . . they are in the process. I have freedom in the way I offer services.” An Army clinician explained that while s/he was using the recommended 26-week offenders’ intervention group, “I tweak parts of it.”

Access

Table 3.5 provides a summary of service availability. On average, FAP offices were open five days each week for 41 hours per week. There was evidence of some after-hours availability for counseling appointments, walk-in services, and information services, but weekend/evening availability was not the norm. Only 3 percent of FAP offices included in the survey sample indicated that their office was open on the weekend, although some services by appointment were available, as were telephone referrals.

Staffing

The survey of installation FAP offices included a request for the number of staff, by category (e.g., social worker, administrative staff) and by status (e.g., civilian, contractor), which is reported in Table 3.6. On average, responding FAP offices reported having approximately 11 staff members. The most common disciplines were social workers and other counselors/advocates. The majority of FAP staff are civilian employees (83 percent).

Table 3.5
Timing of FAP Service Availability

Type	Days Available per Week	Hours Available per Week	Available on Evenings or Weekends
FAP office open	5.0 (5.0, 5.0)	41.0 (40.4, 41.6)	3% (0%, 7%)
Counseling/advocacy (by appointment)	5.0 (5.0, 5.1)	44.5 (39.1, 50.0)	14% (6%, 22%)
Counseling/advocacy (walk-in)	5.1 (4.9, 5.3)	50.1 (41.9, 58.3)	12% (4%, 20%)
Information and referrals (in person or by telephone)	5.3 (5.2, 5.5)	58.9 (48.1, 69.6)	24% (13%, 35%)

NOTE: The second and third columns contain the mean response across installations, followed by the 95% confidence interval in parentheses. The fourth column contains the percentages of installations indicating availability on evenings or weekends, followed by the 95% confidence interval in parentheses. *N* = 63–69.

Table 3.6
Average Number of Installation FAP Staff by Category and Status

Category	Total Staff	Civilians	Civilian Contractors
Social worker	4.2 (3.2, 5.2)	3.4 (2.5, 4.4)	0.7 (0.4, 1)
Psychologist	0.1 (0, 0.1)	0 (0, 0.1)	0 (0, 0)
Other counselors/advocates	2.9 (1.2, 4.7)	2.6 (0.9, 4.3)	0.7 (0.4, 1)
Manager/coordinator	0.6 (0.4, 0.8)	0.5 (0.2, 0.7)	0 (0, 0.1)
Administrative/clerical staff	1.8 (1.4, 2.1)	1.4 (1, 1.7)	0.5 (0.3, 0.7)
Other staff not counted above	1.3 (0.9, 1.7)	1.1 (0.7, 1.5)	0.8 (0.4, 1.2)
TOTAL	10.7 (7.7, 13.7)	8.9 (5.8, 12)	2 (1.3, 2.7)

NOTE: Data cells contain the mean response across installations, followed by the 95% confidence interval in parentheses. Total staff includes full-time and part-time staff working in FAP. Civilians are a subset of total staff, and civilian contractors are a subset of civilians. Manager/coordinator and administrative/clerical staff are listed only if not already counted in other staffing categories. *N* = 48–69.

The installation FAP office survey also contained questions concerning the extent to which FAP office respondents perceived five given logistical and staffing factors as limiting FAP's efforts to provide services. These results are contained in Table 3.7. One-half of the FAP office directors who responded to the survey (49 percent) indicated that the number of available FAP professional staff limited FAP's service provision efforts to a "large" or "very large extent," while 41 percent indicated that staff turnover limited services to a "large" or "very large extent." Ratings for the remaining surveyed factors—space, financial resources, and number of management/administrative staff—were mixed. Many FAP offices rated these factors as not limiting service provision at all. Still, 57–64 percent indicated that these factors influenced service provision to at least a "small extent," suggesting that there may be variability across offices, with some offices experiencing these challenges to a greater extent than others.

The 37 FAP offices that indicated that the number of either "FAP professional staff" or "FAP management/administrative staff" limited efforts to a "large" or "very large" extent were asked to indicate the staffing categories in which there were shortages. Licensed social workers were selected by the greatest number of the 37 offices (70 percent), which is consistent with national statistics confirming a shortage of social workers (Lin, Lin, and Zhang, 2015). Some offices also listed a shortage in administrative staff (38 percent), nurses and other new-parent support staff (30 percent), victim advocates (27 percent), treatment managers (27 percent), outreach/prevention managers (24 percent), other counselors (16 percent), and psychologists (5 percent).

The 28 FAP office respondents who indicated that staff turnover limited service provision to a "large" or "very large" extent were asked to mark the staffing categories in which turnover is a problem. Licensed social workers were selected by the greatest number of the 28 offices

Table 3.7
Perceptions of Factors as Limiting FAP Service Provision

Factor	Not At All	Small Extent	Moderate Extent	Large Extent	Very Large Extent
Number of available FAP professional staff (e.g., social workers, counselors)	18% (9%, 27%)	22% (12%, 32%)	10% (3%, 17%)	16% (7%, 25%)	**33% (22%, 44%)**
Staff turnover	19% (10%, 28%)	**24% (14%, 34%)**	15% (6%, 24%)	19% (10%, 28%)	22% (12%, 32%)
Available FAP office/meeting space	**43% (31%, 55%)**	28% (17%, 39%)	7% (1%, 13%)	13% (5%, 21%)	7% (1%, 13%)
FAP financial resources	**37% (25%, 49%)**	18% (9%, 27%)	27% (16%, 38%)	10% (3%, 17%)	7% (1%, 13%)
Number of FAP management/ administrative staff	**36% (25%, 47%)**	22% (12%, 32%)	18% (9%, 27%)	15% (6%, 24%)	9% (2%, 16%)

NOTE: Data cells contain the percent of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold.
N = 67.

(89 percent), followed by administrative staff (43 percent), treatment managers (36 percent), victim advocates (36 percent), other counselors (29 percent), nurses and other new-parent support staff (21 percent), outreach/prevention managers (18 percent), and psychologists (0 percent). Turnover in social work staff, in particular, may be tied to the national shortage. Given the demand, employees in this category may receive competing and attractive employment offers from other agencies. Without access to a nimble response system to provide counteroffers, FAP may lose these valuable employees.

In response to an open-ended question about challenges, many FAP office respondents, particularly those serving in the Navy, confirmed that limited manpower was one of the primary challenges to delivering prevention programming. Representative responses included: "We just don't have enough clinicians" (Navy), and there are "not enough staff to engage in comprehensive prevention or education" (Navy). There was variation in the perceived source of manpower shortages, with explanations ranging from "large time gaps to onboard necessary staff" (Navy) to "high turnover" (Navy) to concern that "the contracts are not competitive enough to recruit and retain employees on a consistent basis" (Air Force). During our qualitative interviews, FAP service providers attributed staffing shortages to turnover, noncompetitive contracts, and workplace climate. An Air Force victim advocate suggested: "We need to pay the advocates more money and provide them with more self-care time without having to use their personal leave because it is a very stressful job and many people get burned out and leave." An Army provider said simply: "Our staffing needs are desperate."

Despite perceived staffing shortages, FAP office directors were quick to recognize the quality of the staff who were working for FAP. For example, FAP office survey respondents attributed their successes to "how knowledgeable and effective the outreach manager is in communicating what constitutes maltreatment, and how well he or she sells the program" (Air Force) and "seasoned Life Skills staff" (Navy). Similarly, FAP service providers consistently mentioned their coworkers as one of the key contributors to success. An Air Force treatment manager offered: "A big strength is the people that work here. We have all been here for several years, work well together, all have at least basic understanding of each other's jobs so we can

provide services, like each other, spend off time together." Others mentioned "our group—we care, a lot" (Marine Corps, clinical manager), and an Air Force clinical psychologist explained, "I am proud of the services that we provide. I feel that we do provide help to high-risk families. After an event occurs, or whether it is preventative, the program is evidence-based and has good results."

Family Advocacy Program Leadership

FAP office survey respondents and service providers had mixed perceptions of the role of leadership in family violence prevention and response; some saw their relationship with installation leadership as key to the success of the FAP mission. A Marine Corps victim advocate said: "Our prevention group is excellent at getting the word out with commands, and the commands have played a large part in breaking the stigma involved in having their service members reach out for help if they need it." Similarly, in response to the question about FAP strengths and successes, a Navy clinician noted, "We have complete buy-in from our command," and an Air Force survey respondent explained, "Commanders' attitude toward FAP is critical. Some commanders actively request briefings, workshops, etc., while others actively avoid FAP prevention."

The "others" who actively avoid FAP prevention and response services seemed to be less common in our interviews, although there was a smaller proportion of respondents who saw leadership as one of the *challenges* they face. For example, a Marine Corps respondent indicated that a "culture of apathy or resistance to becoming involved in family issues seems to pervade leadership's response to family abuse," and a Marine Corps victim advocate described the following interaction with a commander:

> I spoke to a [commander] once, and he told me, "We invest so much time and training with our Marines, why would we waste our time sending them to FAP?" I tried to say, "Well, sir, he beat his wife," but it fell on deaf ears. Other than getting full buy-in from command, there is not much I can do to help in those situations. I'd say that is the biggest challenge.

Perceived Barriers to Using Family Advocacy Program Services and Targets for Improvements

In the installation FAP office survey, FAP offices indicated which modifications on a list, if any, they believed would increase the willingness of service members and families on the installation to seek FAP help for child abuse and neglect or domestic abuse. The three modifications selected most frequently, as shown in Table 3.8, were related to career consequences and privacy. Most respondents to the FAP office director survey (80 percent) believed that reducing the likelihood of damage to a client's military career would increase help-seeking. Approximately half (52 percent) indicated that allowing more discretion and privacy would have this effect, followed by reducing the likelihood of the commanding officer being notified (45 percent). Additional or improved outreach was endorsed by about one-third of FAP offices (30–39 percent), followed by making it less likely that the abuser would find out that a victim had sought services (28 percent). Few believed that increasing hours of FAP service availabil-

Table 3.8
Modifications to Increase Seeking of FAP Help

Modification	Percentage Indicating It Would Increase Help-Seeking
Making it less likely there will be damage to military career as a consequence of seeking help	80% (71%, 89%)
Finding ways to allow more discretion/privacy when seeking FAP services	52% (40%, 64%)
Making it less likely the commanding officer will be notified	45% (33%, 57%)
More use of social media for outreach	39% (27%, 51%)
More outreach overall	36% (25%, 47%)
Change or better tailor the outreach messages	30% (19%, 41%)
Making it less likely the abuser would find out	28% (17%, 39%)
More hours during which FAP services are available	14% (6%, 22%)
Making it easier for someone to be seen by a counselor or other provider of their preferred gender	12% (4%, 20%)
Nothing would likely make them more willing	6% (0%, 12%)

NOTE: Data cells contain the percentages of installations that marked each response option (respondents selected as many options as applied), followed by the 95% confidence interval. *N* = 69.

ity (14 percent) or making it easier to see a provider of a client's preferred gender (12 percent) would increase the likelihood that a client would seek help. Only 6 percent of respondents to the FAP office director survey believed that nothing could be done to make service members and families more willing to seek FAP help.

The interview protocol for victim advocates and clinicians included a question that asked about the most significant barriers that prevent some families from seeking FAP services. Consistent with the survey responses, many clinicians perceived risk of career harm as a barrier to seeking help and believed that this prevents offenders from coming forward. As one Air Force clinician explained: "Airmen at this base have special duty status . . . and they have a real fear of losing that status and losing their career if they report a domestic violence event to command." Risk of career harm for the offender may also dissuade victims from seeking help. "A spouse can also be worried about losing money, housing, and military benefits that they rely on" (Air Force, FAP officer). An Army social worker echoed the concerns from both the offender and victim perspective:

> Fear of damaging the offender's career—that is a huge [barrier]. For example, in recruiting, if you are suspected of abusing [someone] you are immediately suspended. That can be alarming for the victim. They just want the abuse to stop; they don't want to hurt the offender. Victims know the repercussions if they speak up ("His career is going to be

> ruined; how am I going to feed my family?"). In upper ranks, [if there's] any perception of a problem, they really will not promote you or put you in a command role, so some of the stigma is true.

A Navy victim advocate suggested that the possibility of career repercussions may be used actively by the offender to control the victim: "They are afraid they will lose their job and their housing and will suffer financial constraints. In this way, an abuser can basically hold the family hostage."

Similar to the survey results, FAP victim advocates and clinicians also perceived privacy concerns as one reason why families to do not seek or delay seeking FAP services. For example, an Army social worker explained: "It's so small here [installation population] that people fear their privacy being in jeopardy." However, detailed insights from providers gives further context to these confidentiality concerns, suggesting that the desire for privacy is driven by deeper issues such as shame and embarrassment about experiencing child abuse and neglect or domestic abuse (as the perpetrator or the victim), and the belief that the family can handle the abuse internally without "people knowing their business" (Navy, victim advocate). A clinician in the Navy shared the following:

> Stigma is also a problem—same as you would expect for counseling—the thought that you are broken. [It is] more difficult for men to request help in any area of their lives. They are raised to take care of [their] own problems. Asking for help is seen as a sign of weakness, [and] this is amplified in the military community.

As an Air Force clinician noted, "There is also a lot of denial in domestic abuse situations, and it can be a humiliating moment to come forward and admit that abuse has occurred."

Less often, FAP service providers mentioned structural barriers to seeking help, such as client transportation ("sometimes folks only have one vehicle and the service member took it," Army, social worker), office hours ("we are only open from 7:30 to 4:00, and many civilians who may have another job cannot get to us during those hours," Marines, FAP clinician), and childcare ("[clients] would love to come in for individual or marital counseling, and they just can't get a babysitter," Air Force, clinical treatment manger).

Finally, it should be emphasized that for victims who have been assaulted by their partner in the past, fear of future violence can serve as a potent barrier to seeking services. Some FAP service providers mentioned the following as barriers: the fear of "retribution from the offender" (Army, FAP chief); "physical violence" (Air Force, FAP manager); "reporting the event will only make things worse for them" (Marine Corps, FAP clinician); the offender "getting angry if [the victim] seek[s] services." It should also be expected that spouses who are willing to control their partners may also control the information about and access to FAP services. As an Air Force victim advocate explained, "The service member, who is often the abuser, will not relay the services that are available to their partner."

Outreach and Prevention

The FAP installation office survey also included an assessment of the frequency of public awareness and outreach activities by FAP (Table 3.9). It appears that FAP's resources are allocated to outreach in a fairly limited way. About one-half of FAP offices host a public meeting

Table 3.9
Frequency of FAP Public Awareness and Outreach Activities

Activity	Never	Annually	Semiannually	Quarterly	Monthly	Weekly
Send email announcements	11% (3%, 19%)	3% (0%, 7%)	6% (0%, 12%)	22% (12%, 32%)	**45% (33%, 57%)**	12% (4%, 20%)
Post notices or distribute brochures (hard copy)	1% (0%, 3%)	1% (0%, 3%)	12% (4%, 20%)	13% (5%, 21%)	**40% (28%, 52%)**	31% (20%, 42%)
Use other social media for FAP awareness/outreach	**40% (28%, 52%)**	2% (0%, 5%)	2% (0%, 5%)	17% (8%, 26%)	25% (14%, 36%)	15% (6%, 24%)
Update FAP Facebook page with new information	**44% (32%, 56%)**	2% (0%, 5%)	6% (0%, 12%)	14% (5%, 23%)	14% (5%, 23%)	20% (10%, 30%)
Update FAP website with new information	**49% (37%, 61%)**	9% (2%, 16%)	8% (1%, 15%)	12% (4%, 20%)	11% (3%, 19%)	11% (3%, 19%)
Host public meeting	**56% (43%, 67%)**	13% (5%, 21%)	8% (1%, 15%)	15% (6%, 24%)	5% (0%, 10%)	5% (0%, 10%)
Update FAP Twitter account with new information	**100% (100%, 100%)**	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)

NOTE: Data cells contain the percentages of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 62–67.

(44 percent), update their website (51 percent), or update their Facebook (56 percent) or other social media page (60 percent) at least annually. Sending email announcements and distributing hard-copy brochures were more common; 57 percent of offices sent email announcements monthly or more often, and 71 percent of offices distributed brochures monthly or more often.

In terms of prevention-related services, nearly all installation FAP offices reported that they offered some "outreach and prevention activities" for the installation (93 percent). Three-quarters reported offering new-parent support services (75 percent), a strategy to mitigate the risk of violence that occurs during transitions to parenting. Finally, one-third offered financial counseling for families facing financial challenges (31 percent) (Table 3.3) as a strategy to reduce the risk of violence associated with financial uncertainty.

Several FAP offices offered that child abuse and neglect and domestic abuse do not have the same visibility or public attention as other problem behaviors. As one Marine Corps respondent wrote:

> We still have a culture in which family abuse is not seen as serious a problem as nonintimate-partner sexual assault or substance abuse. Both of these issues have a lot of attention, and thus there is more energy around trying to deal with them. However, neither are any more serious than family abuse is. In fact, intimate-partner violence and child abuse/neglect may be more so because of the lack of focus. Even with the high-profile cases involving murder-suicide that have captured national media attention, the significance of the impact to families and individuals, careers, and leadership has not increased the credible support that is associated with the Sexual Assault Prevention and Response and substance abuse program. . . . The campaign months are an ineffective prevention tool, as other campaign theme months overshadow the importance of DVAM [domestic violence awareness month] and CAPM [child abuse prevention month]. . . . The community is more apt to support something with a positive/fun message rather than domestic violence and child abuse.

Other offices echoed those sentiments: "Getting the public interested in participating in [domestic violence] and child abuse awareness and prevention activities is a constant challenge" (Navy). "There are so many competing topics. . . . Often family violence is the topic that is viewed as less popular to talk about, so it tends to get less attention" (Navy).

The installation FAP office survey included a question that asked the respondent whether they believed that the range of prevention and response activities for child abuse and neglect and domestic abuse were balanced appropriately on the installation. Out of 67 responding FAP offices, 36 (54 percent) indicated that the mix is "about right," 28 (42 percent) believed that more attention should be given to prevention than is currently the case, and only three (4 percent) believed that more attention should be given to response.

Conclusions

The pathways by which service members and their family members access FAP services appear to be broadly similar across installations and service branches. Most FAP cases are initiated after a victim calls law enforcement for help. A standardized intake and determination process identifies offenders who meet the DoD definitions for child abuse and neglect and domestic abuse, and these offenders then receive a treatment plan. Civilian offenders and victims are offered services but are free to decide whether to engage. Across all FAP offices that completed an installation survey, respondents indicated the average annual caseload was 194 cases. An average staff of about 11 members provided response services for these cases, supported voluntary clients, and provided outreach and prevention services to the installation.

According to FAP office directors and service providers, barriers to delivering family advocacy services include the perceived threat of career consequences,[5] desire for privacy, and the shame and embarrassment associated with child abuse and neglect and domestic abuse. The logistical factors perceived as most limiting were the number of available FAP professional staff and staff turnover, with these issues being of greatest concern with respect to licensed social workers. Despite these barriers, FAP office directors and service providers believe that FAP has a positive impact within the military community in helping families overcome child abuse and neglect and domestic abuse. Many directors believed that leadership had played an important role in the program's success, but on some installations providers reported little support from commanders, which can interfere with treatment engagement and success. Also cited as contributing factors to success were the skills and dedication of the professional staff, despite perceived staff shortages. Although FAP provides services specific to child abuse and neglect and domestic abuse, military installations offer other support services that are relevant for victims or perpetrators of child abuse and neglect or domestic abuse, as discussed in the next chapter.

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[5] By policy, the results of an Incident Determination Committee and the receipt of FAP services cannot be used as a basis of command or legal actions. However, the behavior or incident itself, following authentication by command or legal investigation, can lead to career consequences for the offender.

CHAPTER FOUR

Family Advocacy–Relevant Support Services Available on Military Installations

In this chapter, we review family needs that may be referred outside of FAP to other military services. For example, often cases of child abuse and neglect and domestic abuse are associated with other types of problems such as substance abuse, mental health issues, or other life stresses. Military installations may offer support services targeted toward these other problems, and coordination between these services and FAP may improve outcomes in child abuse and neglect and domestic abuse cases. We review the co-occurring needs common among child abuse and neglect and domestic abuse cases, the proportion of cases that are referred to non-FAP services to meet these needs (either on or off military installations), and the perceived quality of coordination between FAP and other service providers.

Co-Occurring Needs Among Family Advocacy Cases

In the FAP installation survey, respondents were asked to estimate how many FAP cases were associated with other types of problems (e.g., limited relationship skills, financial stress). Respondents indicated whether they believed "all," "most," "some," "few," or "no" FAP cases were associated with the problem. Tables 4.1 and 4.2 show the results for domestic violence cases and child abuse/neglect cases, respectively. Over half of FAP office director survey respondents indicated that *most* domestic violence cases were associated with limited relationship or communication skills or anger management issues. They were most likely to indicate that *some* domestic violence cases were related to alcohol use disorder, mental health issues, new parenthood stress, work stress (other than financial stress, limited support networks, or financial stress. Most directors indicated that *few* FAP domestic violence cases were associated with drug use or the stress of deployment.

FAP office directors also indicated the proportion of FAP child abuse/neglect cases that they believed had other co-occurring needs. About half of the office directors believed that *most* child abuse/neglect cases were associated with limited parenting skills or understanding of child development, anger management issues, and limited relationship or communication skills. They were most likely to indicate that *some* child abuse/neglect cases were related to mental health issues, nonfinancial work stress, new parenthood stress, alcohol use disorders, limited support networks, financial stress, stress of deployment, or electronic distractions (33 percent). About half believed that *few* child abuse/neglect cases were related to drug use disorders.

Table 4.1
Estimated Proportion of FAP Domestic Violence Cases Associated with Other Problems

Problem	None	Few	Some	Most	All
Limited relationship or communication skills (one or both partners)	0% (0%, 0%)	3% (0%, 7%)	3% (0%, 7%)	**57% (45%, 69%)**	37% (26%, 48%)
Anger management issues	0% (0%, 0%)	1% (0%, 3%)	34% (23%, 45%)	**52% (40%, 64%)**	12% (4%, 20%)
Alcohol use disorder (one or both partners)	3% (0%, 7%)	28% (17%, 39%)	**63% (51%, 75%)**	6% (0%, 12%)	0% (0%, 0%)
Mental health disorder (one or both partners)	5% (0%, 10%)	21% (11%, 31%)	**59% (47%, 71%)**	14% (6%, 22%)	2% (0%, 5%)
New parenthood stress	11% (3%, 19%)	35% (23%, 47%)	**52% (40%, 64%)**	3% (0%, 7%)	0% (0%, 0%)
(Nonfinancial) work stress	3% (0%, 7%)	17% (8%, 26%)	**52% (40%, 64%)**	21% (11%, 31%)	8% (1%, 15%)
Limited support network (family, friends)	1% (0%, 3%)	13% (5%, 21%)	**45% (33%, 57%)**	34% (23%, 45%)	6% (0%, 12%)
Financial stress	1% (0%, 3%)	19% (10%, 28%)	**45% (33%, 57%)**	31% (20%, 42%)	3% (0%, 7%)
Drug use disorder (one or both partners)	23% (13%, 33%)	**61% (49%, 73%)**	17% (8%, 26%)	0% (0%, 0%)	0% (0%, 0%)
Stress of deployment	15% (6%, 24%)	**42% (30%, 54%)**	36% (25%, 47%)	7% (1%, 13%)	0% (0%, 0%)

NOTE: Data cells contain the percentages of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold.
N = 66–67.

Availability of Services on Installations That Address Correlates of Family Violence

Based on the literature review of risks for child abuse and neglect and domestic abuse (Appendix D), the installation survey included items to assess the availability of behavioral health services on each installation. With respect to behavioral health services, nearly all FAP office director survey respondents (94 percent) indicated that they believed mental health treatment was available on their installation (Table 4.3). Fewer indicated that treatment for alcohol use disorders (81 percent) or other substance use disorders (79 percent) was available on their installation. Two-thirds of directors (66 percent) indicated that their installation offers services for sleep disorders.

As an additional measure of availability, we also assessed the average days of operation per week during which specific behavioral health services were offered. According to the FAP office directors who responded to the survey, mental health treatment and substance use disorder treatment were offered about five days a week, and sleep disorder services were offered about four days a week.

We also asked about the availability of financial education and financial counseling services on installations with FAP offices. Ninety-seven percent of offices indicated that financial planning advice or education (e.g., retirement planning, saving for a first home) and financial

Table 4.2
Estimated Proportion of FAP Child Abuse or Neglect Cases Associated with Other Problems

Problem	None	Few	Some	Most	All
Lack of parenting skills or understanding of child development	0% (0%, 0%)	2% (0%, 5%)	27% (16%, 38%)	**52% (40%, 64%)**	19% (9%, 29%)
Anger management issues	0% (0%, 0%)	12% (4%, 20%)	36% (24%, 48%)	**45% (33%, 57%)**	6% (0%, 12%)
Limited relationship or communication skills (one or both partners)	0% (0%, 0%)	6% (0%, 12%)	30% (19%, 41%)	**44% (32%, 56%)**	20% (10%, 30%)
Mental health disorder (one or both partners)	3% (0%, 7%)	22% (12%, 32%)	**56% (44%, 68%)**	19% (9%, 29%)	0% (0%, 0%)
[Nonfinancial) work stress	5% (0%, 10%)	20% (10%, 30%)	**52% (40%, 64%)**	19% (9%, 29%)	5% (0%, 10%)
New parenthood stress	8% (1%, 15%)	27% (16%, 38%)	**50% (38%, 62%)**	12% (4%, 20%)	3% (0%, 7%)
Alcohol use disorder (one or both partners)	8% (1%, 15%)	41% (29%, 53%)	**50% (38%, 62%)**	2% (0%, 5%)	0% (0%, 0%)
Limited support network (family, friends)	0% (0%, 0%)	8% (1%, 15%)	**48% (36%, 60%)**	36% (24%, 48%)	8% (1%, 15%)
Financial stress	6% (0%, 12%)	22% (12%, 32%)	**45% (33%, 57%)**	23% (13%, 33%)	3% (0%, 7%)
Stress of deployment	22% (12%, 32%)	31% (20%, 42%)	**38% (26%, 50%)**	8% (1%, 15%)	2% (0%, 5%)
Electronic distractions (e.g., cell phone, gaming, internet)	14% (5%, 23%)	20% (10%, 30%)	**33% (21%, 45%)**	30% (19%, 41%)	3% (0%, 7%)
Drug use disorder (one or both partners)	27% (16%, 38%)	**52% (40%, 64%)**	21% (11%, 31%)	0% (0%, 0%)	0% (0%, 0%)

NOTE: Data cells contain the percentages of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 62–64.

Table 4.3
Behavioral Health Service Availability

Type of Service	Available	Days of Operation per Week
Mental health treatment	94% (88%, 100%)	4.9 (4.7, 5.2)
Alcohol use disorder treatment	81% (72%, 90%)	4.7 (4.3, 5.1)
Substance use disorder treatment	79% (69%, 89%)	4.7 (4.3, 5.1)
Sleep disorder services	66% (55%, 77%)	4.1 (3.6, 4.7)

NOTE: The second column contains the percentages of installations indicating that the service is available, and the third column contains the average number of days across installations that such services are available. Both columns show the 95% confidence interval in parentheses. *N* = 50–69.

Table 4.4
Financial Service Availability

Type of Service	Available	Days of Operation per Week
Financial planning advice or education	97% (93%, 100%)	5.0 (5.0, 5.1)
Financial advice in response to current financial stress	97% (93%, 100%)	5.0 (5.0, 5.1)

NOTE: The second column contains the percentages of installations indicating that the service is available, and the third column contains the average number of days across installations that such services are available. Both columns show the 95% confidence interval in parentheses. *N* = 66–69.

advice in response to current financial stress were available on their installation (Table 4.4). They estimated that these services were available five days a week.

During our interviews with FAP service providers, we asked if there were any child abuse and neglect or domestic abuse prevention efforts or services offered on their installation by agencies other than FAP. Some providers mentioned prevention efforts in the areas of mental illness, substance abuse, and sexual assault, sometimes coordinated with FAP, which could have downstream effects on child abuse and neglect and domestic abuse prevention. The chaplaincy's premarital and marital counseling services were seen as an important prevention effort across all service branches. A Marine victim advocate said that "the chaplains also host marriage retreats where I believe they discuss domestic violence and family violence," and an Army clinician mentioned marriage, family, and single-parent retreats that are hosted by the Chaplain Corps. However, many FAP service providers had trouble bringing to mind any other agencies involved in child abuse and neglect and domestic abuse prevention. Several Air Force service providers pointed to violence-prevention coordinators, who work to prevent all forms of other- and self-directed violence and offer a variety of prevention briefings on their installation.

Although not intended as primary violence prevention services, FAP providers saw their value. A Marine Corps prevention and education specialist mentioned a stress-resilience program for families and the availability of Military Family Life Counseling, and a Marine victim advocate noted that "the child development center does a big information fair each August for child abuse awareness month that we partner with." A Navy clinical counselor mentioned that their child development center offers "date nights" for parents of young children and family readiness groups. A Navy area coordinator mentioned that the Morale, Welfare, and Recreation program offers positive family events designed to build strong families, which could in turn prevent violence.

Proportion of Family Advocacy Program Cases That Are Referred to Additional Services On or Off Installation

To understand how often additional resources are used to provide comprehensive care to child abuse and neglect and domestic abuse cases, the installation FAP office survey requested information about the proportion of cases that were referred to on- and off-installation providers

Table 4.5
Referrals to Other Support Services in Past 12 Months

Service	Percentage of Cases Referred to Service *on* Installation	Percentage of Cases Referred to Service *off* Installation	Total Percentage of Cases Referred to Service on or off Installation
Counseling	37% (26%, 48%)	20% (12%, 29%)	57% (46%, 68%)
Legal assistance	24% (15%, 32%)	11% (5%, 18%)	33% (23%, 43%)
Mental health treatment	18% (11%, 25%)	7% (3%, 10%)	23% (15%, 31%)
Financial support	9% (5%, 14%)	6% (0%, 11%)	14% (8%, 20%)
Alcohol abuse treatment	10% (7%, 13%)	2% (1%, 4%)	11% (8%, 15%)
Emergency housing	3% (0%, 5%)	5% (1%, 10%)	8% (3%, 13%)
Drug abuse treatment	3% (0%, 5%)	1% (0%, 1%)	3% (1%, 6%)

NOTE: Data cells contain the mean percentages across installations, followed by the 95% confidence interval in parentheses. Percentages represented in columns 3 and 4 were calculated based on estimated referral frequencies provided directly in the survey. Percentages represented in column 2 were subsequently inferred based on this information. Missing responses on these items may have been used by some respondents as shorthand for a response of zero referrals, suggesting that the actual mean percentages of cases referred may be lower. *N* = 39–49.

(Table 4.5). According to survey respondents, the most common referral was for counseling (37 percent of cases were referred on installation, 20 percent referred off installation). One-third of cases or fewer received referrals for legal assistance, mental health treatment, alcohol or drug abuse treatment, financial support, or emergency housing. In most cases, a higher percentage received referrals are to services *on* the installation than *off* the installation. However, for emergency housing, 3 percent of cases were referred to a service on the installation, while 5 percent were referred to a service off the installation.

Form and Quality of Coordination Between Family Advocacy Program and Other Services on Installation

Using installation FAP office survey data, we examined the frequency of interaction between FAP staff members and behavioral health providers who work outside FAP (but on the same installation) and present the results in Table 4.6. We examined both formal meetings (e.g., to discuss specific cases or strategize on outreach and resource allocation) and informal, as-needed discussions. FAP office directors most commonly reported weekly communication between FAP staff members and behavioral health providers. However, while nearly three-fourths of the directors who responded to the survey (73 percent) reported weekly informal discussions between FAP staff members and behavioral health providers, less than half (42 percent) indicated formal weekly meetings between the two parties.

Table 4.6
Frequency of Interaction with Behavioral Health Providers

Type of Interaction	Never	Annually	Semiannually	Quarterly	Monthly	Weekly
Informal discussions	3% (0%, 7%)	1% (0%, 3%)	1% (0%, 3%)	3% (0%, 7%)	18% (9%, 27%)	**73% (62%, 84%)**
Formal meetings	23% (12%, 32%)	1% (0%, 3%)	1% (0%, 3%)	9% (2%, 16%)	24% (14%, 34%)	**42% (30%, 54%)**

NOTE: Data cells contain the percentages of installations indicating each response for each interaction type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 67.

Table 4.7
Issues in Coordination Between FAP and Behavioral Health Services

	Rating as Problem				
Issue	Not At All	Small Extent	Moderate Extent	Large Extent	Very Large Extent
Other service providers' understanding of FAP concerns	22% (12%, 32%)	22% (12%, 32%)	**28% (17%, 39%)**	14% (5%, 23%)	14% (5%, 23%)
Coordination on treatment of cases	**47% (35%, 59%)**	27% (16%, 38%)	14% (5%, 23%)	11% (3%, 19%)	2% (0%, 5%)
Frequency of communication	**46% (34%, 58%)**	24% (13%, 35%)	16% (7%, 25%)	14% (5%, 23%)	0% (0%, 0%)
Coordination on allocation of resources/staffing across FAP and behavioral health outside FAP	**43% (31%, 55%)**	17% (8%, 26%)	21% (11%, 31%)	11% (3%, 19%)	8% (1%, 15%)
Coordination on outreach/ education efforts	**36% (24%, 48%)**	31% (20%, 42%)	23% (13%, 33%)	5% (0%, 10%)	5% (0%, 10%)

NOTE: Data cells contain the percentages of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 63–64.

The survey also included items to help assess perception of coordination challenges. The respondents to the FAP office director survey indicated the extent to which each coordination issue on a list was a problem for their office (Table 4.7). There was considerable variability in the extent to which respondents perceived "other service providers' understanding of FAP concerns" as a problem. Some saw this as not a problem (22 percent); others saw it as a very large problem (14 percent). The most frequent response was that it was "moderate problem" (28 percent). Many providers rated other coordination challenges as "not at all" a problem. Still, over half identified coordination on treatment cases, frequency of communication, and coordination on allocation of resources and staffing to be a "small" to "very large" problem.

To add context, we also asked FAP service providers in interviews about coordination with other services on their installation, the ease of access, and their perception of how well the coordination process works overall. Their responses were largely consistent with those of the FAP office directors; most reported that coordination "works well" (Marine Corps, clinical case manager), and this was true across service branches. It was rare for providers to indicate that they had a formal referral process, though some noted that there were online forms to

document the referral. Most commonly, they described informal processes such as a phone call to the installation service or a warm handoff, during which the FAP provider walked the client to the installation service office to schedule the intake appointment.

An Air Force counselor explained: "We do not have formal protocols; you can always just walk into an office or pick up a phone, but we do document referrals." A Marine Corps clinician echoed: "There is no formal coordination protocols; we will usually just pick up the phone or walk a client over for a warm handoff." Providers who were located in the same building as other social services (e.g., Navy Fleet and Family Support, some Army providers) often commented that being colocated made referrals particularly simple. A Navy victim advocate commented that referrals are "very easy. Usually I walk them down or go up a floor." Providers saw the process as simple and effective, noting that it rarely took more than a week for a client to receive an intake appointment.

The one consistent exception was for behavioral health services. Some FAP providers noted that it can be challenging for clients to receive regular mental health sessions. For example, a Navy counseling and advocacy supervisor explained:

> As far as mental health services that are available, that gets tough. I have one other counselor right now. We make it our mission that if there is an FAP client that needs an appointment, they get an appointment even if we have to refer them out. We can either see them in-house or at the behavioral health clinic [nearby]. The reason that it's tough is that they also have limited providers, and there are new TRICARE rules that say that all active duty service members have to get mental health services at the clinic. Clinics can't refer out to the community, because TRICARE won't pay, so they are really backed up. They have a full schedule. She is scheduling clients every other week, so folks are not getting intensive treatment over there when sometimes they need it. TRICARE rules and staffing shortage create problems in terms of providing care.

Psychiatric services, and particularly child psychiatric care, was mentioned as particularly challenging to arrange. A Navy Clinician explained:

> To see a psychiatrist, they can even wait two months. [There is] great demand for medication providers. [It is] hard to find child counselors out in the community. Parents have a hard time finding anyone that can take a child. Also, [there is] a long wait for psychiatric assessments out in the community, and we don't have anyone on base that could do a full psychiatric assessment for a child.

Finally, a Marine Corps clinician mentioned, "There is a significant waiting list for a substance abuse program—one to two months before someone can get services there."

Conclusions

In this chapter, we presented our findings related to (1) perceived correlates of child abuse and neglect and domestic abuse and (2) the availability of, referral to, and coordination with other support services. FAP office directors reported that most domestic violence cases are related to communication skills and anger management issues, while most child abuse/neglect cases are associated with lack of parenting skills or understanding of child development, or anger management issues. Mental health treatment was the most available behavioral health service

offered; average days of operation for behavioral health services ranged from 4.1 to 4.9 days per week. The FAP offices most commonly referred cases for counseling and legal assistance, and were more likely to refer cases to on-installation services than those available off installation. Office directors most commonly reported weekly communication, either formal or informal, between FAP staff members and behavioral health providers. Some clinicians mentioned challenges arranging for client access to behavioral health care, and the most pressing barrier to coordinating between FAP and behavioral health services was other providers' understanding of FAP concerns.

CHAPTER FIVE

Family Violence Services Available in the Community Surrounding Military Installations

In addition to family advocacy services provided by FAP and other DoD service providers, we also examined the availability of family advocacy services offered in the communities surrounding installations. In this chapter, we describe findings regarding the availability of such civilian services, formal agreements between FAP and civilian agencies, FAP satisfaction with the quality of and coordination with civilian agencies, and perceived reasons why families may seek services in the community rather than on installation.

Family Violence Services in the Surrounding Civilian Community

As part of the installation survey, FAP offices provided a list of nonmilitary, community organizations that offer and child abuse/neglect services near their installation. For each listed agency, they checked whether they have a formal agreement with the organization, the types of cases the community organization serves (domestic violence and/or child abuse/neglect), and the types of services offered by the organization (e.g., victim advocacy, emergency shelter). Ninety-six percent of installations listed at least one agency, with an average of 4.2 agencies listed per installation (95 percent confidence interval = [3.3, 5.0]; $N = 69$).

As shown in Table 5.1, 94 percent of installations listed at least one agency that addresses cases, and 61 percent of installations had a formal agreement with at least one such agency. Similarly, 92 percent of installations listed at least one community agency that addresses child abuse/neglect cases, and 75 percent of installations had a formal agreement with at least one such agency.

Table 5.1
Civilian Social Services Agencies, by Case Type

Type of Case Associated with Service	Percentage of Installations Listing Agency	Percentage of Installations with Formal Agreement
Domestic violence	94% (88%, 100%)	61% (49%, 72%)
Child abuse/neglect	92% (86%, 99%)	75% (64%, 85%)

NOTE: The second column contains the percentages of installations that listed at least one agency, for each type of case, out of the 66 FAP offices that listed any agency. The third column contains the percentages of installations that indicated a formal agreement with at least one agency, for each type of case, out of the 66 FAP offices that listed any agency. Each data cell contains 95% confidence intervals in parentheses.

In the second column of Table 5.2, we provide the frequency with which installations listed community family violence agencies that provide different types of services. The service types listed by the greatest percentage of installations were emergency shelter (91 percent) and victim advocacy (89 percent), followed by legal advocacy (76 percent), mental health treatment (67 percent), housing assistance (65 percent), offenders' intervention (56 percent), financial assistance (53 percent), and substance abuse treatment (45 percent). Although only 53 percent of installations listed a domestic violence or child abuse/neglect agency that provides financial assistance, in a separate question, 84 percent of installations indicated that there are civilian services (either family-violence-focused or not) addressing current financial stress issues, to which they would refer families as needed (95 percent confidence interval = [75 percent, 93 percent]; $N = 68$).

For each civilian agency listed, FAP offices indicated whether a formal agreement existed with that agency. Out of the 66 offices listing at least one agency, 79 percent indicated that they had a formal agreement with at least one agency (95 percent confidence interval = [69 percent, 89 percent]). In the third column of Table 5.2, we provide the frequency with which installations listed at least one agency with which they have a formal agreement, for each service type. Across service types, typically more than half of installations listing at least one agency of a given service type (column 1) also indicated having a formal agreement with at least one agency of that service type (column 2).

Table 5.2
Civilian Social Services Agencies, by Service Type

Type of Service	Percentage of Installations Listing a Community Agency Providing the Service	Percentage of Installations with a Formal Agreement with a Community Agency Providing the Service
Emergency shelter	91% (84%, 98%)	58% (46%, 69%)
Victim advocacy	89% (82%, 97%)	62% (50%, 74%)
Legal advocacy	76% (65%, 86%)	38% (26%, 50%)
Mental health treatment	67% (55%, 78%)	33% (22%, 45%)
Housing assistance	65% (54%, 77%)	38% (26%, 50%)
Batterers' intervention	56% (44%, 68%)	30% (19%, 41%)
Financial assistance	53% (41%, 65%)	27% (17%, 38%)
Substance abuse treatment	45% (33%, 57%)	21% (11%, 31%)

NOTE: The second column contains the percentages of installations that listed at least one agency, for each type of service, out of the 66 FAP offices that listed any agency. The third column contains the percentages of installations that indicated a formal agreement with at least one agency, for each type of service, out of the 66 FAP offices that listed any agency. 95% confidence intervals are shown in parentheses.

During our interviews, we also asked FAP service providers about whether their installations had formal protocols for coordination with civilian services, and their responses suggested potential variation in what providers perceive as constituting a "formal agreement" or "formal protocol." Most providers responded that there are not formal protocols, with some going on to describe common coordination procedures or an MOU with some agencies. When describing typical processes for referrals to civilian services, some providers mentioned referral sheets that they can submit online to allow clients to be covered by insurance when receiving services from a civilian provider that accepts TRICARE. A Navy victim advocate described the handoff process, saying, "We don't have a formal process in place. I do a warm handoff. I normally call before I refer someone to establish that they have capacity and to establish a warm handoff." Others described sometimes making a call and sometimes providing the client with "the list of services available" (Army clinical worker). A Navy clinician observed that service members can "utilize Military OneSource or the Military and Family Life Counseling Program to locate services in the community."

Many providers specifically referenced processes for handling the release of client information from civilian services to FAP staff. A Marine Corps FAP clinician noted that they "always ask the service member to sign a release of information so that [the clinician] can get some follow-up on their treatment from the civilian provider." Similarly, an Army social worker described requiring a signed release so that they "can get updated info and provide updates to the review board, in cases of mandated treatment." However, an Army behavioral health chief described difficulty in receiving information from civilian services, saying:

> One issue that does come up is that the civilian providers do not want to share any information with me. Even in cases where I have a signed release, they will simply refuse. This impacts my ability to do follow-up and wraparound care.

In contrast to these comments in support of releasing client information to FAP, one Army clinical worker noted that they personally "don't ask [clients] to sign a release or anything so that they feel comfortable that we [at FAP] are not involved." This variation may reflect differences in case management for mandated service members relative to those who are self-referred or voluntary.

When providers mentioned having an MOU with any civilian service, they typically named one to two such services. CPS was named frequently, and other named services included county therapists, courts, local domestic violence agencies, and hospitals or medical clinics. Given that FAP is legally mandated to report child abuse cases to CPS (but not vice versa), it is expected that there would be particularly strong ties with this agency.

Family Advocacy Program Satisfaction with the Quality of and Coordination with Civilian Agencies

The installation survey asked about FAP satisfaction with civilian family violence–related services on the following dimensions: quality, accessibility, overall interactions, waiting time, and coordination with FAP on cases. As shown in Tables 5.3 and 5.4, a plurality of offices were satisfied with each dimension, and satisfaction ratings were similar for domestic violence and child abuse/neglect services.

Table 5.3
FAP Satisfaction with Civilian Family Violence–Related Domestic Violence Services

	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
Quality/effectiveness of these services	4% (0%, 9%)	2% (0%, 6%)	24% (13%, 35%)	**55% (42%, 68%)**	16% (6%, 26%)
Convenience or accessibility for service members and their families	8% (1%, 15%)	8% (1%, 15%)	17% (7%, 27%)	**49% (36%, 62%)**	17% (7%, 27%)
Overall interactions with FAP	5% (0%, 11%)	10% (2%, 18%)	29% (17%, 41%)	**45% (32%, 58%)**	10% (2%, 18%)
Waiting time for services	4% (0%, 9%)	11% (3%, 19%)	35% (23%, 47%)	**42% (29%, 55%)**	9% (2%, 16%)
Coordination with FAP on cases referred to them by FAP	9% (2%, 16%)	12% (4%, 20%)	34% (22%, 46%)	**36% (24%, 48%)**	9% (2%, 16%)

NOTE: Data cells contain the percentages of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 55–59.

Table 5.4
FAP Satisfaction with Civilian Family Violence–Related Child Abuse or Neglect Services

	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
Quality/effectiveness of these services	5% (0%, 11%)	9% (2%, 16%)	29% (17%, 41%)	**41% (28%, 54%)**	16% (7%, 25%)
Convenience or accessibility for service members and their families	8% (1%, 15%)	14% (5%, 23%)	12% (4%, 20%)	**46% (33%, 59%)**	20% (10%, 30%)
Overall interactions with FAP	3% (0%, 7%)	14% (5%, 23%)	31% (19%, 43%)	**39% (27%, 51%)**	14% (5%, 23%)
Waiting time for services	7% (0%, 14%)	16% (6%, 26%)	23% (12%, 34%)	**41% (28%, 54%)**	12% (3%, 21%)
Coordination with FAP on cases referred to them by FAP	2% (0%, 6%)	22% (11%, 33%)	22% (11%, 33%)	**37% (25%, 49%)**	17% (7%, 27%)
Notification of FAP of cases involving service members that originate with these providers	10% (2%, 18%)	21% (11%, 31%)	22% (11%, 33%)	**31% (19%, 43%)**	16% (7%, 25%)

NOTE: Data cells contain the percentages of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 55–59.

The results of our qualitative research added to these survey data by highlighting the value of successful coordination between FAP and civilian services. For example, our interviews with service-level FAP leadership highlighted that civilian and FAP services are not intended to duplicate one another. Some service-level FAP leaders noted that smaller installations tend to work more closely with civilian services in order to complement FAP programming, whereas larger installations may be able to offer more comprehensive services in-house.

Previous qualitative research found evidence that some civilian social service providers may assume that military services are already providing for the needs of military families, and thus may not conduct outreach to this population (CFRP, 2016).

Paralleling the survey findings in Tables 5.4 and 5.5, when we asked FAP services providers during the interviews to comment on coordination with civilian providers and what might improve it, most providers commented that it was generally working well. One Marine Corps victim advocate described collaborating on "toy drives for the local domestic violence safe house" and holding "joint events." Nonetheless, many providers mentioned potential areas of improvement in relationships with civilian services. Such providers referenced topics such as information sharing, directness of interaction, and staff continuity. With respect to information sharing, one Army social worker described wanting to make "sure communication goes both ways—receiving referrals from the community as well [as providing referrals to the community]." Some service-level FAP leadership commented that it would be preferable not only for FAP to be required to report child abuse and neglect cases to CPS, but also for CPS to be required to report to FAP cases that involve military families. An Army behavioral health chief echoed these concerns:

> One thing that doesn't work well is the sharing of information between agencies. I have a terrible time getting information from civilian providers, even [CPS]. I try to get [CPS] to come to the post and work with our [child development center], but they refuse to come. We even had trouble getting [an MOU] with the local [CPS]. They claimed that they see the military as an employer, and they have a policy of not sharing any information with employers.

Describing the indirectness of interaction with civilian services, a Marine Corps victim advocate stated, "We also do not have [an MOU] in place with the local police, which I think should be improved. Right now the local police must go through [the Naval Criminal Investigative Service] or command, and cannot come directly to us." A Marine Corps victim advocate elaborated on this point:

> I think in general it works well, especially with child abuse and neglect cases. The only thing that would improve it is the fact that we do not have a close relationship with local law enforcement. We use [the Criminal Investigation Command] or in extreme cases [the Naval Criminal Investigative Service], and the local law enforcement rarely interacts with us but prefers to go through the [Provost Marshal's Office].

Several providers commented on staff continuity as an issue for coordination between FAP and civilian services. For example, an Air Force FAP officer commented that "if we could have people stay in liaison positions that would help. We have had a ton of turnover in those positions."

One Air Force FAP manager at an installation outside the United States described more severe issues related to coordination with civilian services, saying, "There are no child protective services here, and we do not have a working relationship with the [local] police. So it can be a real problem for emergency situations. We often have no way to pull a child from an abusive home."

Perceived Preferences for Military or Civilian Services

Most providers whom we interviewed commented that it is uncommon for potential clients to seek out civilian services, due to factors such as the value of FAP's understanding of military culture and the cost of some off-base services. A Navy clinician commented:

> I think by and large clients are comfortable using FAP services. The majority of the time people are comfortable coming here. Active duty prefers coming here, because we understand military lifestyle, culture, and command structure. Also, we are easily accessible during the work day (command gives them time off to use our services).

With respect to cost, a Navy clinical counselor commented, "We don't do copayments here, but if they go out to a civilian they may have to pay a copay, or some providers won't take TRICARE so they may have to pay a fee to see a provider like a psychiatrist." Another Navy clinician referred specifically to domestic violence services, saying that a client "would have to pay for group counseling in the community, so they prefer to get services on base. A domestic violence group in the community is $25/session and it's 20 to 25 sessions, so it adds up." However, other providers mentioned civilian services for victims that cost nothing, such as "counseling services available that are run by the local domestic violence crisis center that are free, [with] no need to use TRICARE" (Navy victim advocate). Only a small number of providers described the majority of clients as being interested in civilian services.

We also asked FAP staff for their perceptions of why some military families do choose civilian services. In the installation FAP office survey, FAP offices indicated their perception of the overall importance of each of a set of factors in the decision of service members and families to use civilian social services (whether on their own or after first coming to FAP). As shown in Table 5.5, a majority of offices rated avoidance of reporting an incident to the military (66 percent) and privacy concerns (63 percent) as very important factors. Offices tended to rate convenience as slightly important (43 percent), and the following factors as not at all important: FAP being unable to meet demand (53 percent), FAP not providing the service (48 percent), and clients preferring a counselor of a preferred gender (48 percent).

FAP service providers perceived avoidance of reporting to military authorities, privacy, and convenience as the motivating factors for service members to seek civilian services. The providers also mentioned service offerings as a factor. Describing the preference to avoid reporting to military authorities, a Navy clinical counselor described a service member who was "willing to pay out of pocket because he didn't want [psychiatric services] on his service record." The counselor went on to state, "We are a joint base, we deal with pilots and people that are high ranking, so a lot of times they don't want different things on their record."

Discussing privacy considerations, a Navy victim advocate described seeking services in the community as "more private; there aren't a million eyes on you like on the base," and noted that they always provide community referrals as an option to potential clients. An Air Force treatment manager echoed this point, saying:

> If someone is receiving services off the base, they are concerned about providers reporting things back to command. There is much more privacy. I think the main reason would be so that they can get help without their command finding out about it. . . . There is also the issue of stigma, if they can get services off base they do not have to face their fellow service members with the stigma of needed help or having lost control.

Table 5.5
Perceived Importance of Factors in Use of Civilian Social Services

Factor	Not at All Important	Slightly Important	Moderately Important	Very Important
Clients hope to avoid reporting to military authorities or legal system by going outside the installation	6% (0%, 12%)	11% (3%, 19%)	16% (7%, 25%)	**66% (54%, 78%)**
Clients prefer providers not associated with the military to ensure their privacy	5% (0%, 10%)	15% (6%, 24%)	18% (8%, 28%)	**63% (51%, 75%)**
Clients prefer providers outside this installation because it is more convenient	26% (15%, 37%)	**43% (31%, 55%)**	20% (10%, 30%)	11% (3%, 19%)
FAP/installation provides the needed service(s) but is unable to meet the demand	**53% (40%, 66%)**	20% (10%, 30%)	17% (7%, 27%)	12% (4%, 20%)
FAP/installation does not provide the needed service(s)	**48% (35%, 61%)**	20% (10%, 30%)	13% (4%, 22%)	18% (8%, 28%)
Clients prefer a counselor of a preferred gender	**48% (35%, 61%)**	46% (33%, 59%)	3% (0%, 7%)	3% (0%, 7%)

NOTE: The data cells contain the percentages of installations selecting each response option, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item is indicated in bold. *N* = 60–62.

Providers raised scheduling and transportation as aspects of convenience that might lead individuals to seek civilian services. A number of providers noted that civilian services may offer evening or weekend availability. One Marine Corps FAP clinician observed, "I think time can be a factor. We are strictly 7:30 to 4:30, so if the civilian spouse has a day job and they need to get resources in the evenings or on weekends, they have to go out to the community." Several providers described having had discussion about possible changes to timing of service availability to accommodate schedules, such as "opening on a Saturday so that couples that can't come during the week can come here so that they don't have to go to civilian provider" (Navy clinical counselor). A Marine Corps clinical case manager raised a counterpoint, noting that there have been "some conversation about offering two evenings in which they do office hours, but the reality is that a lot of times when people say they need evenings, they end up not showing up. The attendance at Tuesday evening hours is not great. We've tried offering groups and classes on Tuesday evening, with not great attendance." Some providers raised transportation as a barrier to seeking services on the installation, depending on where an individual lives and the transportation options available. An Army social worker commented that "for people that live 30 minutes away, it's more convenient for them to go somewhere near their home." Other providers described lack of public transportation to get from the surrounding community to their installation.

Providers or service-level FAP leadership mentioned that the type of services individuals might seek in the community due to their unavailability on base included victim support groups, restraining order support, "play therapy" for children, a men's group in the community that "resonated well with service members," and services for specific case types (e.g., child sexual abuse cases). Additionally, several providers described cases in which a FAP client was already seeing a counselor in the community, and continued with this civilian service while working with FAP.

When asked about subgroups that seem more likely to have an interest in civilian services, providers mentioned families that live off the base, high-ranking officers, individuals not under active orders, and individuals at recruiting stations. Providers' discussion of families that live off the base were typically linked to the transportation barriers described previously.

Many providers noted that high-ranking officers may be concerned about being seen by junior service members if they are seeking services on the installation. A Navy counseling and advocacy supervisor commented:

> We have tried to provide voluntary groups on base, and we get zero attendance. I'm told that because this is a higher-ranking base, the higher ranks will not show up to a group where a lower-rank service member will be. They prefer to go to something in the community where they are anonymous and less likely to run into someone they know.

For similar privacy concerns, one Navy victim advocate also raised male victims as a group that may be more likely to seek services in the community "due to the stigma of admitting that they are victims."

When queried about individuals not under active orders, providers across service branches typically stated that the Reserve component cannot receive services at FAP unless they are activated. They observed that nonactivated Reserves and National Guard, as well as retirees, must turn to civilian services. One Army social worker linked the exclusion of non-active-duty individuals to "eligibility and insurance." Another Army social worker linked the exclusion of retirees to the lack of "a command that we can work with," and went on to say that if retirees "are in family medicine and report an incident of domestic violence, we can triage that, but we refer them to civilian sector." A small number of providers described informal ways of serving non-active-duty individuals. A Navy clinical counselor described treating retirees or guard and reserve on a space-available basis, saying, "If they are not activated we are not allowed to see them, but in truth, some of us have seen them." A Marine Corps clinical counselor noted, "We do offer services to retirees, or Reserve or Guard. We wouldn't turn them away (although we don't have any)." Finally, an Army social worker stated, "Anybody coming to the hospital, if medical reaches out to us, we go, and we assist."

Some providers also mentioned families at recruiting stations as likely to seek civilian services. An Army behavioral health chief observed, "We are responsible for the recruiters and have a large catchment area, so we have a lot of service members in isolated areas that are not likely to come back to the post to obtain services." Echoing this point, a Marine victim advocate commented:

> I'd say families living in recruiting stations are the most likely subgroup [to seek civilian services]. Most of them are out in the middle of nowhere, and there is a lot of pressure on the spouse when they are that isolated. We do not get nearly as many domestic violence referrals from those families as I would expect, so I hope they are getting the help they need in the community.

When asked if there are any resources in the civilian community that clients would like to access but cannot, most providers commented that this issue has not come up. Several providers noted barriers, such as insurance and transportation, however. An Air Force treatment manager commented that certain providers are not TRICARE eligible, such as those that offer programming to address "teen male sexual offenders" or "sexual pornography," and that this

issue is "getting to be a big problem—we need to figure out resources for that." Additionally, an Army FAP chief commented that driving to and from civilian services can be costly for young service members. A Navy clinical counselor similarly observed, "Sometimes we can free a vehicle from the pool to have someone taken for [civilian] services, but then another service member knows that they are going, which may be a deterrent."

Perspective of Civilian Community Agencies

Our interviews with domestic violence state coalition leaders in Hawaii, Kansas, Kentucky, North Carolina, Texas, Guam, and Virginia provided a high-level but limited perspective on how civilian child abuse and neglect and domestic abuse agencies view their relationships with the local installation FAP office and other military contacts. These states were selected based on large military presence.

The state coalition leaders' perspectives on coordination with military installations were similar to the perspectives we heard from FAP service providers. They indicated that MOUs were variable across agencies, but also noted that the most critical thing was positive professional relationships between military and civilian staff regardless of whether the relationship was supported by a formal agreement or not. They believed that MOUs worked best when there is a clear understanding of confidentiality and reporting so that each agency (civilian or military) understands the philosophy and requirements of the other. For example, they noted that military providers sometimes "pressure" civilian domestic violence programs to report back on case referrals.

It appeared to us that this may be indicative of a fundamental misunderstanding between FAP and civilian agencies, with FAP providers frustrated that they are unable to access the necessary information to document whether or not an offender is fulfilling the requirements of his or her treatment plan, and civilian providers frustrated that FAP would ask them to violate confidentiality requirements under the Violence Against Women Act and the Family Violence Prevention and Services Act. As described previously, some FAP providers noted that signed releases from the client sometimes, but not always, resolved the conflict. Several coalition leaders also reported ongoing problems with jurisdictional concerns, including for law enforcement investigations and enforcement of orders of protection. Finally, coalition leaders perceived high staff turnover in FAP offices and noted that knowledge about local civilian providers and agencies is not always passed on to replacement staff members, making coordination an ongoing and difficult challenge.

State coalition leaders' perspectives on why some military members seek out civilian agencies for family violence services were also largely consistent with FAP service provider perspectives. Coalition leaders noted that some military members seek out civilian services even when comprehensive military services are available. They believed that the most common reason for clients to select civilian resources was because they did not want the military, and in particular command, to know about the abuse. They suggested that service members may not understand what information can be shared confidentially with FAP. Some coalition leaders believed that victims may fear getting their spouse or partner in trouble with command, and noted that this may be particularly true for victims who are economically dependent on their offender. Coalition leaders were aware of the financial assistance that is available to military-affiliated victims who are fleeing abuse, but stated that many victims were not aware of this available

support. They also described transportation issues that may make it challenging for families that live in the community to access support services located on installation.

Some state coalition leaders described negative perceptions about the FAP program that FAP service providers did not mention in their interviews. They suggested that families may be unlikely to share these perspectives with FAP, but they will divulge them to community services. For example, they noted that clients who seek out civilian services describe FAP victim advocacy and related services as low quality. They described a misperception among military victims that they are not allowed to access FAP services until they are ready to end their relationship with the offender. Finally, some leaders noted that military clients are concerned that they may know FAP staff members (particularly on small installations), or that FAP staff may know them or their family members socially.

Finally, some coalition leaders told us that offender intervention programs were an area of concern. They believed that both military and civilian offender intervention programs are falling short in addressing abuse in safe and effective ways. They pointed to the use of anger management and couples counseling approaches in military settings as out of alignment with their perception of best practices, and also described civilian programs as falling short in their capacity to handle specific challenges facing service members, including posttraumatic stress disorder (PTSD) and traumatic brain injury. One coalition leader commented that offenders and victims would be better served if programs were built on the expertise of both sectors.

Conclusions

We found evidence that the majority of FAP offices know of available civilian social services for both domestic violence cases and child abuse/neglect cases, but that availability or knowledge varies by the type of service. Notably, when a given service type was not listed by an installation as available in the surrounding community, we do not know whether it is because the service is unavailable in the community or because the FAP office is unaware of agencies offering the service. FAP offices that completed a survey were particularly likely to list civilian victim advocacy and emergency shelter services, relative to other service types. Among installations that offered a particular type of service, typically more than half had a formal agreement with an agency offering that service type.

Even though civilian social services were available for many installations and sometimes even formally coordinated with FAP, the FAP offices typically indicated feeling only neutral or satisfied with these services and their coordination with FAP. When asked why some clients use civilian resources, the reasons that were reported as most important by FAP respondents were that the client wished to ensure their own privacy, and the client wished to avoid reporting to military authorities or the military legal system. This perception was shared by both the FAP providers and the providers in the civilian community.

Our interviews with state coalition leaders provided a unique perspective that largely corroborated the perspective of FAP service providers. They also perceived challenges in coordinating military and civilian resources and saw the value of professional relationships. Coalition leaders noted that military members may seek out civilian services, not out of scarcity of services in the military system, but instead when they are motivated to protect their privacy. Coalition leaders saw relative strengths and weaknesses across the two systems and pointed to strong collaborative relationships as an opportunity to improve services.

CHAPTER SIX

Conclusions and Recommendations

The information drawn from our conversations with FAP service leaders and installation survey results, and discussed in earlier chapters, can be combined to provide an overarching map of the process by which families access FAP or other family advocacy services. In addition, they help provide information about how family members are then referred out for additional support services as needed. In this final chapter we present a system map of FAP services and offer a series of recommendations for improving FAP—recommendations that are drawn from the experiences of FAP directors and service providers that deliver family advocacy services to military families.

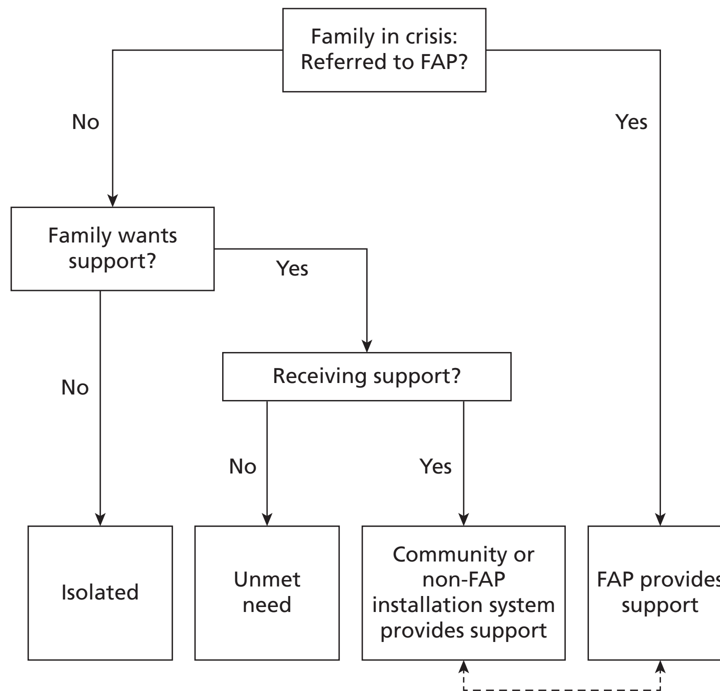
System Map of Family Advocacy Program Services

FAP is tasked with providing both preventative services for the entire active duty population and indicated response services for military-affiliated perpetrators and victims of child abuse and neglect or domestic abuse. Preventative services such as the New Parent Support Program (NPSP), couples counseling, briefings, and other outreach activities are offered before abuse occurs and are often designed to reduce or eliminate risk factors for child abuse and neglect and domestic abuse. For example, NPSP is designed to reduce the stress of transitioning to parenthood by providing education and psychosocial support.

Despite their best efforts, these prevention activities are not perfectly effective, and some military families will experience child abuse and neglect and domestic abuse each year. The CDC estimated that 41,000 military-affiliated women were physically assaulted, raped, or stalked by an intimate partner in the year 2010 (Black and Merrick, 2013). In addition, military family advocacy services are available to other military-affiliated women and men not included in the CDC estimate, including victims of psychological abuse and unmarried romantic or sexual partners who share a residence or child. Many of these eligible cases will not be referred to FAP. Barriers to seeking help, discussed in previous chapters, may prevent many families in crisis from obtaining services. For example, in FY 2010, DoD identified only 8,206 unique victims who met criteria as an incident of domestic abuse.

Figure 6.1 illustrates the transitions these families face. All perpetrators and victims of child abuse and neglect and domestic abuse who are referred to FAP (by self, authority, or service provider), regardless of whether they are confirmed to have committed or experienced DoD-defined abuse or neglect, are offered FAP services. Not all perpetrators and victims choose to engage with those services, but all are provided the opportunity. For families experiencing violence who are not referred to FAP, the arrow to the left of the top box depicts their

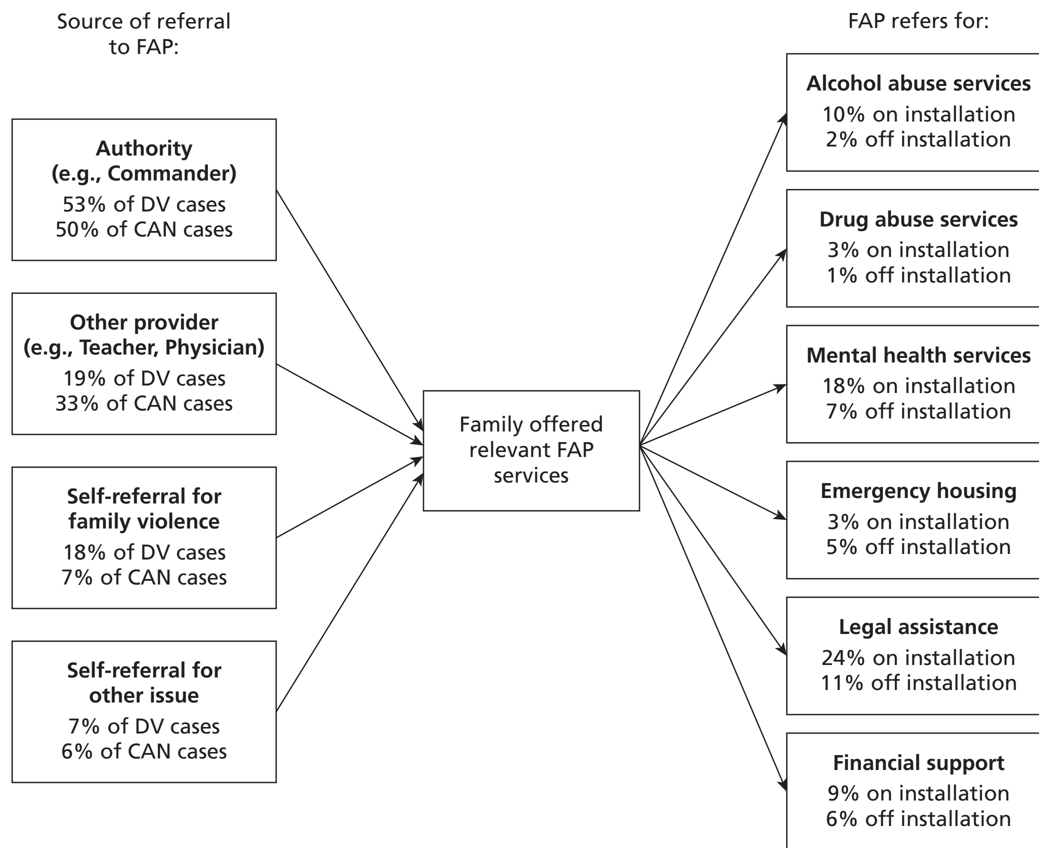
Figure 6.1
Military Families in Crisis



path. Some of these families may not want any support or services, and they remain isolated from care. Given their isolation, it is difficult for DoD to estimate their needs or even the size of the population. Universal prevention efforts are one of the few ways to access this group (e.g., screening in medical facilities). Some of the families who do not come to the attention of FAP may want and seek non-FAP services in the civilian community or on installation (e.g., chaplain support). Of these families who are seeking support, some have not been able to access it (e.g., due to transportation barriers, costs, victims who are isolated/monitored by their perpetrator). This group, along with the isolated group, represents unmet needs. Other perpetrators and victims successfully access non-FAP services, depicted as the group for which the community system is providing support. The dashed line between FAP support and other military/community support reflects the collaboration between these systems; some families may receive services through both support systems.

For families who are referred to FAP for services, Figure 6.2 depicts how they reach FAP and how they are directed out to the greater military and civilian community for adjunctive support. FAP office director survey respondents indicated that about half of FAP cases arrive via a referral from an authority such as military law enforcement or the perpetrator's commander. One-fifth of domestic violence cases and one-third of child abuse/neglect cases are referrals to FAP from service providers such as physicians, counselors, or teachers. Self-referral is less common. Once FAP is aware of a military-affiliated family experiencing violence, staff members reach out to the family to offer support, recommendations, and referrals. The treatment plan may become mandatory for the perpetrator if the case is substantiated to be abuse and the commander requires treatment engagement. Victims and voluntary clients are still welcomed and encouraged to access relevant services.

Figure 6.2
Process of Referral into FAP Services and FAP Referrals to Other Providers for Supporting Services



NOTE: DV = domestic violence, CAN = child abuse and neglect.

Given the multiple risk factors that can lead to incidents of child abuse and neglect or domestic abuse (e.g., substance use, financial stress) and the consequences of child abuse and neglect or domestic abuse (e.g., PTSD, depression, substance use), FAP may not be able to provide all the services the family needs. When a need is better served by other professionals, FAP staff will provide a referral to the appropriate service organization or provider (right column in Figure 6.2).

Recommendations

FAP directors and service providers offered many recommendations to improve FAP services. The six recommendations listed below were mentioned by multiple key informants and often were supported by both survey and interview findings.

Reconsider Staffing Levels

FAP office directors and service providers repeatedly and consistently mentioned staffing shortages as a key barrier to providing comprehensive services. There was variation in their

perception of the causes of the shortages (e.g., lag time for hiring, noncompetitive compensation package), but it was common for providers to indicate that although they are able to meet minimum standards for required response services, additional outreach or prevention services could not be supported. One goal of our interviews was to uncover innovative programming that could be considered for further rollout, but we did not find evidence that offices were able to support proactive, exploratory programming. If DoD would like to expand FAP offerings or increase the emphasis on outreach and child abuse and neglect and domestic abuse prevention, it will be important to first reconsider whether the current staffing allocated (and average percentage of allowed staff roles that are filled) is sufficient to meet current and new requirements. At the time of this report, we understand that an external evaluator is conducting domestic abuse victim advocate staffing model analyses for the organization to determine appropriate staff sizes. Many of the subsequent recommendations may be addressed, at least partially, by a staff size well matched to the breadth of the FAP mission.

Assess Outreach Efforts Across the Portfolio of Problem-Behavior Prevention

FAP staff members pointed to significant growth in DoD efforts to prevent military sexual assault, suicide, and substance abuse. Our informants did not perceive the same level of investment in prevention of child abuse and neglect and domestic abuse and voiced frustration that they were not able to deliver comprehensive outreach and prevention programming. They saw the threat to mission readiness as similar for service members experiencing child abuse and neglect and domestic abuse as it would be for those recovering from military sexual assault (for example). They recommended that DoD consider strategies to provide comprehensive prevention programming applicable to a wide range of problem behaviors (which share some common risk factors) and suggested the need for additional funding and staffing to deliver child abuse and neglect and domestic abuse prevention services to their installation.

Identify Lessons Learned from Installations with Strong Leadership Support and Community Coordination

In our interviews, there was variation in the perception of leadership as engaged, supportive, and critical to FAP success versus other installations where installation leaders were seen as nonsupportive and even as a barrier to an effective response to incidents of child abuse and neglect and domestic abuse. Similarly, some installations had strong, bidirectional relationships with community resources, whereas others had not been able to forge those connections. The variation suggests an opportunity to probe for lessons learned from offices with a strong support network for child abuse and neglect and domestic abuse prevention and response.

Explore Strategies to Reduce Prominent Barriers to Care

Both survey data and provider interviews identified the fear of career harm to military members (and possible subsequent family harm) and loss of privacy as key barriers that prevent families in crisis from seeking FAP support. Many believed that if these barriers could be mitigated, a greater number of perpetrators and victims of child abuse and neglect and domestic abuse would be willing to accept help. One strategy is already in place. FAP is currently able to offer domestic abuse victims who have not disclosed to a mandated reporter (e.g., security forces, a commander) the opportunity to access services via a restricted report, which should protect family privacy and prevent any subsequent career harm. However, unlike in sexual assault reporting, victims rarely take this route, either because the violence has already been

disclosed, because victims prefer the command involvement of unrestricted reports, or possibly because they were unaware of the opportunity. Military service members receive annual training about sexual assault reporting options, which has resulted in a significant increase in the number of restricted reports, whereas service members have less regular access to information about child abuse and neglect and domestic abuse reporting. Other possibilities include initial entry points that can be anonymous, such as online support groups or chat rooms, text-based support, and smartphone apps.

Explore Strategies to Support and Speed Establishment of Memoranda of Understanding with Community Resources

FAP providers noted that MOUs with community resources were challenging and time intensive to secure, typically due to military service delays. Individual installation FAP offices may need support from headquarters or influential supporters to improve the process. Ensuring that MOUs are established and maintained allows the FAP to leverage community resources to substitute for and expand the reach of their available resources. For example, if an MOU is in place with a community batterers' intervention program, open communication allows FAP to document a perpetrator's compliance with mandated treatment. This kind of relationship allows FAP to meet its mandate while also freeing clinician hours to provide services they might not otherwise be resourced to deliver (e.g., indicated treatment for a high-risk family).

Consider the Balance of Prevention and Response

Most respondents to the installation survey reported that the mix of prevention and response services was "about right," but 42 percent believed more attention should be committed to prevention. Similarly, during our interviews with FAP providers, some mentioned that although they believed they were providing sufficient response resources, they wished they had the person hours to improve prevention. They wished FAP could deliver comprehensive outreach and prevention similar to the scope of sexual assault and suicide prevention programming. Others saw opportunities to improve collaboration with offices addressing sexual assault, suicide, harassment and discrimination, and substance misuse to leverage their combined expertise and resources to address shared risk factors or deliver one-stop information services.

Summary

FAP is tasked with a broad mission of preventing and responding to child abuse and neglect and domestic abuse. As in the civilian sector, not all families in crisis will seek out services or otherwise come to the attention of FAP, but those who do are offered comprehensive family advocacy services, typically delivered by FAP, and referrals to supportive services to address co-occurring risk factors for violence and the consequences of violence. Despite this broad mandate, and perceived staffing shortages, FAP service providers were proud of their work and their teams. Based on their collective experience, we offer several recommendations that could help improve the services provided by FAP: reconsider staffing levels, assess DoD outreach efforts across the entire portfolio of problem-behavior prevention, identify lessons learned from installations with strong leadership support and community coordination, explore strategies to reduce prominent barriers to care, explore strategies to maintain MOUs with community resources, and consider possible changes to the current balance between prevention and response.

Family Advocacy Program Service Provider Interview Protocol

Thank you for taking the time to talk with us today. The purpose of this call is to follow up on discussions we have had with FAP representatives so that we can understand your unique perspective as a service provider who works directly with clients. There are no right or wrong answers; we're simply interested in learning more about your day-to-day work to guide our study and help FAP in its work. Your responses will not be used to evaluate individual FAP services at the installation level. Your responses will be kept completely confidential, and your participation is completely voluntary. If I ask a question that makes you uncomfortable, you are free to skip it, and you can stop the interview at any point. Summary information from these interviews may be reported in aggregate in published reports. No identifying information will be included in the report, and no identifiers will be linked to your responses. This is an approved collection cleared under RCS DD-P&R(OT)2662.

Record role (e.g., victim advocate, treatment manger) and years in the role:

1. **Standard FAP services: We've learned about some of the standard services that are offered by FAP across different service branches and installations (e.g., awareness campaigns, newcomer orientation, clinical intervention, victim services).**

   1a. We're interested in learning more about how FAP at your installation goes about implementing these services. How much discretion do your teams have in deciding how to provide these services? How much discretion does each provider have? Are there ways that you customize them to fit your community?

   [PROBE] How is your [program mentioned by FAP] different from what other installations might offer?

   1b. Are there other unique activities on your installation, even outside of FAP, that might be related to preventing intimate-partner violence or child abuse and neglect?

   [PROBE] For example, are there other groups or people who lead their own prevention efforts (independent from FAP)?

   1c. Where are the FAP programs located within your installation? What is located around your program office(s)?

   - Is the waiting room or building shared with other types of services? What other types?

2. FAP access:

2a. TYPE OF CASES: In the work you primarily do, are you mostly providing service to adult clients about intimate-partner violence, or do you also work on cases of child abuse/neglect?

[IF BOTH: Let's talk first about the cases of adult partner violence.]

2b. Can you talk us through the typical path that someone on your installation would take to seek help for this issue?

[PROBE IF NEEDED]

- How do people typically learn about FAP services?
  - How frequently are clients referred to FAP by another program?
  - What might be alternative ways that people learn about FAP services (e.g., neighbors, ministers, teachers, bank employees, etc.)?
- What have clients told you about why they didn't come to FAP earlier?
- Is it typically perpetrators or victims, or both, who contact FAP? Or someone outside the household?
- How do these pathways to FAP differ between families who are mandated to receive services relative to those who seek them out voluntarily?

2c. Thinking of your most recent 10 cases, how many followed a path similar to the one you just described?

2d. When someone didn't take this path, how did they come into FAP? How common is that?

2e. IF PROVIDER WORKS WITH BOTH ADULT AND CHILD CASES: Now moving to the other type of case that you work on (child abuse/neglect), does the pathway to FAP look the same in those cases? How does it differ?

2f. In your mind, what are the most significant barriers that prevent some families from seeking FAP services?

3. Intake/treatment: Can you talk us through the intake and treatment process on your installation, once someone has made contact with FAP?

[PROBE IF NEEDED]

- Can you tell me about the case determination process? Are there steps that are especially challenging?
- Once a family is connected with FAP, what kinds of services would they be offered? Which ones would they be most likely to use?
- Who would be provided services through FAP? How would this decision be made?
- Can you tell me about how long families typically use services, FAP or otherwise? How do the cases close?
- What role would the family have in the filing of a report, notification of commanders, and involvement of law enforcement?

4. **<u>Non-FAP military programs</u>: We've talked a bit about other military programs, outside of FAP services, that target risk factors for intimate-partner violence and child abuse or neglect—programs like parent counseling, financial counseling, and mental health care. I'd like to ask a bit more about these programs.**

    4a. Can you describe a bit more how FAP and these non-FAP services interact or coordinate on your installation?

    [PROBE] In a typical [week/month], how often do you interact with staff from non-FAP services of this sort? In what capacity?

    4b. When you refer a client or family to these services, how easy is it to access them? For example, are there waiting lists? Evening/weekend hours? Formal coordination protocols?

    4c. Do you think it works well overall? Why or why not? What would improve it?

5. **<u>Civilian services</u>: What about coordination with civilian providers of family advocacy or related services?**

    5a. How frequently do potential clients express interest in civilian services? How frequently do potential clients go directly to civilian services, bypassing FAP?

    5b. What, if any, are the potential trade-offs and advantages of going to a civilian provider? Money? Time? Anything else? Do you discuss these with potential clients when they are considering civilian providers? Do they ask about them?

    5c. Are there subgroups that would be more/less likely to have interest in civilian services (e.g., families that are active duty vs. reserve, families living off base, families concerned about stigma, families experiencing violence vs. neglect)?

    [PROBE] Is there anything that your team is doing or considering to meet the needs of those choosing civilian providers? Is this a point for discussion?

    [PROBE] Are there any resources in the civilian community that your clients would like to access but can't? What gets in the way?

    5d. Are there formal protocols for coordination at your installation?

    5e. Do you think it works well overall? Why or why not? What would improve it?

6. **[ENSURE THAT SUFFICIENT TIME REMAINS] <u>FAP strengths and weaknesses:</u>**

    6a. Thinking broadly, what would you say are the main strengths or successes of the [NAME OF SERVICE] FAP programs?

    [PROBE IF NEEDED] What aspects of the programs help FAP's work with clients to go smoothly? In what contexts does it feel like FAP is able to accomplish its goals?

    6b. And on the other hand, what would you say are the main constraints to meeting needs for intimate-partner violence and child abuse or neglect that FAP currently faces in [NAME SERVICE]?

[PROBE IF NEEDED] Lack of coordination, lack of staff, lack of awareness on the part of families, stigma, etc. (this should go beyond supply-side issues).

Thanks very much for taking the time to talk with us today; this has been very helpful. We will be in touch if any other questions come up.

APPENDIX B

Survey Instrument Provided to Installation Family Advocacy Program Offices

Instructions: This questionnaire asks about the FAP services provided at your installation for domestic violence and child abuse or neglect in military families. It does not address cases that occur in Department of Defense schools, childcare facilities, or youth programs. Please answer these questions as best as you can. Results from this study will not be used to evaluate individual FAPs at the installation level. All findings will be reported in the aggregate, so individual installations cannot be singled out. Participation is voluntary. All responses will remain confidential. This is an approved collection cleared under RCS DD-P&R(OT)2662. When you have completed the questionnaire, please mail a printed copy to Dr. Margaret Tankard, RAND Corporation, 1776 Main Street, Santa Monica, California 90401-3208; or contact Ms. Praise Iyiewuare. Ms. Iyiewuare can help you upload the document electronically through a secure system. She can be reached at piyiewua@rand.org or (310) 393-0411, ext. 6620.

1. FAP STAFFING AND ACTIVITIES

For FAP director/most knowledgeable person

Q.1.1. Staffing by Category. Please indicate the number of FAP staff at your installation in the different categories by background as shown below. If a staffer fits in more than one category (for example, someone is both a social worker and manager) include them only once, in the first relevant row (social worker in this case).

Note: The total in the first column should equal the total number of individuals on your staff.

Category	(1) Total Number working in FAP (full- or part-time)	(2) Full time equivalents	(3) Number from Column 1 who are civilians	(4) Of civilians in Column 3, number who are contractors
Social worker				
Psychologist				
Other counselors/advocates				
Manager/Coordinator (if not counted above)				
Administrative/clerical staff (if not counted above)				
Other staff not counted above				
TOTAL				

Q1.2. Staffing by activity. Please indicate if FAP on this installation offers the activities listed, and indicate the number of staff members who spend all or part of their time in the activities. Staff members engaged in more than one activity should be counted in each one.

Activity	FAP offers the activity? (Enter Yes/No)	If yes, number of FAP staff engaged in the activity
Counseling—individual		
Counseling—group		
New Parent Support		
Victim advocacy/Legal assistance		
Financial education		
Case management		
Outreach and prevention activities		

Q.1.3. Classes, workshops, and seminars. Please indicate how many times each class or event listed below was offered in the past 12 months (if none, enter 0). Do not count the same class or workshop in more than one category.

Type	Number times offered in the last 12 months
Couples communication	
Anger management, stress management	
Effective parenting	
Conflict resolution	
Education programs for leaders	
Parent-child interactive groups	
Other (specify) ____________________	

Q.1.4. Public awareness and outreach activities. Please indicate how often, if ever, your FAP engages in the following activities at this installation. (For social media, such as websites and Facebook, please indicate how often your FAP office puts new information on or updates a site.)

For each activity, please mark your answer with an X.

	Approximately how often does FAP engage in the activity?					
Activity	Never/ not used	Annually	Semi-annually	Quarterly	Monthly	Weekly
Host public meeting						
Send email announcements						
Post notices or distribute brochures (hard copy)						
Update FAP website with new information						
Update FAP Facebook page with new information						

Activity	Approximately how often does FAP engage in the activity?					
	Never/ not used	Annually	Semi-annually	Quarterly	Monthly	Weekly
Update FAP Twitter account with new information						
Use other social media for FAP awareness/ outreach						

Q1.5. How many hours per week are the following available? If not applicable, write "NA".

	Number of days of open/available per week (0–7)	Usually available on evenings or weekends? (Enter Yes/No)	Total number of hours available per week
FAP office open			
Counseling/Advocacy (by appointment)			
Counseling/Advocacy (walk in)			
Information and referrals (in person or by telephone)			
Other (specify) ____________________			

Q1.6. Do you provide offenders' intervention groups, also known as batterer's intervention? Please include services for those who have been identified as having committed domestic violence, not individuals who are at risk of becoming an offender.

Please indicate whether the following are provided to offenders:

Type	Provided? (enter yes/no)
Groups/Classes	
Individual counseling	
Other (specify) _________________	

2. OTHER SERVICES

For FAP director/most knowledgeable person

Q2.1. Are the following **behavioral health services** available at this installation for service members?

Service	Available? (enter yes/no)	Number of days of operation per week (0–7)
Mental health treatment		
Alcohol use disorder treatment		
Substance use disorder treatment		
Sleep disorder services		

If your installation offers behavioral health services, please answer questions Q2.2 and Q2.3. If behavioral health services are not offered, skip to question Q2.4.

Q2.2. How often do FAP staff members have regular, formal meetings with behavioral health providers who work outside of FAP (but on this installation)? For example, to discuss specific cases or strategize on outreach and on resource allocations.

1. No formal meetings
2. Annually
3. Semiannually
4. Quarterly
5. Monthly
6. Weekly

Q2.3. Do FAP staff members have informal, as needed, discussions with behavioral health providers who do not work in FAP? How often? Please choose the closest answer.

1. No such discussions
2. Annually
3. Semiannually
4. Quarterly
5. Monthly
6. Weekly

Q2.4. Are the following financial education and financial counseling services available at this installation for service members and their families?

Service	Available? (enter yes/no)	Number of days available per week (0–7)
Financial planning advice or education (e.g., retirement, home buying, saving)		
Financial advice in response to current financial stress		

Q2.5. For current financial stress issues, are there civilian services to which you would refer families as needed (whether or not FAP also provides such services)?

Yes ____ No ____

The next questions ask about nonmilitary services available outside this installation. The questions refer specifically to nonmilitary domestic violence and child abuse/neglect services, though the agencies may also provide related services such as in behavioral health. These agencies should be available to service members or their families (whether through a referral from FAP or through direct contact).

Q2.6. Please list the nonmilitary, community organizations that offer domestic violence and child abuse/neglect services. Indicate if you have a formal arrangement with them (e.g. a Memorandum of Understanding or MOU) and which services each agency provides (regardless of whether you have a formal arrangement).

If there are no such organizations, please put '0' under Name in the first row.

Name	Have formal agreement with them? (enter yes/no)	Type of cases handled by organization (enter yes/no for each)		Does this organization provide the listed service? (enter yes/no for each)							
		Domestic violence	Child abuse/ neglect	Victim advocacy	Emergency shelter	Housing assistance	Legal advocacy	Financial assistance	Batterer's inter- vention	Substance abuse treatment	Mental health treatment

3. DOMESTIC VIOLENCE AND CHILD ABUSE/NEGLECT CASES

For the FAP director/most knowledgeable person. These questions ask for information about your FAP's domestic violence and child abuse/neglect caseload in the last 12 months.

Q3.1. *IN THE PAST 12 MONTHS,* what was your caseload? Please reply about documented incidents of domestic violence and child abuse/neglect. Please do not include at-risk families who had not yet experienced violence.

Note that a "case" refers to a family file. For example, a couple who experiences multiple incidents of domestic violence is a single case.

	Number of cases in the last 12 months
Cases of domestic violence only	
Cases of child abuse or neglect only	
Cases of both domestic violence and child abuse/neglect in the same family	
TOTAL	

Q3.2. In how many of the domestic violence cases in the last 12 months (that is, domestic violence alone or combined with child abuse/neglect) did the victim choose a restricted report? _________ cases

Q3.3. How does your FAP receive domestic violence cases? Please estimate the percentage of cases in each category during the past twelve months.

Type of referral	Percent of domestic violence cases
Service member or family self-refers for domestic violence	_________ %
Service member or family self-refers for a different issue (e.g. stress or relationship problem) and domestic violence is revealed after	_________ %
Service member or family is referred to FAP by another provider (e.g., physician, therapist, substance abuse counselor)	_________ %
The incident of domestic violence is reported to FAP by an authority (e.g., commander), and the service member or family is invited or required to receive FAP services	_________ %
Other (specify) ____	_________ %

Q3.4. How does your FAP receive child abuse/neglect cases? Please estimate the percentage of cases in each category over the past twelve months.

Type of referral	Percent of child abuse/ neglect cases
Service member or family self-refers for child abuse/neglect	_________ %
Service member or family self-refers for a different issue (e.g. stress or relationship problem) and child abuse/neglect is revealed after	_________ %
Service member or family is referred to FAP by a teacher or provider (e.g., daycare worker, physician, therapist, substance abuse counselor)	_________ %
The incident of child abuse/neglect is reported to FAP by an authority (e.g., commander), and the service member or family is invited or required to receive FAP services	_________ %
Other (specify) ____	_________ %

In question Q3.1, you answered that in the last 12 months your FAP office provided services for a total of ______ cases of family violence (including domestic violence and child abuse/neglect). These next questions ask whether your FAP referred some of these cases to other programs for behavioral health services, whether to providers on- or off-installation.

Q3.5. How many cases did you refer for the following services?

Service	How many family violence cases did your FAP refer in the last 12 months for treatment to all providers (on- or off-installation)?	How many of these referrals were to providers off the installation?
Alcohol abuse treatment		
Drug abuse treatment		
Mental health treatment		

Q3.6. In how many of these cases of family violence in the last 12 months did your FAP refer the victim (in the case of domestic violence) or the victim's caregiver (for child abuse or neglect) to resources for the following (include the same case in multiple rows as appropriate)?

Service	How many family violence cases did your FAP refer to these resources in the last 12 months (on- or off-installation)?	How many of these referrals were to resources off the installation?
Emergency housing		
Legal assistance		
Financial support		
Counseling or support groups		

4. OTHER ASPECTS OF FAP SERVICES AND DIRECTOR'S PERCEPTIONS

For FAP director only

Q4.1. In your estimation, how many FAP domestic violence cases were likely associated with the following other problems? Please place an X in the appropriate column.

	All	Most	Some	Few	None
Limited relationship or communication skills (one or both partners)					
Anger management issues					
Alcohol use disorder (one or both partners)					
Drug use disorder (one or both partners)					
Mental health disorder (one or both partners)					
Financial stress					
New parenthood stress					
Stress of deployment					
Other work stress					
Limited support network (family, friends)					
Other (specify) ______________________________					

Q.4.2. In your estimation, how many FAP child abuse and neglect cases were likely associated with the following other problems? Please place an X in the appropriate column.

	All	Most	Some	Few	None
Limited relationship or communication skills (one or both partners)					
Anger management issues					
Alcohol use disorder (one or both partners)					
Drug use disorder (one or both partners)					
Mental health disorder (one or both partners)					
Financial stress					
Electronic distractions (e.g., cell phone, gaming, internet)					
New parenthood stress					
Lack of parenting skills or understanding of child development					
Stress of deployment					
Other work stress					
Limited support network (family, friends)					
Other (specify) ______________________________					

Q4.3. What measures do you think would increase the willingness of service members and families at this installation to seek FAP help for domestic violence and child abuse/neglect? Choose as many as are relevant.

1. More hours during which FAP services staff are available
2. Finding ways to allow more discretion/privacy when seeking FAP services (to reduce the possibility that others will know the individual or family has a domestic violence or child abuse/neglect issue)
3. Making it easier for someone to be seen by a counselor or other provider of their preferred gender
4. More outreach overall
5. More use of social media for outreach
6. Change or better tailor the outreach messages
7. Making it less likely there will be damage to military career as a consequence of seeking help
8. Making it less likely the commanding officer will be notified
9. Making it less likely that abuser would find out
10. Nothing would likely make them more willing
11. Other (specify) _________________

Q4.4. If you answered, "Change or better tailor the outreach messages" as a way to help, how should the messaging change? Please do not include any Personally Identifiable Information (PII).

Q4.5. In Section 2, we asked about use of off-installation family violence services.

Based on your experience, why do service members and families choose off-installation family violence services (whether on their own or after first coming to FAP)? Please indicate the overall importance of each of the following factors in the decision to seek nonmilitary services. Please place an X in the column representing the closest answer.

	Very important	**Moderately important**	**Slightly important**	**Not at all important**
FAP/installation does not provide the needed service(s)				
FAP/installation provides the needed service(s) but is unable to meet the demand				
Clients prefer providers not associated with the military to ensure their privacy				
Clients prefer a counselor of a preferred gender				
Clients prefer providers outside this installation because it is more convenient				
Clients hope to avoid reporting to military authorities or legal system by going outside the installation				
Other (specify) ____________________				

Q4.6. To what extent, if at all, are your FAP's efforts to provide services for family violence among service members and their families limited by the following? Please place an X in the column representing the closest answer.

Efforts limited by . . .	Very large extent	Large extent	Moderate extent	Small extent	Not at all
Number of available FAP professional staff (e.g., social workers, counselors, psychologists)					
Available FAP office/meeting space					
FAP financial resources					
Number of FAP management/ administrative staff					

Q4.7. If you indicated that your efforts were to a "large" or "very large" extent limited by the number of professional or management/administrative staff, in what categories are there shortages? Select all that apply.

1. Licensed social worker
2. Nurses/other New Parent Support staff
3. Psychologist
4. Victim advocate
5. Other counselor
6. Treatment manager
7. Outreach/prevention manager
8. Administrative staff
9. Other (specify) ________________________________

Q4.8. To what extent is staff turnover a problem in carrying out FAP functions?

1. Very large extent
2. Large extent
3. Moderate extent
4. Small extent
5. Not at all

Q4.9. If turnover is a problem to a "large" or "very large" extent, in which categories is it a problem? Select all that apply.

1. Licensed social worker
2. Nurses/other New Parent Support staff
3. Psychologist
4. Victim's advocate
5. Other counselor
6. Treatment manager
7. Outreach/prevention manager
8. Administrative staff

Q4.10. With respect to the coordination of FAP and behavioral health services on this installation, to what extent are the following issues a problem? Please place an X in the column representing the closest answer.

Lack of or not enough...	Very Large Extent	Large Extent	Moderate Extent	Small Extent	Not at all
Frequency of communication					
Coordination on treatment of cases					
Coordination on outreach/education efforts					
Coordination on allocation of resources/staffing across FAP and behavioral health outside of FAP					
Other service providers understanding of FAP concerns					

Q4.11. The next questions ask about the quality of **off-installation, domestic violence services** as a whole. These nonmilitary, domestic violence services include shelters, legal and financial assistance, and counseling for victims and families.

How satisfied are you with these non-military services for domestic violence? Please place an X in the column representing the closest answer. If you do not have adequate information about these services, place an X in the "Don't know" column.

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	Don't know
Convenience or accessibility for service members and their families						
Waiting time for services						
Quality/effectiveness of these services						
Coordination with FAP on cases referred to them by FAP						
Overall interactions with FAP						

Q4.12. The next questions ask about the quality of **off-installation, child abuse/neglect services** as a whole.

How satisfied are you with these nonmilitary services for child abuse/neglect? Please place an X in the column representing the closest answer. If you do not have adequate information about these services, place an X in the "Don't know" column.

	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	Don't know
Convenience or accessibility for service members and their families						
Waiting time for services						
Quality/effectiveness of these services						
Coordination with FAP on cases referred to them by FAP						
Notification of FAP of Child Abuse/Neglect cases involving service members that originate with these providers						
Overall interactions with FAP						

Q4.13. Please elaborate on any very good or particularly problematic aspects of nonmilitary services for domestic violence and child abuse/neglect. Please specify if you are referring to domestic violence or child abuse/neglect, or both. Please do not include any Personally Identifiable Information (PII).

Q4.14. What proportion of *unrestricted* domestic violence cases are discussed with the individual's commanding officer?

1. All—required to report to commanding officer
2. All—even though not required to report to commanding officer
3. Most
4. About half
5. About one quarter
6. Less than a quarter
7. None

Q4.15. If not "all," why are some cases not discussed with the commanding officer? Indicate more than one if applicable.

1. Commanding officer often does not want to get involved or is not interested
2. Commanding officer wants to avoid harm to the individual's career
3. Commanding officer wants to avoid legal trouble for the individual
4. Some cases are less serious and can be resolved with commanding officer involvement
5. Other (specify): ______________________________

Q4.16. Overall, when the case of domestic violence or child abuse/neglect is discussed with the commanding officer, is this helpful in dealing with the case?

1. Very helpful
2. Helpful
3. Neither helpful nor unhelpful
4. Unhelpful
5. Very unhelpful

Q4.17. If discussing with the commanding officer is not helpful, what is the reason? Indicate more than one if applicable.

1. Commanding officer often does not want to get involved or is not interested
2. Commanding officer wants to avoid harm to the individual's career
3. Commanding officer wants to avoid legal trouble for the individual
4. Other (specify): ______________________________

Q4.18. FAP (and possibly other services on this installation) typically provides a range of prevention and response activities for family violence. With regard to the balance between the two, would you say:

1. The mix is about right
2. More attention should be given to prevention than is currently the case
3. More attention should be given to response than is currently the case

5. CLOSING PERSPECTIVES

For FAP director only

Q5.1. What are the most important factors that contribute to your success preventing or responding to domestic violence and child abuse/neglect among service members and their families on this installation? This can include the factors covered above or other factors.

A. Please specify factors related to preventing domestic violence and child abuse/neglect (or both). Please do not include any Personally Identifiable Information (PII)

B. Please specify factors related to responding to domestic violence and child abuse/neglect (or both). Please do not include any Personally Identifiable Information (PII)

Q5.2. What are the most important **challenges you face** in preventing or responding to domestic violence and child abuse/neglect among service member families on this installation? This can include the factors covered above or other factors.

A. Please specify challenges related to preventing domestic violence and child abuse/neglect (or both). Please do not include any Personally Identifiable Information (PII)

B. Please specify challenges related to responding to domestic violence and child abuse/neglect (or both). Please do not include any Personally Identifiable Information (PII)

APPENDIX C

Tables of Survey Results by Service Branch

In this appendix, survey data by service branch are presented. Tables are ordered in the same order as the questions appeared in the installation FAP office survey (Appendix B), and are numbered consistently with the survey item numbers. For example, the table presenting the data from survey question 1.1 is labeled Table C.1.1. The sample size of installation offices was not sufficiently powered to allow statistical analyses of differences across service branches. We present data by branch here to provide each service with access to their unique survey results to support internal planning and messaging.

Table C.1.1
Average Number of FAP Staff by Service Branch

Category	Staff type	Air Force	Army	Navy	Marine Corps
Social worker	Total staff	3.6 (3.1, 4.2) N=20	5.3 (2.5, 8.2) N=12	4.5 (2.5, 6.5) N=28	2.9 (1.7, 4) N=9
	Civilians	2.6 (2.0, 3.2) N=18	4.1 (1.5, 6.7) N=11	4.8 (2.6, 7) N=25	3.4 (2.3, 4.5) N=7
	Civilian contractors	1.2 (0.7, 1.7) N=16	0.1 (0, 0.3) N=11	0.7 (0.1, 1.4) N=19	0.3 (0, 1) N=6
Psychologist	Total staff	0 (0, 0.1) N=20	0 (0, 0) N=10	0 (0, 0.1) N=25	0.2 (0, 0.5) N=9
	Civilians	0 (0, 0) N=17	0 (0, 0) N=10	0 (0, 0.1) N=21	0.3 (0, 0.6) N=7
	Civilian contractors	0 (0, 0) N=16	0 (0, 0) N=10	0 (0, 0) N=16	0 (0, 0) N=6
Other counselors/ advocates	Total staff	1.0 (0.7, 1.2) N=20	1.1 (0.1, 2.1) N=10	3.6 (0, 7.3) N=27	8.2 (2.7, 13.8) N=9
	Civilians	0.8 (0.4, 1.1) N=17	1.1 (0.1, 2.1) N=10	3.8 (0, 8.2) N=23	9.7 (2.9, 16.5) N=7
	Civilian contractors	0.9 (0.7, 1.2) N=17	0.4 (0, 1) N=10	0.7 (0, 1.5) N=18	0.5 (0, 1.5) N=6
Manager/ coordinator	Total staff	0.2 (0, 0.3) N=20	0.7 (0.3, 1.1) N=11	0.9 (0.4, 1.4) N=27	0.7 (0.2, 1.1) N=9
	Civilians	0 (0, 0) N=17	0.5 (0.2, 0.8) N=10	1 (0.4, 1.5) N=24	0.7 (0.2, 1.3) N=7
	Civilian contractors	0.1 (0, 0.2) N=16	0 (0, 0) N=10	0 (0, 0) N=17	0.2 (0, 0.5) N=6

Table C.1.1—Continued

Category	Staff type	Air Force	Army	Navy	Marine Corps
Administrative/ clerical staff	Total staff	1.8 (1.5, 2.1) N=20	2.7 (1.4, 3.9) N=12	1.3 (0.7, 1.8) N=27	2.3 (1.5, 3.1) N=9
	Civilians	1.3 (0.9, 1.8) N=18	2.1 (0.8, 3.3) N=11	1.3 (0.6, 2) N=23	2.6 (1.6, 3.5) N=7
	Civilian contractors	1.1 (0.7, 1.4) N=16	0.2 (0, 0.4) N=11	0.2 (0, 0.4) N=17	0.3 (0, 1) N=6
Other staff not counted above	Total staff	1.3 (0.9, 1.7) N=20	0.4 (0, 1.2) N=10	1.3 (0.5, 2) N=26	2.9 (1.4, 4.4) N=8
	Civilians	1.1 (0.7, 1.6) N=18	0.4 (0, 1.2) N=10	1.3 (0.4, 2.1) N=22	3 (1.3, 4.7) N=7
	Civilian contractors	0.8 (0.5, 1.2) N=17	0.4 (0, 1.2) N=10	1.2 (0.2, 2.3) N=17	0.3 (0, 1) N=6
TOTAL	Total staff	7.9 (6.8, 9.0) N=20	9.6 (5.5, 13.6) N=12	11.2 (4.7, 17.8) N=28	16.7 (8.3, 25) N=9
	Civilians	5.2 (3.7, 6.7) N=20	6.9 (3.2, 10.7) N=12	10.3 (3.7, 16.9) N=28	15.2 (5.9, 24.5) N=9
	Civilian contractors	3.2 (2.2, 4.2) N=20	1 (–0.1, 2.1) N=12	1.8 (0.5, 3.1) N=28	1.1 (0, 3.3) N=9

NOTE: Each data cell contains the mean response across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. Total staff includes full-time and part-time staff working in FAP. Civilians are a subset of total staff, and civilian contractors are a subset of civilians. Manager/coordinator and administrative/clerical staff are listed only if not already counted in other staffing categories.

Table C.1.2
Percentage of FAP Offices That Provide a Family Violence Service by Service Branch

	FAP Office Offers Activity			
Activity	**Air Force**	**Army**	**Navy**	**Marine Corps**
Counseling—individual	100% (100%, 100%) N=20	92% (77%, 100%) N=12	100% (100%, 100%) N=28	100% (100%, 100%) N=9
Counseling—group	90% (77%, 100%) N=20	83% (62%, 100%) N=12	57% (39%, 75%) N=28	100% (100%, 100%) N=9
New-parent support	90% (77%, 100%) N=20	67% (40%, 94%) N=12	64% (46%, 82%) N=28	89% (69%, 100%) N=9
Victim advocacy/legal assistance	80% (62%, 98%) N=20	75% (50%, 100%) N=12	82% (68%, 96%) N=28	100% (100%, 100%) N=9
Financial education	10% (0%, 23%) N=20	17% (0%, 38%) N=12	63% (45%, 81%) N=27	0% (0%, 0%) N=9
Case management	95% (85%, 100%) N=20	83% (62%, 100%) N=12	100% (100%, 100%) N=28	89% (69%, 100%) N=9
Outreach and prevention activities	100% (100%, 100%) N=20	67% (40%, 94%) N=12	96% (89%, 100%) N=28	100% (100%, 100%) N=9

NOTE: Data cells contain the percentages of installations indicating that their FAP offers the activity, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.1.3
Percentage of FAP Offices Offering Specialized Classes, Workshops, and Seminars by Service Branch

	Offered Activity in Last 12 Months			
Type	**Air Force**	**Army**	**Navy**	**Marine Corps**
Couples communication	100% (100%, 100%) N=19	91% (74%, 100%) N=11	63% (45%, 81%) N=27	62% (28%, 96%) N=8
Anger management, stress management	100% (100%, 100%) N=19	73% (47%, 99%) N=11	93% (84%, 100%) N=28	100% (100%, 100%) N=8
Effective parenting	100% (100%, 100%) N=19	91% (74%, 100%) N=11	70% (53%, 87%) N=27	100% (100%, 100%) N=8
Conflict resolution	56% (33%, 79%) N=18	73% (47%, 99%) N=11	56% (37%, 75%) N=25	57% (20%, 94%) N=7
Education programs for leaders	83% (66%, 100%) N=18	45% (16%, 74%) N=11	81% (66%, 96%) N=26	57% (20%, 94%) N=7
Parent-child interactive groups	50% (27%, 73%) N=18	25% (1%, 50%) N=12	33% (15%, 51%) N=27	50% (15%, 85%) N=8

NOTE: Data cells contain the mean responses across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.1.4a
Frequency with Which FAP Office Hosts a Public Meeting by Service Branch

Response Option	**Air Force**	**Army**	**Navy**	**Marine Corps**
Never	**44% (21%, 67%)**	**73% (47%, 99%)**	**54% (35%, 73%)**	**57% (20%, 94%)**
Annually	11% (0%, 25%)	0% (0%, 0%)	15% (1%, 29%)	29% (0%, 63%)
Semiannually	11% (0%, 25%)	18% (0%, 41%)	4% (0%, 12%)	0% (0%, 0%)
Quarterly	17% (0%, 34%)	0% (0%, 0%)	19% (4%, 34%)	14% (0%, 40%)
Monthly	11% (0%, 25%)	0% (0%, 0%)	4% (0%, 12%)	0% (0%, 0%)
Weekly	6% (0%, 17%)	9% (0%, 26%)	4% (0%, 12%)	0% (0%, 0%)
	N=18	N=11	N=26	N=7

NOTE: Data cells contain the percentages of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.4b
Frequency with Which FAP Office Sends Email Announcements by Service Branch

Response Option	Air Force	Army	Navy	Marine Corps
Never	6% (0%, 17%)	27% (1%, 53%)	7% (0%, 16%)	14% (0%, 40%)
Annually	6% (0%, 17%)	0% (0%, 0%)	0% (0%, 0%)	14% (0%, 40%)
Semiannually	0% (0%, 0%)	18% (0%, 41%)	7% (0%, 16%)	0% (0%, 0%)
Quarterly	28% (7%, 49%)	0% (0%, 0%)	32% (15%, 49%)	0% (0%, 0%)
Monthly	**50% (27%, 73%)**	**45% (16%, 74%)**	**39% (21%, 57%)**	**57% (20%, 94%)**
Weekly	11% (0%, 25%)	9% (0%, 26%)	14% (1%, 27%)	14% (0%, 40%)
	N=19	N=11	N=28	N=7

NOTE: Data cells contain the percentages of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.4c
Frequency with Which FAP Office Posts Notices or Distributes Brochures by Service Branch

Response Option	Air Force	Army	Navy	Marine Corps
Never	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	11% (0%, 31%)
Annually	5% (0%, 15%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
Semiannually	0% (0%, 0%)	27% (1%, 53%)	18% (4%, 32%)	0% (0%, 0%)
Quarterly	11% (0%, 25%)	0% (0%, 0%)	21% (6%, 36%)	11% (0%, 31%)
Monthly	**58% (36%, 80%)**	27% (1%, 53%)	**32% (15%, 49%)**	**44% (12%, 76%)**
Weekly	26% (6%, 46%)	**45% (16%, 74%)**	29% (12%, 46%)	33% (2%, 64%)
	N=19	N=11	N=28	N=9

NOTE: Data cells contain the percentage of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.4d
Frequency with Which FAP Office Updates FAP Website by Service Branch

Response Option	Air Force	Army	Navy	Marine Corps
Never	**56% (33%, 79%)**	**45% (16%, 74%)**	**54% (36%, 72%)**	25% (0%, 55%)
Annually	0% (0%, 0%)	18% (0%, 41%)	11% (0%, 23%)	12% (0%, 35%)
Semiannually	0% (0%, 0%)	0% (0%, 0%)	7% (0%, 16%)	**38% (4%, 72%)**
Quarterly	11% (0%, 25%)	18% (0%, 41%)	14% (1%, 27%)	0% (0%, 0%)
Monthly	17% (0%, 34%)	0% (0%, 0%)	11% (0%, 23%)	12% (0%, 35%)
Weekly	17% (0%, 34%)	18% (0%, 41%)	4% (0%, 11%)	12% (0%, 35%)
	N=18	N=11	N=28	N=8

NOTE: Data cells contain the percentage of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.4e
Frequency with Which FAP Office Updates FAP Facebook Page by Service Branch

Response Option	Air Force	Army	Navy	Marine Corps
Never	**44% (21%, 67%)**	**64% (36%, 92%)**	**39% (21%, 57%)**	**29% (0%, 63%)**
Annually	6% (0%, 17%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
Semiannually	0% (0%, 0%)	0% (0%, 0%)	11% (0%, 23%)	14% (0%, 40%)
Quarterly	6% (0%, 17%)	0% (0%, 0%)	29% (12%, 46%)	0% (0%, 0%)
Monthly	22% (3%, 41%)	0% (0%, 0%)	11% (0%, 23%)	**29% (0%, 63%)**
Weekly	22% (3%, 41%)	36% (8%, 64%)	11% (0%, 23%)	**29% (0%, 63%)**
	N=18	N=11	N=28	N=7

NOTE: Data cells contain the percentage of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.4f
Frequency with Which FAP Office Updates FAP Twitter Account by Service Branch

Response Option	Air Force	Army	Navy	Marine Corps
Never	**100% (100%, 100%)**	**100% (100%, 100%)**	**100% (100%, 100%)**	**100% (100%, 100%)**
Annually	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
Semiannually	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
Quarterly	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
Monthly	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
Weekly	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)	0% (0%, 0%)
	N=18	N=10	N=27	N=7

NOTE: Data cells contain the percentage of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.4g
Frequency with Which FAP Office Uses Other Social Media for FAP Outreach by Service Branch

Response Option	Air Force	Army	Navy	Marine Corps
Never	**26% (6%, 46%)**	**55% (26%, 84%)**	**44% (25%, 63%)**	**38% (4%, 72%)**
Annually	0% (0%, 0%)	0% (0%, 0%)	4% (0%, 11%)	0% (0%, 0%)
Semiannually	0% (0%, 0%)	0% (0%, 0%)	4% (0%, 11%)	0% (0%, 0%)
Quarterly	**26% (6%, 46%)**	0% (0%, 0%)	19% (4%, 34%)	12% (0%, 35%)
Monthly	21% (3%, 39%)	18% (0%, 41%)	26% (9%, 43%)	**38% (4%, 72%)**
Weekly	**26% (6%, 46%)**	27% (1%, 53%)	4% (0%, 11%)	12% (0%, 35%)
	N=19	N=11	N=27	N=8

NOTE: Data cells contain the percentage of installations indicating each response for each activity type, followed by the 95% confidence interval in parentheses. The most frequently selected response to each item for each service branch is indicated in bold. The bottom row contains the number of installations upon which the information is based for each item.

Table C.1.5a
Average Number of Days FAP Services Are Available by Service Branch

	Days Available per Week			
Type	Air Force	Army	Navy	Marine Corps
FAP office open	5 (5, 5) N=20	5 (5, 5) N=12	5 (5, 5) N=28	5 (5, 5) N=9
Counseling/advocacy (by appointment)	5.2 (4.9, 5.5) N=20	5 (5, 5) N=12	5 (5, 5) N=28	4.9 (4.6, 5.1) N=8
Counseling/advocacy (walk-in)	5.1 (4.9, 5.3) N=20	5.2 (4.8, 5.5) N=12	5 (5, 5) N=28	5.2 (3.9, 6.6) N=8
Information and referrals (in person or by telephone)	5.5 (5.1, 5.9) N=20	5.7 (5.1, 6.2) N=12	5 (5, 5) N=28	5.7 (4.8, 6.6) N=7

NOTE: Data cells contain the mean response across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.1.5b
Percentage of FAP Offices with Evening or Weekend Availability by Service Branch

	Available on Evenings or Weekends			
Type	Air Force	Army	Navy	Marine Corps
FAP office open	0% (0%, 0%) N=18	8% (0%, 23%) N=12	0% (0%, 0%) N=27	11% (0%, 31%) N=9
Counseling/advocacy (by appointment)	11% (0%, 25%) N=18	8% (0%, 23%) N=12	11% (0%, 23%) N=27	38% (4%, 72%) N=8
Counseling/advocacy (walk-in)	6% (0%, 17%) N=18	17% (0%, 38%) N=12	7% (0%, 17%) N=27	43% (6%, 80%) N=7
Information and referrals (in person or by telephone)	39% (16%, 62%) N=18	33% (6%, 60%) N=12	0% (0%, 0%) N=27	67% (29%, 100%) N=6

NOTE: Data cells contain the percentage of installations indicating availability on evenings or weekends, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.1.5c
Average Number of Hours FAP Services Are Available (Weekly) by Service Branch

	Hours Available per Week			
Type	Air Force	Army	Navy	Marine Corps
FAP office open	41.3 (40.0, 42.5) N=19	40.4 (39.6, 41.2) N=12	40.6 (39.8, 41.4) N=28	42.2 (40.0, 44.5) N=9
Counseling/advocacy (by appointment)	47.0 (33.7, 60.2) N=19	40.5 (39.6, 41.3) N=11	44.7 (35.7, 53.7) N=28	43.8 (40.8, 46.8) N=7
Counseling/advocacy (walk-in)	47.0 (33.7, 60.2) N=19	52.1 (29.4, 74.8) N=11	40.2 (39.2, 41.2) N=28	89.6 (44.5, 134.6) N=8
Information and referrals (in person or by telephone)	57.8 (39.0, 76.6) N=19	82.7 (47.0, 118.3) N=12	40.2 (39.2, 41.2) N=28	95.6 (45.4, 145.8) N=7

NOTE: Data cells contain the mean response across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.1.6
Percentage of FAP Offices Offering Offender's Intervention Programming by Service Branch

	Offer Programming			
Type of Programming	**Air Force**	**Army**	**Navy**	**Marine Corps**
Groups or classes	90% (77%, 100%) N=20	67% (40%, 94%) N=12	64% (46%, 82%) N=28	89% (69%, 100%) N=9
Individual counseling	100% (100%, 100%) N=20	83% (62%, 100%) N=12	96% (89%, 100%) N=27	100% (100%, 100%) N=9

NOTE: Data cells contain the percentage of installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.2.1
Percentage of FAP Offices with Access to Installation Behavioral Health Services by Service Branch

	Service Is Available on Installation			
Type of Service	**Air Force**	**Army**	**Navy**	**Marine Corps**
Mental health treatment	100% (100%, 100%) N=20	100% (100%, 100%) N=12	86% (73%, 99%) N=28	100% (100%, 100%) N=9
Alcohol use disorder treatment	100% (100%, 100%) N=20	83% (62%, 104%) N=12	61% (43%, 79%) N=28	100% (100%, 100%) N=9
Substance use disorder treatment	100% (100%, 100%) N=20	83% (62%, 104%) N=12	56% (37%, 75%) N=27	100% (100%, 100%) N=9
Sleep disorder services	100% (100%, 100%) N=20	75% (50%, 100%) N=12	41% (22%, 60%) N=27	50% (15%, 85%) N=8

NOTE: Data cells contain the percentages of installations indicating that the service is available, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.2.2/2.3
Percentage of FAP Offices That Report Interacting with Behavioral Health Providers Weekly by Service Branch

	Weekly Interaction with Behavioral Health			
Type of Interaction	**Air Force**	**Army**	**Navy**	**Marine Corps**
Formal meetings	85% (69%, 100%) N=20	50% (22%, 78%) N=12	15% (1%, 29%) N=26	11% (0%, 31%) N=9
Informal discussions	95% (85%, 100%) N=20	75% (50%, 100%) N=12	54% (35%, 73%) N=26	78% (51%, 100%) N=9

NOTE: Data cells contain the percentages of installations indicating that the interaction type occurs weekly (vs. less often than weekly), followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.2.4
Percentage of FAP Offices with Access to Installation Financial Services by Service Branch

	Service Is Available on Installation			
Type of Service	**Air Force**	**Army**	**Navy**	**Marine Corps**
Financial planning advice or education	100% (100%, 100%) N=20	92% (77%, 107%) N=12	96% (89%, 103%) N=28	100% (100%, 100%) N=9
Financial advice in response to current financial stress	100% (100%, 100%) N=20	92% (77%, 107%) N=12	96% (89%, 103%) N=28	100% (100%, 100%) N=9

NOTE: Data cells contain the percentages of installations indicating that the service is available, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.2.5
Percentage of FAP Offices with Access to Civilian Referral Services for Financial Stress by Service Branch

	Air Force	**Army**	**Navy**	**Marine Corps**
% indicating presence of civilian services addressing current financial stress, to which they refer families	85% (69%, 100%) N=20	82% (59%, 100%) N=11	86% (73%, 99%) N=28	78% (51%, 100%) N=9

NOTE: Data cells contain the percentages of installations indicating access to civilian referral services, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.2.6
Percentage of FAP Offices That Have Civilian Service Organizations to Which They Can Refer Clients, and Percentage with a Formal Agreement with Agency by Service Branch

Type of Service	**List Organization or Have Formal Agreement**	**Air Force**	**Army**	**Navy**	**Marine Corps**
Victim advocacy	List organization	83% (66%, 100%) N=18	92% (76%, 100%) N=12	96% (90%, 100%) N=28	88% (65%, 100%) N=8
	Have formal agreement	78% (59%, 97%) N=18	83% (62%, 100%) N=12	54% (35%, 72%) N=28	25% (0%, 55%) N=8
Emergency shelter	List organization	89% (74%, 100%) N=18	92% (76%, 100%) N=12	96% (90%, 100%) N=28	8% (65%, 100%) N=8
	Have formal agreement	83% (66%, 100%) N=18	67% (40%, 93%) N=12	50% (31%, 69%) N=28	12% (0%, 35%) N=8
Housing assistance	List organization	78% (59%, 97%) N=18	50% (22%, 78%) N=12	64% (47%, 82%) N=28	75% (45%, 100%) N=8
	Have formal agreement	78% (59%, 97%) N=18	25% (1%, 50%) N=12	25% (9%, 41%) N=28	25% (0%, 55%) N=8
Legal advocacy	List organization	78% (59%, 97%) N=18	83% (62%, 100%) N=12	79% (63%, 94%) N=28	62% (29%, 96%) N=8
	Have formal agreement	78% (59%, 97%) N=18	50% (22%, 78%) N=12	32% (15%, 49%) N=28	12% (0%, 35%) N=8

Table C.2.6—Continued

Type of Service	List Organization or Have Formal Agreement	Air Force	Army	Navy	Marine Corps
Financial assistance	List organization	56% (33%, 79%) N=18	50% (22%, 78%) N=12	54% (35%, 72%) N=28	62% (29%, 96%) N=8
	Have formal agreement	44% (21%, 67%) N=18	33% (7%, 60%) N=12	18% (4%, 32%) N=28	12% (0%, 35%) N=8
Batterers' intervention	List organization	72% (52%, 93%) N=18	33% (7%, 60%) N=12	54% (35%, 72%) N=28	75% (45%, 100%) N=8
	Have formal agreement	67% (45%, 88%) N=18	17% (0%, 38%) N=12	18% (4%, 32%) N=28	25% (0%, 55%) N=8
Substance abuse treatment	List organization	61% (39%, 84%) N=18	17% (0%, 38%) N=12	54% (35%, 72%) N=28	38% (4%, 71%) N=8
	Have formal agreement	39% (16%, 61%) N=18	8% (0%, 24%) N=12	18% (4%, 32%) N=28	25% (0%, 55%) N=8
Mental health treatment	List organization	72% (52%, 93%) N=18	67% (40%, 93%) N=12	64% (47%, 82%) N=28	75% (45%, 100%) N=8
	Have formal agreement	61% (39%, 84%) N=18	25% (1%, 50%) N=12	21% (6%, 37%) N=28	38% (4%, 71%) N=8
Type of Case Associated with Service		**Air Force**	**Army**	**Navy**	**Marine Corps**
Domestic violence	List organization	94% (84%, 100%) N=18	92% (76%, 100%) N=12	100% (100%, 100%) N=28	88% (65%, 100%) N=8
	Have formal agreement	89% (74%, 100%) N=18	83% (62%, 100%) N=12	43% (25%, 61%) N=28	25% (0%, 55%) N=8
Child abuse/ neglect	List organization	100% (100%, 100%) N=18	92% (76%, 100%) N=12	93% (83%, 100%) N=28	88% (65%, 100%) N=8
	Have formal agreement	94% (84%, 100%) N=18	75% (50%, 100%) N=12	68% (51%, 85%) N=28	62% (29%, 96%) N=8

NOTE: For the "list organization" rows, data cells contain the percentages of installations that listed at least one organization, for each type of service or type of case, out of FAP offices that listed any organization. For the "have formal agreement" rows, data cells contain the percentages of installations that indicated a formal agreement with at least one organization, for each type of service or type of case, out of FAP offices that listed any organization. This information is followed in all data cells by the 95% confidence intervals in parentheses, followed by the number of installations upon which the information is based.

Table C.3.1
Average Annual Caseload by Type and Service Branch

	Average Number of Cases in Past 12 Months			
Case Type	Air Force	Army	Navy	Marine Corps
Domestic violence only	52 (37, 68) N=18	190 (34, 345) N=9	75 (12, 137) N=23	171 (0, 352) N=8
Child abuse or neglect only	58 (36, 80) N=18	165 (35, 295) N=9	32 (14, 50) N=23	135 (0, 269) N=8
Both domestic violence and child abuse/neglect in the same family	20 (6, 34) N=18	127 (0, 284) N=9	24 (3, 46) N=23	44 (0, 91) N=7
TOTAL	130 (89, 172) N=18	482 (88, 875) N=9	131 (32, 230) N=23	198 (54, 342) N=7

NOTE: Data cells contain the mean response across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.3.2
Percentage of Domestic Violence Cases That Are Restricted Reports by Service Branch

	Air Force	Army	Navy	Marine Corps
% of cases in which victim chose restricted report	11% (7%, 15%) N=20	8% (5%, 12%) N=12	16% (11%, 21%) N=28	17% (13%, 21%) N=9

NOTE: Data cells contain the percentages of cases with restricted reports across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.3.3/3.4
Percentage of Cases Received via Different Referral Sources by Case Type (Domestic Violence or Child Abuse/Neglect) and Service Branch

		FAP-Estimated Percentage of Cases			
Referral Type	Case Type	Air Force	Army	Navy	Marine Corps
Service member or family self-refers for domestic violence or child abuse/neglect	DV	15% (9%, 20%) N=20	11% (4%, 18%) N=10	20% (13%, 27%) N=26	26% (19%, 33%) N=8
	CAN	5% (3%, 8%) N=19	3% (0%, 6%) N=10	7% (2%, 12%) N=25	18% (8%, 28%) N=7
Service member or family self-refers for a different issue	DV	6% (3%, 9%) N=20	7% (3%, 12%) N=10	9% (5%, 13%) N=26	6% (0%, 12%) N=6
	CAN	5% (2%, 8%) N=18	7% (2%, 11%) N=10	6% (3%, 8%) N=25	11% (0%, 23%) N=5
Service member or family is referred to FAP by another provider	DV	17% (12%, 21%) N=20	22% (9%, 35%) N=10	20% (10%, 29%) N=26	21% (10%, 33%) N=8
	CAN	30% (19%, 42%) N=19	23% (10%, 36%) N=10	40% (28%, 52%) N=25	27% (17%, 38%) N=7
The incident of domestic violence is reported to FAP by an authority	DV	57% (48%, 66%) N=20	52% (32%, 73%) N=10	51% (40%, 63%) N=26	48% (38%, 58%) N=8
	CAN	48% (35%, 61%) N=19	65% (49%, 82%) N=10	46% (35%, 58%) N=25	47% (28%, 67%) N=8
Other	DV	6% (0%, 12%) N=17	8% (0%, 22%) N=10	1% (0%, 2%) N=25	2% (0%, 5%) N=5
	CAN	14% (3%, 24%) N=16	2% (0%, 6%) N=10	1% (0%, 2%) N=23	8% (0%, 23%) N=6

NOTE: Data cells contain the mean FAP-estimated percentages across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. DV = domestic violence. CAN = child abuse or neglect.

Table C.3.5/3.6
Percentage of Cases That Are Referred to Other Support Services by Service Type, Location (On or Off Installation), and Service Branch

Service Type	Location	Air Force	Army	Navy	Marine Corps
Alcohol abuse treatment	% referrals on installation	8% (5%, 11%) N=14	17% (2%, 32%) N=7	10% (5%, 15%) N=19	6% (3%, 8%) N=3
	% referrals off installation	0% (0%, 0%) N=14	3% (0%, 7%) N=7	4% (2%, 7%) N=19	NR
	Total % cases referred	8% (5%, 11%) N=17	20% (1%, 38%) N=7	12% (7%, 17%) N=21	NR
Drug abuse treatment	% referrals on installation	1% (0%, 2%) N=13	3% (0%, 8%) N=6	4% (0%, 9%) N=17	NR
	% referrals off installation	0% (0%, 0%) N=14	1% (0%, 1%) N=6	1% (0%, 2%) N=17	NR
	Total % cases referred	2% (0%, 5%) N=15	4% (0%, 9%) N=6	4% (0%, 9%) N=20	NR
Mental health treatment	% referrals on installation	9% (5%, 13%) N=12	30% (7%, 54%) N=7	22% (10%, 35%) N=19	NR
	% referrals off installation	1% (0%, 2%) N=12	9% (0%, 20%) N=7	10% (4%, 17%) N=19	NR
	Total % cases referred	11% (7%, 15%) N=16	39% (9%, 70%) N=7	30% (16%, 43%) N=21	NR
Emergency housing	% referrals on installation	3% (0%, 6%) N=12	2% (0%, 6%) N=6	4% (0%, 8%) N=19	0% (0%, 0%) N=5
	% referrals off installation	6% (2%, 9%) N=12	1% (0%, 1%) N=6	3% (1%, 4%) N=19	20% (0%, 59%) N=5
	Total % cases referred	8% (3%, 13%) N=13	3% (0%, 8%) N=6	8% (2%, 13%) N=21	17% (0%, 49%) N=6
Legal assistance	% referrals on installation	27% (9%, 46%) N=12	7% (0%, 14%) N=5	23% (11%, 34%) N=18	34% (6%, 62%) N=5
	% referrals off installation	10% (2%, 17%) N=12	2% (0%, 4%) N=5	9% (2%, 16%) N=18	33% (0%, 71%) N=5
	Total % cases referred	33% (14%, 53%) N=14	9% (2%, 15%) N=5	32% (19%, 45%) N=21	56% (19%, 94%) N=6
Financial support	% referrals on installation	6% (2%, 10%) N=12	10% (0%, 25%) N=5	12% (5%, 18%) N=18	NR
	% referrals off installation	3% (0%, 6%) N=12	0% (0%, 1%) N=5	4% (0%, 10%) N=18	NR
	Total % cases referred	9% (4%, 14%) N=13	10% (0%, 25%) N=5	15% (8%, 22%) N=21	27% (0%, 65%) N=5
Counseling	% referrals on installation	33% (10%, 55%) N=12	NR	37% (22%, 52%) N=21	34% (0%, 73%) N=5
	% referrals off installation	15% (0%, 31%) N=12	NR	22% (11%, 34%) N=21	32% (0%, 73%) N=5
	Total % cases referred	52% (26%, 77%) N=13	NR	60% (46%, 74%) N=21	58% (31%, 85%) N=6

NOTE: Data cells contain the mean percentages across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. A case may receive both on-installation and off-installation referrals. NR = nonreportable due to cell size N<5.

Table C.4.1/4.2
Average Perceived Frequency with Which FAP Cases Are Associated with Other Problems, by Case Type (Domestic Violence or Child Abuse/Neglect) and Service Branch; Ratings Ranged from 1 (None) to 5 (All Cases)

Problem	Case Type	Air Force	Army	Navy	Marine Corps
Limited relationship or communication skills (one or both partners)	DV	4.3 (4.1, 4.5) N=20	4.2 (3.9, 4.6) N=12	4.3 (4.0, 4.5) N=27	4.2 (3.5, 4.9) N=9
	CAN	4.0 (3.6, 4.3) N=20	3.7 (3.2, 4.2) N=12	3.8 (3.4, 4.1) N=24	3.6 (2.9, 4.4) N=8
Anger management issues	DV	3.8 (3.5, 4.1) N=20	3.6 (3.1, 4.0) N=12	3.9 (3.7, 4.2) N=26	3.3 (2.9, 3.8) N=9
	CAN	3.7 (3.4, 4.0) N=20	3.3 (2.9, 3.8) N=12	3.5 (3.1, 3.8) N=24	3.0 (2.4, 3.6) N=8
Alcohol use disorder (one or both partners)	DV	2.5 (2.1, 2.8) N=20	3 (2.8, 3.2) N=12	2.7 (2.5, 3.0) N=26	2.9 (2.5, 3.3) N=9
	CAN	2.5 (2.1, 2.8) N=20	2.7 (2.4, 2.9) N=12	2.3 (2.1, 2.6) N=24	2.5 (2.0, 3.0) N=8
Drug use disorder (one or both partners)	DV	1.8 (1.6, 2.1) N=20	2.4 (2.0, 2.8) N=11	1.8 (1.6, 2.0) N=26	2.1 (1.6, 2.6) N=9
	CAN	1.8 (1.5, 2.2) N=19	2.2 (1.9, 2.6) N=12	1.8 (1.6, 2.1) N=24	2.0 (1.5, 2.5) N=8
Mental health disorder (one or both partners)	DV	3.0 (2.7, 3.2) N=20	3.2 (2.7, 3.6) N=11	2.7 (2.4, 3.1) N=26	2.7 (2.2, 3.1) N=9
	CAN	2.9 (2.6, 3.2) N=20	3.3 (3.0, 3.7) N=12	2.8 (2.5, 3.1) N=24	2.6 (2.0, 3.3) N=8
Financial stress	DV	3.1 (2.9, 3.4) N=20	3.2 (2.8, 3.6) N=12	3.3 (2.9, 3.6) N=26	2.8 (2.2, 3.3) N=9
	CAN	3.0 (2.8, 3.2) N=20	2.9 (2.3, 3.5) N=12	3.0 (2.6, 3.5) N=24	2.6 (1.9, 3.4) N=8
New parenthood stress	DV	2.6 (2.4, 2.9) N=20	2.5 (2.1, 3.0) N=11	2.2 (1.9, 2.5) N=26	2.8 (2.2, 3.3) N=9
	CAN	3.0 (2.7, 3.4) N=20	2.5 (2.0, 3.0) N=12	2.5 (2.2, 2.9) N=24	3.1 (2.5, 3.7) N=8
Stress of deployment	DV	2.2 (2.0, 2.4) N=20	2.6 (2.1, 3.0) N=12	2.2 (1.9, 2.6) N=26	2.8 (2.1, 3.4) N=9
	CAN	2.4 (2.1, 2.7) N=20	2.3 (1.7, 2.9) N=12	2.2 (1.8, 2.7) N=24	2.8 (2.0, 3.5) N=8
Other work stress	DV	3.1 (2.9, 3.4) N=20	2.9 (2.5, 3.3) N=11	3.2 (2.7, 3.6) N=26	3.3 (2.8, 3.9) N=9
	CAN	3.1 (2.8, 3.4) N=20	2.8 (2.3, 3.4) N=12	3.0 (2.7, 3.4) N=24	2.8 (2.0, 3.5) N=8
Limited support network (family, friends)	DV	3.5 (3.2, 3.7) N=20	3.4 (2.8, 4.0) N=12	3.0 (2.7, 3.4) N=26	3.6 (3.2, 3.9) N=9
	CAN	3.5 (3.3, 3.8) N=20	3.5 (2.9, 4.1) N=12	3.3 (3.0, 3.6) N=24	3.5 (3.1, 3.9) N=9
Electronic distractions (e.g., cell phone, gaming, internet)	CAN	3.1 (2.7, 3.6) N=20	3.2 (2.6, 3.7) N=12	2.5 (2.1, 3.0) N=24	2.8 (2.1, 3.4) N=9
Lack of parenting skills or understanding of child development	CAN	3.8 (3.4, 4.2) N=19	3.9 (3.5, 4.4) N=12	3.9 (3.6, 4.1) N=23	4.1 (3.7, 4.6) N=8

NOTE: DV = domestic violence, CAN = child abuse/neglect. Data cells contain the mean ratings across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. The following categorical response options were coded on a 1–5 Likert scale: none (1), few (2), some (3), most (4), all (5). Electronic distractions and lack of parenting skills were included on the problem list only for CAN cases.

Table C.4.3
Percentage of FAP Offices That Believed a Given Modification Would Increase Help-Seeking by Service Branch

	Percentage Indicating It Would Increase Help-Seeking			
Modification	**Air Force**	**Army**	**Navy**	**Marine Corps**
More hours during which FAP services are available	5% (0, 15%) N=20	17% (0%, 38%) N=12	21% (6%, 36%) N=28	11% (0%, 31%) N=9
Finding ways to allow more discretion/privacy when seeking FAP services	55% (33%, 77%) N=20	50% (22%, 78%) N=12	50% (31%, 69%) N=28	56% (24%, 88%) N=9
Making it easier for someone to be seen by a counselor or other provider of their preferred gender	10% (0%, 23%) N=20	17% (0%, 38%) N=12	11% (0%, 23%) N=28	11% (0%, 31%) N=9
More outreach overall	30% (10%, 50%) N=20	42% (14%, 70%) N=12	39% (21%, 57%) N=28	33% (2%, 64%) N=9
More use of social media for outreach	20% (2%, 38%) N=20	25% (1%, 50%) N=12	50% (31%, 69%) N=28	67% (36%, 98%) N=9
Change or better tailor the outreach messages	30% (10%, 50%) N=20	33% (6%, 60%) N=12	29% (12%, 46%) N=28	33% (2%, 64%) N=9
Making it less likely there will be damage to military career as a consequence of seeking help	85% (69%, 100%) N=20	83% (62%, 100%) N=12	75% (59%, 91%) N=28	78% (51%, 100%) N=9
Making it less likely the commanding officer will be notified	45% (23%, 67%) N=20	17% (0%, 38%) N=12	46% (28%, 64%) N=28	78% (51%, 100%) N=9
Making it less likely that abuser would find out	30% (10%, 50%) N=20	17% (0%, 38%) N=12	29% (12%, 46%) N=28	33% (2%, 64%) N=9
Nothing would likely make them more willing	0% (0%, 0%) N=20	0% (0%, 0%) N=12	11% (0%, 23%) N=28	11% (0%, 23%) N=9

NOTE: Data cells contain the percentages of installations that marked each response option (respondents selected as many options as applied), followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.4.5
Average Perceived Importance of Reasons for Off-Installation Service Use by Service Branch; Importance Was Rated from 1 (Not at All Important) to 4 (Very Important)

	Rating			
Factor	**Air Force**	**Army**	**Navy**	**Marine Corps**
FAP/installation does not provide the needed service(s)	1.8 (1.3, 2.3) N=17	2.2 (1.4, 3.0) N=10	2.3 (1.8, 2.8) N=25	1.4 (1.0, 1.7) N=8
FAP/installation provides the needed service(s) but is unable to meet the demand	1.5 (1.1, 2.0) N=17	2.5 (1.7, 3.3) N=10	1.9 (1.5, 2.3) N=25	1.4 (0.9, 1.9) N=8
Clients prefer providers not associated with the military to ensure their privacy	3.4 (3.0, 3.8) N=17	3.6 (3.2, 4.1) N=11	3.2 (2.8, 3.6) N=26	3.6 (3.1, 4.1) N=8

Table C.4.5—Continued

	Rating			
Factor	Air Force	Army	Navy	Marine Corps
Clients prefer a counselor of a preferred gender	1.5 (1.2, 1.7) N=17	2.0 (1.3, 2.7) N=10	1.6 (1.3, 1.8) N=26	1.6 (1.3, 2.0) N=8
Clients prefer providers outside this installation because it is more convenient	1.9 (1.4, 2.4) N=17	2.1 (1.6, 2.6) N=10	2.4 (2.0, 2.8) N=26	2.1 (1.4, 2.8) N=8
Clients hope to avoid reporting to military authorities or legal system by going outside the installation	3.3 (2.8, 3.8) N=17	3.8 (3.6, 4.1) N=11	3.2 (2.8, 3.6) N=26	3.8 (3.3, 4.2) N=8

NOTE: Data cells contain the mean responses across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. The following categorical response options were coded on a 1–4 Likert scale: not at all important (1), slightly important (2), moderately important (3), very important (4).

Table C.4.6
Average Perceived Extent to Which Given Factors Limit FAP Services by Service Branch; Ratings Ranged from 1 (Not at All) to 5 (Very Large Extent)

	Rated Extent of Limiting Effects			
Factor	Air Force	Army	Navy	Marine Corps
Number of available FAP professional staff (e.g., social workers, counselors, psychologists)	3.6 (3.0, 4.3) N=20	3.5 (2.5, 4.4) N=11	3.0 (2.4, 3.6) N=27	2.8 (1.8, 3.8) N=9
Available FAP office/meeting space	2.5 (1.9, 3.1) N=20	2.1 (1.3, 2.9) N=11	1.8 (1.4, 2.2) N=27	2.4 (1.4, 3.5) N=9
FAP financial resources	2.8 (2.1, 3.4) N=20	1.8 (1.2, 2.5) N=11	2.3 (1.8, 2.8) N=27	2.1 (1.3, 2.9) N=9
Number of FAP management/ administrative staff	2.7 (2.1, 3.3) N=20	2.0 (1.4, 2.5) N=11	2.3 (1.7, 2.8) N=27	2.6 (1.6, 3.5) N=9
Staff turnover	3.5 (2.9, 4.2) N=20	2.6 (1.9, 3.4) N=11	2.8 (2.2, 3.4) N=27	2.9 (2.0, 3.8) N=9

NOTE: Data cells contain the mean responses across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. The following categorical response options were coded on a 1–5 Likert scale: not at all (1), small extent (2), moderate extent (3), large extent (4), very large extent (5).

Table C.4.10
Average Perceived Coordination Challenges Between FAP and Behavioral Health Services by Service Branch; Ratings Ranged from 1 (Not at All) to 5 (Very Large Extent)

	Rating as Problem			
Issue	Air Force	Army	Navy	Marine Corps
Frequency of communication	1.8 (1.4, 2.2) N=20	1.6 (1.0, 2.2) N=11	2.4 (1.9, 2.9) N=24	1.8 (1.1, 2.4) N=8
Coordination on treatment of cases	1.6 (1.2, 2.0) N=20	1.5 (1.1, 2.0) N=11	2.5 (2.0, 3.0) N=25	1.6 (1.0, 2.3) N=8
Coordination on outreach/ education efforts	2.0 (1.5, 2.4) N=20	2.0 (1.5, 2.5) N=11	2.2 (1.8, 2.7) N=25	2.2 (1.4, 3.1) N=8

Table C.4.10—Continued

Issue	Rating as Problem Air Force	Army	Navy	Marine Corps
Coordination on allocation of resources/staffing across FAP and behavioral health outside of FAP	2.0 (1.4, 2.6) N=20	2.1 (1.4, 2.8) N=11	2.5 (1.9, 3.1) N=24	2.1 (1.3, 3.0) N=8
Other service providers' understanding of FAP concerns	2.4 (1.8, 2.9) N=20	3.2 (2.4, 4.0) N=11	3.0 (2.4, 3.5) N=25	2.6 (1.8, 3.4) N=8

NOTE: Data cells contain the mean responses across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. The following categorical response options were coded on a 1–5 Likert scale: not at all (1), small extent (2), moderate extent (3), large extent (4), very large extent (5).

Table C.4.11/4.12
Average Satisfaction with Coordination Between FAP and Nonmilitary Services, by Case Type (Domestic Violence or Child Abuse/Neglect) and Service Branch; Ratings Ranged from 1 (Very Dissatisfied) to 5 (Very Satisfied)

Issue	Case Type	Satisfaction Rating Air Force	Army	Navy	Marine Corps
Convenience or accessibility for service members and their families	DV	3.8 (3.3, 4.4) N=18	3.2 (2.4, 4.0) N=11	3.4 (3.0, 3.9) N=23	4.0 (3.6, 4.4) N=7
	CAN	3.8 (3.3, 4.4) N=19	3.1 (2.3, 3.9) N=10	3.5 (3.0, 4.0) N=23	3.7 (3.0, 4.4) N=7
Waiting time for services	DV	3.8 (3.4, 4.1) N=17	3.2 (2.6, 3.8) N=11	3.1 (2.7, 3.6) N=22	3.9 (3.3, 4.4) N=7
	CAN	3.7 (3.2, 4.1) N=18	3.0 (2.1, 3.9) N=9	3.1 (2.7, 3.6) N=22	3.7 (2.7, 4.7) N=7
Quality/effectiveness of these services	DV	3.8 (3.3, 4.2) N=17	3.5 (2.7, 4.3) N=10	3.8 (3.6, 4.1) N=22	4.2 (3.6, 4.8) N=6
	CAN	3.8 (3.4, 4.2) N=18	3.2 (2.5, 3.9) N=11	3.6 (3.2, 4.0) N=22	3.3 (2.5, 4.1) N=7
Coordination with FAP on cases referred to them by FAP	DV	3.4 (2.9, 3.9) N=17	2.9 (2.3, 3.5) N=10	3.2 (2.7, 3.7) N=23	3.4 (2.7, 4.0) N=8
	CAN	3.6 (3.1, 4.0) N=18	3 (2.4, 3.6) N=11	3.7 (3.2, 4.1) N=23	3.3 (2.3, 4.3) N=9
Overall interactions with FAP	DV	3.8 (3.4, 4.2) N=17	3.3 (2.6, 3.9) N=11	3.2 (2.7, 3.6) N=23	3.9 (3.3, 4.4) N=7
	CAN	3.9 (3.5, 4.2) N=18	2.5 (1.7, 3.4) N=11	3.2 (2.7, 3.8) N=22	3.4 (2.6, 4.3) N=7
Notification of FAP of cases involving service members that originate with these providers	CAN	3.4 (3.0, 3.9) N=18	3.0 (2.3, 3.7) N=11	3.3 (3.0, 3.8) N=23	3.6 (2.8, 4.3) N=7

NOTE: DV = domestic violence, CAN = child abuse/neglect. Data cells contain the mean responses across installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based. The following categorical response options were coded on a 1–5 Likert scale: very dissatisfied (1), dissatisfied (2), neither satisfied nor dissatisfied (3), satisfied (4), very satisfied (5). Offices rated satisfaction with being notified about cases only for child abuse/neglect, not for domestic violence.

Table C.4.14/4.16
Communication with Command by Service Branch

	Air Force	Army	Navy	Marine Corps
% of installations indicating that all unrestricted cases are discussed with commanding officer by requirement	100% (100%, 100%) N=20	91% (74%, 100%) N=11	59% (40%, 78%) N=27	89% (69%, 100%) N=9
% of installations indicating that when cases are discussed with commanding officer, it is helpful or very helpful	80% (62%, 98%) N=20	91% (74%, 100%) N=11	81% (66%, 96%) N=27	78% (51%, 100%) N=9

NOTE: Data cells contain the percentages of installations, followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

Table C.4.18
Perceptions of Mix of Prevention and Response Activities by Service Branch

	Air Force	Army	Navy	Marine Corps
Mix is about right	70% (50%, 90%) N=20	36% (8%, 64%) N=11	48% (29%, 67%) N=27	56% (24%, 88%) N=9
More attention should go to prevention	30% (10%, 50%) N=20	55% (26%, 84%) N=11	44% (25%, 63%) N=27	44% (12%, 76%) N=9
More attention should go to response	0% (0%, 0%) N=20	9% (0%, 26%) N=11	7% (0%, 17%) N=27	0% (0%, 0%) N=9

NOTE: Data cells contain the percentages of installations that marked each response option (respondents selected only one option), followed by the 95% confidence interval in parentheses, followed by the number of installations upon which the information is based.

APPENDIX D

Risk Factors and Consequences of Family Violence

Family violence victimization can negatively impact physical, mental, social, and financial health. Stress and financial strain are also risk factors for family violence. As an example of the interrelationship between risk factors, financial strain and psychological distress may make households vulnerable to family violence. These factors also place an additional burden on victims that may make it challenging for them to find the time and mental resources to identify and pursue any form of services.

On the other hand, these same factors may increase the likelihood that individuals will seek assistance from at least one type of military-provided service (i.e., financial planning, mental health care) that could in turn lead to a referral to family violence services. Seeking counseling services for psychological distress, for example, could lead to a direct referral to family violence services if family violence victimization is disclosed during treatment. Seeking financial management services could serve as a first step to becoming comfortable pursuing military-based services and being aware of available services. Specifically, a family violence victim who has a positive experience engaging with financial services may be more likely to search for or engage with family violence services than a family violence victim who has no experience engaging with available support services Thus, to comprehensively prevent and respond to family violence, it may be important to connect the resources addressing the consequences of and risk factors for family violence.

In this appendix, we present the results of a literature review covering three broad risk factors and consequences of family violence: finances, behavioral health, and physical health. For each factor, we describe its relationship to victimization and service provision at different levels, including a range of potentially relevant civilian services and specific services offered in military settings. We also discuss life stage as a cross-cutting factor that, according to the research literature, is correlated with family violence, and we consider the relationship between this factor and the other domains. This literature informed the development of our survey and interview protocols, which we used to better understand how families connect with FAP services and the additional services they may subsequently need to access in order to provide a comprehensive response to their needs.

Finances

Financial factors include an individual's income, savings, housing situation, employment, and neighborhood socioeconomic status. Domestic violence itself is a source of financial challenges. Abusive strategies are frequently applied to personal finances, and can include preventing a

partner from working, blocking access to family resources, or ruining a partner's credit rating (Adams et al., 2008; Postmus, Plummer, et al., 2012; Raphael, 1999; Tolman and Rosen, 2001). The stress and demands of living with an abusive partner can make it challenging for victims to commit the energy and time to work toward their own financial goals (Kenney and Brown, 1996).

Additionally, although domestic violence is present across socioeconomic groups, low income, unemployment, recent personal financial crises, and financial stress are associated with physical domestic violence victimization among men and women (Capaldi et al., 2012; Roberts, McLaughlin, et al., 2011; Stith, Smith, et al., 2004). Ten percent of women with household incomes under $25,000 report having experienced rape, physical violence, or stalking by an intimate partner in the last 12 months, a rate that is more than three times higher than for women with household incomes greater than $50,000. Similarly, lower-income men are more than twice as likely as higher-income men to experience victimization (Black et al., 2011). Unemployment and low income are stronger and more robust risk factors for domestic violence than education, controlling for other factors such as age, relationship factors, and alcohol use (Capaldi et al., 2012). Low income and unemployment at the household level, and poverty at the community level, also tend to be associated with abuse or neglect of children (Brown et al., 1998; Krug et al., 2002; Sedlak et al., 2010; Stith, Liu, et al., 2009).

Financial services may help to prevent family violence victimization, through mechanisms such as improved psychological well-being, although additional research is needed. Research in the United States and internationally has provided some evidence for the link between economic empowerment and reduced exposure to domestic violence, although evidence has been mixed depending on the economic program and population (Gibbs, Jacobson, and Kerr Wilson, 2017; Matjasko, Niolon, and Valle, 2013; Niolon et al., 2017). One study found that U.S. welfare-to-work programs (which help welfare recipients pursue employment through job-search assistance or skill-building activities) led to lower reports of past-year physical domestic violence victimization in a follow-up interview five years later (Hamilton and Freedman, 2001). Multiple forms of cash transfers have led to reductions in domestic violence internationally (Gibbs, Jacobson, and Kerr Wilson, 2017), with one study finding causal evidence that a cash transfer led to both reduced stress and reduced domestic violence (Haushofer and Shapiro, 2016).

Financial services for parents may also help to prevent child maltreatment, although most of the research to date has been centered on effects of financial services on risk factors for child maltreatment, such as parents' mental health (Fortson et al., 2016). In one experiment examining direct effects on child maltreatment, mothers entering Temporary Assistance for Needy Families who received a greater monthly child support income were less likely to have a child maltreatment report that was investigated by CPS (Cancian, Yang, and Slack, 2013).

Much of this research, however, has not focused specifically on individuals who have already been victimized. The limited research to date suggests that financial services tailored to the needs of domestic violence victims leads to improved financial well-being among this population. For example, a quasiexperimental study of the Redevelopment Opportunities for Women economic education program, which was developed specifically for battered women, found improvements in financial self-efficacy two weeks later (Sanders, Weaver, and Schnabel, 2007). More recently, a randomized controlled trial of the financial education curriculum developed by the Allstate Foundation and the National Network to End Domestic Violence for domestic violence victims found improvements one year later in financial knowledge, inten-

tions, and behavior, and a decrease in financial strain (Postmus, Hetling, and Hoge, 2015). Additional research is needed to understand potential social effects of victim financial services, such as effects on revictimization and victim decisionmaking about custody or housing.

Although the efficacy of economic empowerment via microfinance programs has primarily been studied in international contexts (Gibbs, Jacobson, and Kerr Wilson, 2017), these programs may also be beneficial for low-income communities in the United States (Niolon et al., 2017). Economic policies that implement national programs for financial support include Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, and Earned Income Tax Credits (Niolon et al., 2017; Center on Budget and Policy Priorities, 2016). The U.S. military offers various financial services to provide service members with the knowledge and tools for increased financial literacy. Military OneSource, a website with resources related to navigating military life, links service members to financial and legal services (Military OneSource, undated-b). Personal finance resources include educational information and resources on budgeting, saving, borrowing, retirement planning, and finance protection. The website also includes tips and references for preparing and filing taxes, and financial planning before deployment. Given the financial difficulties that can accompany deployment, the military offers financial assistance to deployed families through the individual service branches (Military OneSource, undated-b). Each branch has a nonprofit organization dedicated to supporting service members through grants or low-interest and no-interest loans for emergency situations.

Behavioral Health

Domestic violence victimization is associated with severe behavioral health consequences, including suicidal ideation, substance misuse, and posttraumatic stress (Coker et al., 2002; O'Leary, 1999; Roberts, Klein, and Fisher, 2003). Stress and reduced mental bandwidth (i.e., mental resources for attention and computation) can make individuals less able to engage in longer-term thinking and optimal decisionmaking (Mullainathan and Shafir, 2013). Stress also tends to increase substance use (Keyes, Hatzenbuehler, and Hasin, 2011). PTSD and depression, which may occur following a traumatic event (O'Donnell, Creamer, and Pattison, 2004), have been associated with significant impairments in quality of life, functioning, and physical health (Greenberg et al., 2003; Schnurr, Spiro, and Paris, 2000; Zayfert et al., 2002). In the case of child maltreatment, behavioral health services may be most relevant as an opportunity to intersect with caregivers or families, rather than with victims alone. Low parental mental health and functioning is related to the incidence of child maltreatment. More specifically, according to a meta-analysis of risk factors for child maltreatment, parental mental health indicators that are associated with a higher likelihood of child maltreatment include stress, anger, low self-esteem, anxiety, depression, low social support, and alcohol abuse (Stith, Liu, et al., 2009).

Relationship health is also related to family violence. The most consistent interpersonal factor related to domestic violence, for example, is relationship conflict (Capaldi et al., 2012; Krug et al., 2002). Marital dissatisfaction and domestic violence have a strong association, and previous domestic violence perpetration tends to predict new domestic violence perpetration (Stith, Smith, et al., 2004). Family conflict is also associated with child abuse and neglect (Brown et al., 1998; Stith, Liu, et al., 2009). Specifically, likelihood of child maltreatment is

associated with low marital satisfaction, low family cohesion, a high number of family members, spousal violence, parental use of corporal punishment disciplinary methods, a poor parent-child relationship, and parents' viewing their child as difficult (Stith, Liu, et al., 2009).

Reaching victims through their contact with the behavioral health system may be an opportunity to refer them to victim services, if victimization is disclosed in the course of treatment. In some cases, screenings are conducted across clients to detect potential victimization (Todahl and Walters, 2011). Additionally, while a greater evidence base is needed, improvements in behavioral health in and of itself may help to prevent revictimization. Stress and substance use may impair one's ability to detect a potential abuser, and potential abusers may target individuals who appear vulnerable (for example, due to engaging in high-risk behaviors such as substance use; Breslau et al., 1991; Cottler and Mager, 1992; Kessler et al., 1995; Kilpatrick et al., 1997). Engaging in risk behaviors prior to victimization does not imply victim responsibility, but it has been posited, for example, that addressing heavy drinking among potential victims may reduce cases of incapacitated rape and risky encounters that result in rape (Testa and Livingston, 2009; Testa, Livingston, and Collins, 2000), including in military settings (Farris and Hepner, 2015). Some recent evaluations of alcohol interventions in college settings have provided causal support for this effect (e.g., Clinton-Sherrod et al., 2011; Testa et al., 2010).

Domestic violence perpetrator treatment programs typically take the form of a group intervention modeled on the Duluth approach, which posits patriarchy and men's relatively higher social standing as the root causes of domestic violence (Stover, Meadows, and Kaufman, 2009). Another common model for perpetrator treatment programs is group cognitive behavioral therapy, which aims to provide participants with tools for emotional regulation (e.g., anger management skills, relaxation techniques) and healthy communication, thus equipping them with alternatives to violence. Increasingly, programs have combined aspects of the Duluth and cognitive behavioral therapy models in their delivery (Stover, Meadows, and Kaufman, 2009). There is not strong support for the effectiveness of batterers' intervention programs. In fact, most studies estimate that one-third of domestic violence cases will have a new episode of domestic violence within six months with or without perpetrator intervention (Stover, Meadows, and Kaufman, 2009).

Interventions for survivors show more promise than those for perpetrators. Although these programs can use a range of therapeutic modalities, such as forgiveness therapy and feminist-oriented therapy, those employing cognitive behavioral therapy approaches demonstrate the greatest effectiveness (Eckhardt et al., 2013). For example, Cognitive Trauma Therapy for Battered Women, a program for domestic violence survivors who have ended the relationship with the perpetrator, showed significant reductions in PTSD symptoms, depression symptoms, and trauma-related guilt six months after intervention (Eckhardt et al., 2013). Another program of note, Helping to Overcome PTSD Through Empowerment, incorporates cognitive behavioral therapy techniques and is targeted toward women currently in shelter. Initial research has found the intervention to be associated with reduced physical domestic violence victimization, higher levels of social support, and lower levels of depression (Eckhardt et al., 2013). Altogether, the literature on the effectiveness of cognitive behavioral therapy–based behavioral interventions for domestic violence survivors is encouraging.

Behavioral health services can also be a setting for treatment options for families in which incidents of child maltreatment have been reported. One of the primary behavioral health interventions for child maltreatment cases, Parent-Child Interaction Therapy, is designed for

parents of children ages two to seven and works with parents and children to improve the parent-child attachment relationship (Chaffin et al., 2011; Thomas and Zimmer-Gembeck, 2011; Timmer et al., 2011). Studies have found some evidence of positive effects in cases of child maltreatment. For example, in a randomized controlled trial, mothers who had undergone this form of therapy had observed improvements in parent-child communication, child behavior, and sensitivity toward their child (Thomas and Zimmer-Gembeck, 2011). Another study found that combining Parent-Child Interaction Therapy with a motivational treatment was especially beneficial in preventing child maltreatment recidivism (Chaffin et al., 2011).

Parenting programs to support new parents have also shown potential for reducing or preventing child maltreatment. Home visiting and parent education are the two main programs currently available to provide parenting support (Chen and Chan, 2016). Parent education is defined by group-based programs in which an instructor develops the participants' parenting knowledge and skills (Chen and Chan, 2016). Home visitation, by contrast, is an individualized program in which a trained home visitor provides parenting support and training. A recent meta-analysis of randomized controlled trials found evidence that parenting programs lead to long-term reduction in child maltreatment (Chen and Chan, 2016). Specifically, the studies analyzed found a small reduction in the rate of child maltreatment reports, psychological abuse, severe disciplinary methods, physical abuse, and neglect (Chen and Chan, 2016).

Physical Health

Physical health consequences associated with domestic violence victimization include physical injuries, death from homicide, poor sexual and reproductive health, and revictimization (Black, 2011; Breiding, Black, and Ryan, 2008; Coker et al., 2002; Exner-Cortens, Eckenrode, and Rothman, 2013; Leserman and Drossman, 2007; O'Leary, 1999; Roberts, Klein, and Fisher, 2003). Domestic violence victimization has also been associated with risky sexual behavior such as not using contraception or barrier protection, which can lead to sexually transmitted infections and unwanted pregnancy (Campbell, 2002; Gee et al., 2009).

Physical health services are an opportunity to screen for victimization and provide referrals to victim services, and screenings in medical settings have shown effectiveness at detecting victimization (Rickert et al., 2009; Soglin et al., 2009; Todahl and Walters, 2011). Because health providers tend to see patients individually, appointments offer victims of domestic violence an opportunity to disclose victimization without the offender monitoring their help-seeking (de Boinville, 2013). This setting also may allow health providers to discuss the health effects of domestic violence victimization, and individuals may prefer to disclose victimization to a trusted provider as opposed to a stranger (de Boinville, 2013).

Thus, physician referrals are a key access point to reach victims who may not otherwise access victim support services. Although it was not focused specifically on family violence, one study found that only 23 percent of injury victims with probable PTSD obtained mental health care in the following year (Jaycox, Marshall, and Schell, 2004), in most cases after a physician referral (Wong et al., 2009). This study highlights medical referrals as a potential mechanism to increase participation in other services. Emergency departments are another physical health setting with the potential to identify victims of domestic violence (de Boinville, 2013). In one study of women who were victims of intimate-partner homicide, 44 percent of

the women studied had been to an emergency department within the two preceding years to seek assistance (Wadman and Muelleman, 1999).

Life Stage

Life stage is one factor correlated with family violence that cuts across the domains of finances, behavioral health, and physical health. *Life stage* may refer to the age or rank of an individual or the individual's partner. Young adults are at particularly high risk for first-time domestic violence victimization, with the majority of adult domestic violence victims indicating that they first experienced domestic violence before age 25 (Black et al., 2011). Among military populations, specifically, being in a lower rank and younger in age have been associated with domestic violence and child abuse (Bell, Harford, Fuchs, et al., 2006; Cozza et al., 2015; Foran, Slep, and Heyman, 2011; McCarroll, Ursano, Newby, et al., 2003; Newby et al., 2005; Rumm et al., 2000; Schaeffer et al., 2005; Schmaling, Blume, and Russell, 2011; Cesur and Sabia, 2016).

Resources targeting younger adult populations—such as early-career retirement planning financial programs, mentoring programs, or training sessions for newly recruited service members—may offer opportunities for intersecting with this population for prevention efforts or referrals to response services. Military resources targeting younger adult populations include family support in preparation for deployment through the Family Readiness System (Military OneSource, 2018a) and the New Parent Support Program (Military OneSource, 2018c).

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Family violence occurs in the U.S. military as it does in the civilian population, but unique stresses of military life may contribute to the risk of child abuse or neglect (CAN) and domestic abuse (DA) among service members. The Department of Defense (DoD) holds itself accountable for preventing and addressing CAN and DA and does so primarily through the congressionally mandated Family Advocacy Program (FAP), and also in coordination with other military and civilian services. At the request of the Under Secretary of Defense for Personnel and Readiness, RAND conducted a multimethod study to review current resources available to military-affiliated victims and perpetrators of CAN and DA, describe the barriers to utilization, document the challenges faced by military service providers working to prevent and respond to CAN and DA, and provide recommendations to improve services. Surveys and interviews with FAP leadership and providers suggest that FAP offers a wide range of important services to military-affiliated families. However, additional targeted resources and stronger leadership support could improve the program, particularly in improving the balance between prevention and response.

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