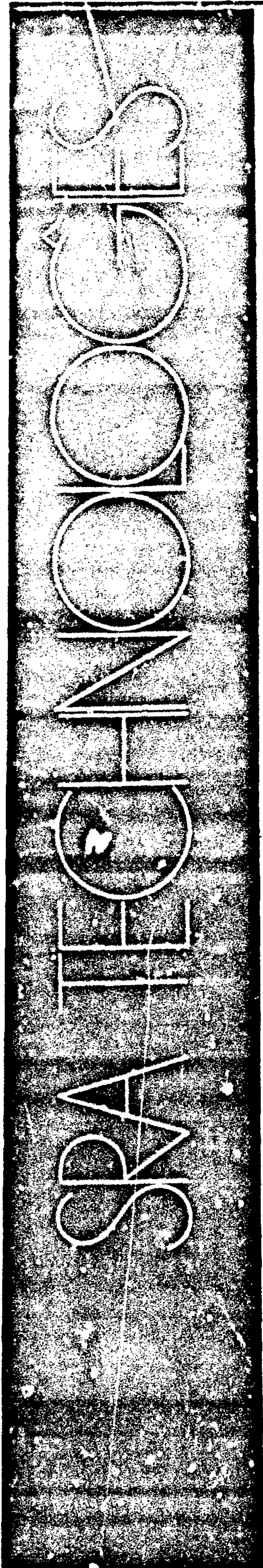


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# Department of the Navy Family Advocacy Program Service Need and Service Response

## Phase II Report: Assessment

Sponsored by
Department of the Navy
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Arlington, Virginia 22217

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# Family Advocacy Program
# Service Need and Service Response

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# DEPARTMENT OF THE NAVY
# FAMILY ADVOCACY PROGRAM:
# SERVICE NEED AND SERVICE RESPONSE

## PHASE II REPORT: ASSESSMENT

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This report assesses the operation of the Navy Family Advocacy Program at the command level. Based on site visits to 13 Navy and Marine Corps bases worldwide, the report: (1) describes the structure and operational context of the programs in the late winter of 1983; (2) assesses the relationship between service need and service response; (3) identifies major program strengths, program concerns, and program dilemmas; and (4) discusses the —


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interactions between medical and nonmedical personnel, both military and civilian, in the treatment and prevention of child abuse, spouse abuse, and sexual assault or rape. The report also identifies program needs and recommendations for program improvement. Findings are based on approximately 300 individual and group personal interviews with Department of the Navy and civilian personnel, case statistics, program documents, and structured observations of Family Advocacy Committee meetings.

The findings indicate a high degree of variation in program structure and operation across sites. Program strengths include interagency cooperation availability of civilian resources, command support, and ongoing training of Family Advocacy participants. Areas of concern include: lack of program clarity, insufficient staff resources, role ambiguity between medical and line personnel, focus on child maltreatment and confusion about reporting procedures. Differences in base and community resources and the perceived scope of abuse and neglect often are intervening variables in program development.

## EXECUTIVE SUMMARY

Family Advocacy Programs exist in all branches of the Armed Services. In the 1970's the Chief of the Bureau of Medicine and Surgery (BUMED) established an Instruction for the Department of the Navy Medical Corps. In 1981 the Department of Defense issued a Family Advocacy Directive which mandated line involvement in the program. At present, the Office of the Secretary of the Navy is drafting an Instruction which will delineate the responsibilities toward family advocacy shared by the Navy Medical Command, the Marine Corps, and the U.S. Navy.

The Instruction referred to throughout this report is the one issued by the Bureau of Medicine and Survey.

Commanding officers of all Naval medical facilities are responsible for implementing local Family Advocacy Programs at their facilities. Naval regional medical centers and hospitals must establish local policies and directives for implementing a Family Advocacy Program at their commands. A Family Advocacy Representative and a standing Family Advocacy Committee are established at the medical facility that oversee the operation of the local program, make plans for the management of cases, and submit recommendations on program management to the commanding officer of the hospital.

This investigation examines the structure and operation of the Family Advocacy Program at the command level. Study objectives, design, findings, and conclusions are summarized in the following sections. The format of the summary is generally consistent with the report format which includes three major sections: (1) Family Advocacy Program Descriptions; (2) Program Overview; and (3) Conclusions.

### THE RESEARCH

The Department of the Navy through the Office of Naval Research requested an indepth review of the extent and nature of personal abuse and

neglect in the Navy and Marine Corps, and an assessment of how the Navy Family Advocacy Program, designed to address these problems, is performing worldwide.

SRA Technologies of Arlington, Virginia was contracted in 1982:

- To learn the numerical extent and nature of abuse and neglect incidence, conditions, and effects in the military;
- To develop baseline data and profiles of at-risk military families based on literature research and site visit case studies at 13 Navy and Marine Corps bases in five states, Japan, Italy, and Sardinia;
- To compare military and civilian populations for incidence, prevalence, and at-risk profiles;
- To assess the structure and operation of the Navy's Family Advocacy Programs at the command level; and
- To develop recommendations for future military policies, programs, and budget planning.

The project will be completed in the Fall of 1983.

This report, the second of three planned, presents an assessment of the effectiveness of the Navy Family Advocacy Program at the command level. Based on site visits to 13 Navy and Marine Corps bases worldwide, the assessment was guided by the following objectives:

- Describe the structure and operation of the Navy's Family Advocacy Program at the command level;
- Assess the current relationship between service need and service response;

- Identify major program strengths, concerns, and dilemmas;
- Document effective program practices;
- Examine the extent of liaison between medical personnel and nonmedical personnel in the treatment and prevention of abuse and neglect; and
- Identify program needs and recommendations for program improvement.

The report is intended to provide an in-depth review for Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention and whose decisions depend upon the best available information.

Using a case study approach, the assessment was conducted at 13 Navy and Marine Corps bases: Naval Station, Charleston; Marine Corps Air Station, Cherry Point; Naval Air Station, Brunswick; Naval Air Station, Memphis; San Diego Area Activities; Marine Corps Base, Camp Pendleton; Marine Corps Air Ground Combat Center, Twentynine Palms; Marine Corps Logistics Base, Barstow; Fleet Activities, Yokosuka; Marine Corps Air Station, Iwakuni; Naval Air Facility, Atsugi; Naval Support Activities, Naples; and Naval Support Office LaMaddalena. Approximately 300 in-person interviews both individual and group, were conducted with a broad sample of Department of Navy and civilian personnel across the 13 bases: command leadership, medical personnel, Navy and Marine Corps human service providers, security and legal personnel, base volunteer groups, and representatives from civilian agencies.

In addition to interviews, SRA project staff attended family advocacy committee meetings, examined case records, and visited base and civilian support facilities. SRA designed interviewing and recording guides to structure interviews and observations, and to provide data consistency among project staff.

After collecting and aggregating the data from the interviews, case records, and observations, SRA staff prepared summary case study reports for each site visited. SRA then compared data across commands on the key variables of the study. This analysis focused largely on differences in the structure and operation of the individual programs and the reasons for these differences.

Although the bases chosen for the assessment were selected because of variations in command responsibilities, geographic location, base demographics, and availability and sophistication of support services, care is recommended in generalizing study results to other Navy and Marine Corps installations because of the restricted number of sites and their non-random selection. Still, study results do make a heuristic contribution to understanding the current status of the Department of the Navy Family Advocacy Program and provide a foundation for developing hypotheses at other Navy and Marine Corps installations.

## FAMILY ADVOCACY PROGRAM DESCRIPTIONS

This section provides summary descriptions of the 13 Family Advocacy Programs visited during the course of the assessment. Its purpose is to provide a general overview of responses to abuse and neglect across Navy and Marine Corps installations. In highlighting program variations across sites, the section provides an important foundation for discussing the overall structure and operation of the Family Advocacy Program.

Each program profile contains information organized in the following categories:

- **Introduction:** geographic location and mission of the base or installation, population demographics, stress factors for families, and available support services.

- **Program Context:** the nature of the medical facility, staffing patterns, and history and development of the Family Advocacy Program.

- **Program Structure:** the number and composition of the Family Advocacy Committees, frequency of Family Advocacy Committee meetings, and role of the Family Advocacy Representative.

- **Program Operation:** the number of abuse and neglect cases, the nature of interorganizational cooperation, types of referral sources, and recommendations of respondents for program improvements.

- **Current Directions:** new or planned Family Advocacy Program developments, obstacles to effective response, and recommendations of respondents.

Findings from the program descriptions document wide variation in program structure and operation across installations. Some base programs are more developed and integrated than others. Regardless of their program status, however, most base personnel recognize the seriousness of abuse and neglect and the importance of responding to these problems through effective interagency cooperation and coordination. Differences in base and community resources and the perceived scope of abuse and neglect often are intervening variables in program development.

**PROGRAM OVERVIEW**

The 13 Family Advocacy Programs assessed during the site visits exhibit both similarities and differences in program structure and operations. Although some Family Advocacy Programs closely follow the program guidelines set forth in BUMED Instruction 6320.57, those at other sites are more rudimentary. Differences between programs more often result

from variations in available resources and program history than from lack of concern and initiative for program development.

This section of the report discusses distinctive program variations, provides explanations for these differences, and presents program issues raised by respondents and observed by research teams during the site visits. The issues chosen for discussion reflect general program concern and are not specific to any particular location. The section concludes by outlining recommendations from base respondents for increasing program effectiveness.

**Program Context**

Sites chosen for the study represent the heterogenous character of Navy and Marine Corps locations and functions. The aim was to assess the development, structure, and operation of the Family Advocacy Program across a number of demographic, mission, and support service variables. The range of site contexts alone provided several straightforward explanations for Family Advocacy Program variations:

- Smaller bases and hospital facilities usually have one rather than three working subcommittees; otherwise the same personnel would be assigned to all three.
- Overseas installations are dependent on base resources for family advocacy case investigation and intervention because civilian resources are unavailable.
- At small CONUS bases, family cases requiring treatment services often are referred to civilian resources because of the shortage of hospital and base facilities and personnel.

- Unlike CONUS installations, overseas Family Advocacy Committee discussions often focus on the merits of the "early return" of families involved in abuse and neglect.

- Bases with a entry-level technical training mission have less well developed Family Advocacy Programs because of the transient nature of the population.

- Navy Family Advocacy Representatives are more likely than civilian Family Advocacy Representatives to have additional collateral duty responsibilities.

All the Family Advocacy Programs examined share one element in common: the evolution of greater specification and refinement in program structure and operation. The development of line-based activities in family advocacy areas is a major reason for program change. Stimulated by the forthcoming SECNAV Instruction, training sessions in family advocacy issues, and the recently issued Marine Corps Family Advocacy Order, the awareness of advocacy issues is spreading throughout the Navy and Marine Corps communities.

Another influence on the Family Advocacy Program, especially at smaller installations, is the introduction of military and civilian social workers into Navy medical settings. Trained hospital social workers expedite the work of the Family Advocacy Committees by assuming investigative and coordinating responsibilities in abuse and neglect cases.

**Program Structure**

The BUMED Instruction creating the Family Advocacy Program is a policy rather than a program statement intended to set general guidelines for often highly disparate local situations. It outlines a program structure but is less specific about how this structure should operate. The Instruction specifies the number and composition of Family Advocacy Committees, meeting frequency, position and role of the Family Advocacy Representatives and the Duty Family Advocacy Representatives, and procedures for case

reporting. It also directs hospital personnel to perform a number of family advocacy functions: case identification, assessment, treatment, prevention, education, and reporting.

The Instruction stresses the importance of cooperation between base agencies and base and civilian resources, but does not provide detailed guidance about developing and maintaining this cooperation. Given the importance of community response to family advocacy and the need for effective interface between hospital, civilian, and line personnel, this poses a serious problem, especially for inexperienced FAP staff who feel a need for specific procedures.

In general, the BUMED Instruction does not contain detailed program goals nor parameters for program evaluation. Instead, the emphasis is on statistical reporting requirements of family advocacy cases. In addition, the case procedures outlined by the Instruction for handling abuse and neglect cases are more applicable to cases of child maltreatment than to spouse abuse, sexual assault or rape. Frequently, the Instruction combines the problems of child maltreatment and abuse between adults.

The Instruction's emphasis on child maltreatment is reflected in many local programs. Child maltreatment subcommittees usually meet more frequently and regularly than do the other subcommittees. There are no spouse abuse or sexual assault/rape subcommittees at some bases visited. The focus of the Instruction and local programs on child maltreatment stems from both historical factors and the perceived seriousness of the offense, although the recorded incidence of spouse abuse is higher in many locations.

**Role of the Family Advocacy Representative.** The Family Advocacy Representative plays a key role in the program. On the bases the research team visited, the prooortion of time that Famiily Advocacy Representatives spend in family advocacy related duties ranges from 10 to 100 percent. Most Family Advocacy Representatives, however, have responsibility not only for the Family Advocacy Program, but also for such duties as outpatient and

discharge planning, adoption coordination, weight control programs, social work administration, and medical caseloads.

Results indicate little consensus among Family Advocacy Representatives about their primary duties. Most see their roles as primarily administrative with responsibilities in the areas of case reporting, case management, and program coordination. A few focus as well on clinical practice and perform direct crisis intervention, family mediation, and case investigation. All Family Advocacy Representatives interviewed say that education and prevention of abuse and neglect cannot be given a high priority because of time and resource constraints.

The site visits demonstrated that the Family Advocacy Representative is central to the functioning of the Family Advocacy Program: a good one can turn "a paper program" into an actual one. On the other hand, the simple designation of a Family Advocacy Representative without the ingredients of time, treatment resources, command support, and interest in abuse and neglect problems is insufficient for success.

**Role of Committees.** The BUMED Instruction mandates a minimum of four types of local family advocacy committees for medical centers, regional medical centers, and hospitals. These include a standing Family Advocacy Committee and three working subcommittees: (1) child abuse and neglect, (2) spouse abuse and neglect, and (3) sexual assault and rape. SRA staff observed Family Advocacy Committee meetings of both central and working subcommittees at five site locations. These observations and the interview data revealed a high degree of variation among bases in the structure, composition, and functions of committees.

In general, however, medical facilities are more likely to have an organized child abuse subcommittee. The presence of spouse abuse/neglect and sexual assault/rape subcommittees is less predictable, even at the larger medical complexes. Program staff often cited too few cases and lack of program staff as reasons for having fewer than the required number of subcommittees.

Committee membership also varies across sites, particularly that of nonmedical personnel. At one end of the continuum, all committee members are medical personnel or assigned to the hospital. Other Family Advocacy Committees, especially subcommittees, are more open to nonmedical personnel, including directors and staff members of Navy and Marine Corps Family Service Centers and command representatives. In CONUS, some but not all child abuse subcommittees invite a representative from the local Child Protection Service unit in the civilian community to attend Family Advocacy Committee meetings.

There is general agreement among Family Advocacy Committee members interviewed that family advocacy subcommittees have three principal tasks. First, they provide case disposition of abuse and neglect cases occurring in their community. Second, they ensure that cases are referred to appropriate service resources. Third, they evaluate the treatment received in the medical setting. Committee members often see the Family Advocacy Representative as the primary response person in cases of abuse and neglect; the subcommittee oversees the Family Advocacy Representative's response and monitors case management.

In general, the focus of the subcommittees is geared more toward case diagnosis than treatment response. At times, diagnostic debates among committee members become time consuming and focus more on personal debates over definitions of abuse and neglect than on responding to an identified need.

In the fall of 1982, a new set of Family Advocacy Coordinating Teams initiated by Navy Family Service Centers began in several commands. These committees differ structurally and functionally from the medical committees developed through the BUMED Instruction. Chaired by the director or a staff member of a Navy Family Service Center, these committees include a wide range of command representatives and service providers. At the time of the site visits, these base committees were planning to develop a community response to abuse and neglect through better interagency cooperation

and to sponsor educational activities aimed at command personnel and family members.

## Program Operation

**Case Identification.** The BUMED Instruction assumes that a viable Family Advocacy Program will develop clear, routine channels for reporting incidents along with community awareness and understanding of the prevalence and nature of domestic violence and sexual assault. Although progress is being made, neither of these objectives is being met fully in either civilian or military communities. Some of the 13 Navy and Marine Corps bases visited during the study had just begun to establish community education programs and to develop defined reporting procedures.

The vast majority of family advocacy cases handled through the Family Advocacy Program surface through medical channels, primarily from the emergency room, or from pediatric or other medical officers. Although hospital personnel usually are more aware of reporting requirements than other base personnel, a significant number expressed a need for more in-service training in family advocacy case identification and management. In addition, a number of medical personnel expressed confusion about the role of the Family Advocacy Representatives and purposes of the Family Advocacy Committees.

Outside the hospital, the greatest awareness of family advocacy issues and reporting requirements is found among Navy and Marine Corps Family Service Center staffs. However, Family Service Center staffs at some bases express reluctance to report cases to the hospital, especially spouse abuse cases, primarily because of the unclear impact of case reports, the secondary nature of abuse to other family problems, and perceived potential violations of client privacy.

Interviews with other agency representatives demonstrated wide variations in knowledge about advocacy issues and reporting procedures. In most

cases, client confidentiality supersedes family advocacy reporting requirements.

**Intake and Assessment.** According to the BUMED Instruction, the Family Advocacy Representative is responsible for gathering background information on a family advocacy case, and presenting it to the working committees for disposition. In the Family Advocacy Representative's absence, the Duty Family Advocacy Representative, a rotating position drawn from a roster of "on call" personnel provides intake services.

The importance of the intake and assessment process lies in its impact on case disposition, diagnosis, and the subsequent design of effective intervention strategies. The inability to perform a proper case assessment because of lack of time and staff resources often delays the Family Advocacy Committee from executing its function or forces it to make case decisions without a sound basis.

Caseflow as outlined in the Instruction seems relatively straightforward--medical officers or other command personnel transfer information to the Family Advocacy Representative who logs the information and conducts an interview and initial assessment. The Family Advocacy Representative then brings the case to the committee's attention. In actuality, however, there are variations in this flow at the 13 sites. In general, intake and assessment processes are most effective when cases originate within the hospital setting; the problem involves child maltreatment, the incident occurs in CONUS; and when the Family Advocacy Representative has adequate time or staff resources to devote to the process.

**Intervention and Prevention.** The Enclosure to BUMED Instruction 6320.57 provides operational guidelines for family advocacy intervention and prevention. Patterned after the medical model, the Instruction specifies three levels of program intervention: primary, secondary, and tertiary.

At present, tertiary intervention in abuse and neglect cases is the major focus of family advocacy personnel. Family Advocacy Representatives recognize their responsibilities for prevention activities, but their efforts are aimed primarily at families where abuse or neglect already has occurred. Family advocacy personnel usually attribute the lack of secondary and primary intervention activities to shortages of base and community service resources and staff.

Regardless of the balance between primary, secondary, and tertiary intervention activities at the base level, most respondents recommend increasing the prevention focus of the local Family Advocacy Program. They are less specific, however, about how to turn the concept of prevention into program activities.

The BUMED Instruction provides very general guidelines for service intervention in family advocacy cases. It states that the most effective method of treatment intervention is behavioral, which focuses on the need to train individuals to use constructive methods to deal with stress and conflict. Although this statement reflects an orientation toward treatment and a goal of intervention, it does not provide personnel involved in family advocacy with clear-cut service response methods.

Although most respondents believe that "stopping the abuse or neglect" is a major goal of intervention, they are less clear about related service strategies. For example, family advocacy personnel often disagree over whether to remove the abused or the abuser from the home, whether the abused or the abuser should be the focus of intervention, or how the Family Advocacy Committee should proceed in a case where the victim is reluctant or unwilling to seek outside assistance.

Although respondents may disagree about the best response to abuse and neglect, they prefer a treatment to an administrative response to these cases. With the exception of sexual assault and rape, Family Advocacy Committee members often choose not to involve the sponsor's Commanding

Officer in abuse and neglect cases unless the family member fails to follow committee recommendations.

In most base situations, family advocacy personnel have limited resources for intervention. In fact, they note the lack of such resources as a recurring frustration. For example, although the Family Service Centers and Alcohol Rehabilitation Services often provide a major Family Advocacy Program resource, neither are present on all bases. In addition, some Family Service Centers are limited to information and referral services and lack clinical staffs.

Most military-sponsored services that are fully staffed and capable of assisting in family advocacy are located on larger bases. Overseas locations rarely have the needed treatment resuurces. Even in communities where civilian support services augment base resources, obstacles, such as jurisdictional issues, sometimes prevent coordination and adequate response to abuse and neglect cases involving military personnel and families.

**Jurisdiction.** The question of who has legal authority in a given situation is an extremely complex issue at many bases. Authority for intervention depends upon the location of the incident, military or civilian status of the victim and perpetrator, the severity of the incident, and the types of agreements existing between potential intervenors. Jurisdictional issues vary considerably across bases. Status of forces agreements and the reporting protocols in child maltreatment cases, especially in areas of exclusive juridiction, may present major roadblocks to effective service response.

**Interorganizational Cooperation.** The BUMED Instruction recognizes the importance of interorganizational cooperation among medical, line, and civilian agencies to program success. Although Family Advocacy Committee members usually report effective cooperation between base and community organizations in responding to abuse and neglect incidents, the degree of

cooperation varies across organizations and across sites. At those bases where linkages between agencies are more developed, there are several factors at work:

- The Family Advocacy Program has clear and established objectives;

- The Family Advocacy Representative has established liaison with people in other service agencies, both military and civilian;

- The network of agencies involved with the Family Advocacy Program is larger and includes not only the medical facility, but also available base and community agencies; and

- The Family Advocacy Representative maintains open communication channels with base and community agencies.

These observations indicate that interorganizational linkages are built largely upon good communication and a clear understanding of Family Advocacy Program tasks and objectives. The success of the Family Advocacy Program depends on various agencies providing information about abuse and neglect incidents through medical reporting channels, so that the Family Advocacy Representatives can coordinate an effective service response. Interorganizational cooperation also depends on a two-way flow of information in which base and community personnel receive feedback about case disposition and service response.

**Case Reporting.** At all 13 sites, abuse and neglect cases are being reported to the Family Advocacy Representative by a variety of civilian and military agencies and individuals. However, reporting procedures are more institutionalized at bases with a more established Family Advocacy Program.

Child maltreatment and sexual assault and rape cases are more likely to be self-referred or reported through Family Advocacy Program channels than those dealing with spouse abuse. This reflects the continuing ambiguity about handling spouse abuse and the precedence for reporting child

and sexual abuse. Not only do spouse abuse cases surface at a wider range of agencies and referral sources, but also base personnel feel less obligated to report spouse abuse cases and often leave the reporting decision to the abused spouse.

Reporting from one military installation to another when sponsors are transferred is often a problem area. Although most Family Advocacy Representatives indicate that they are forwarding records in the majority of established cases, they report receiving only a small number.

**Follow-Up Procedures.** Procedures for the follow up of family advocacy cases are an essential component to effective management of abuse and neglect cases and are discussed in several sections of the BUMED Instruction. The Instruction specifies that the Family Advocacy Representative and the Family Advocacy Committee members are to establish internal reporting and follow-up procedures. This consists of providing treatment recommendations and maintaining periodic contact with the family to insure that no further indications of abuse or neglect occur. As interpreted in the field, follow-up procedures usually refer to tracking the case after referral to treatment facilities. In general, case follow up often is hindered by shortages of staff resources and inadequate criteria for changing the status of a case from active to inactive.

**Program Evaluation.** The Instruction recommends systematic program evaluation and specifies that the success of the program rests on its ability to evaluate and redirect current resources in a manner that maximizes medical care to Navy and Marine Corps members and families.

Across the installations visited, however, there are few efforts to evaluate the effectiveness of the local Family Advocacy Program. The Family Advocacy Representatives and Family Advocacy Committees generally assume that the program is working if there is an increase in reported cases. This informal assessment is often skewed, however, because records involving family violence or sexual abuse have been kept systematically only in the past few years. As a consequence, comparison figures for the

rate of abuse and neglect across a specified time period may reflect more improvements in case identification and record keeping than an actual increase in the number of cases. Only a few bases have the necessary case records to estimate realistically the effects of the program.

**Program Recommendations**

During the site visits, respondents were asked to offer specific recommendations for strengthening the Family Advocacy Program on their bases. They were asked to make these recommendations while assuming two different situations: the possibility and the impossibility that base resources and staff would be increased to respond to abuse and neglect cases. Their recommendations include:

- Increasing the number of Family Advocacy program staff;
- Increasing abuse and neglect prevention efforts, including more community education in family advocacy issues and greater outreach to families under stress;
- Providing greater program guidance especially around issues of interorganizational liaison, case disposition, and reporting procedures;
- Providing additional family advocacy training, especially in the area of case identification and assessment;
- Encouraging more active involvement of the sponsor's Commanding Officer in abuse and neglect cases; and
- Conducting better prescreening before overseas assignments.

## CONCLUSIONS

In reviewing the assessment data across installations, SRA project staff identified current program strengths as well as the concerns and dilemmas facing Family Advocacy Program and related base personnel. Factors associated with Family Advocacy Program effectiveness also are discussed.

### Program Strengths

Despite variation in Family Advocacy Program development and sophistication across installations, bases share certain strengths in their response to abuse and neglect. For example, medical personnel at most locations visited have responded to the BUMED Instruction and established policies and procedures for handling abuse and neglect cases. Although some program efforts are more developed than others, medical and base personnel generally share a pro-family advocacy stance and demonstrate program initiative and flexibility. Other program strengths include:

- **Competent and Professional Staffs.** Although the number and expertise of support personnel vary, most base and medical personnel demonstrate an awareness of abuse and neglect dynamics and are attempting to coordinate service response.

- **Program Responsiveness.** Despite professional resource limitations at some bases, Family Advocacy Program personnel at each base have initiated policies and protocol for identifying and coordinating service response to abuse and neglect cases.

- **Case Successes.** Program personnel report a number of successes in resolving abuse and neglect situations.

- **Interagency Cooperation.** In general, a solid foundation has been laid between Family Advocacy Program representatives and other base service providers.

- **Availability of Civilian Resources.** At most CONUS installations visited, base resources are augmented by civilian services and programs.

- **Established Emergency Room Protocol.** To facilitate program response, clear guidelines for handling abuse and neglect cases are posted in most base medical centers.

- **Command Support.** With few exceptions, both hospital and base leadership recognize the threat that abuse and neglect pose to personal, family, and community well-being and they support Family Advocacy Program efforts.

- **Positive Impact of Family Advocacy Training.** The recent family advocacy training workshops attended by medical and line personnel have facilitated cooperation between medical and base service providers.

- **Foundation for Program Development.** Although the developmental status and sophistication of Family Advocacy Programs varied across bases, each base has developed a foundation for improving prevention and intervention services in areas of abuse and neglect.

**Areas of Concern**

The Family Advocacy Program is confronted today by a number of concerns that are best described as developmental. For example, the increasing number of family advocacy cases have not necessarily been paralleled by increases in program staff and resources. As a consequence, case assessment and disposition is hindered at some bases by an increasing backlog of

cases. This and other concerns identified during the site visits are outlined below:

- **Lack of Program Clarity.** Despite the program detail provided in the BUMED Instruction, base and medical personnel often are unsure of the goals of the Family Advocacy Program, the role of the Family Advocacy Committees, and the responsibilities of the Family Advocacy Representative.

- **Family Advocacy Representative as a Collateral Duty.** The amount of time the Family Advocacy Representative devoted to Family Advocacy Program-related duties often is insufficient given program responsibilities.

- **Role Ambiguity Between the Family Advocacy Representative and Family Service Center Staff.** Lack of effective liaison and coordination between the Family Advocacy Representative and the Family Service Center staff promotes duplication of efforts and confuses base service providers about appropriate referral protocol.

- **Insufficient Assessment and Treatment Resources.** Although procedures for case identification have often improved at bases, staff resources for case assessment and treatment have remained relatively constant.

- **Diagnostic Emphasis.** Because of time devoted to discussing case diagnosis, the focus and energy of Family Advocacy Committees often are diverted from developing treatment strategies and followup procedures.

- **Lack of Training in Program Development.** In general, medical and base personnel demonstrate limited knowledge about how to develop a coordinated service response to abuse and neglect issues that minimizes program duplication and maximizes program effectiveness.

- **Child Maltreatment Focus.** At the bases visited, program attention and response more often are directed to child maltreatment than to spouse abuse or sexual assault and rape.

- **Program Procrastination.** In some cases, Family Advocacy Program participants attribute program inertia to the anticipation of a new line Instruction or to the scheduled opening of a base Family Service Center.

- **Confusion about Procedures for Case Reporting to Gaining Medical Commands.** Although most Family Advocacy Representatives report forwarding case materials to the gaining medical facility when a family advocacy case relocates, few reported receiving such notification.

- **Failure to Understand the Full Scope of the Family Advocacy Program.** Medical and base personnel, even Family Advocacy Representatives and Family Advocacy Committee members, often are unsure of the impact of establishing an abuse or neglect case on the sponsor's career and how case reports are processed at the Washington level.

- **Reactive Orientation.** Although the BUMED Instruction suggests that family advocacy intervention should incorporate both prevention and treatment services, base programs focus more on responding to existing abuse and neglect cases than on preventing new cases.

- **Working Relationships with Civilian Child Protection Services Units.** Although in some situations, Child Protection Service workers share incident reports and the results of child maltreatment investigations with the Family Advocacy Representative, at other bases the Child Protection Service workers will not provide feedback in child maltreatment cases involving Navy or Marine Corps personnel or dependents without a signed release of information.

## Program Dilemmas

Other issues facing the Family Advocacy Program are not necessarily program concerns, but require choices between potentially equally justifiable alternatives. In some instances, these dilemmas arise from policies and procedures beyond the control of Family Advocacy Program staff; in other instances, they involve making program and case decisions within policy, resource, and legal parameters. They include:

- **Notification of Commanding Officers.** Medical and base personnel often differ concerning when or if to notify the sponsor's commanding officer in abuse and neglect cases.

- **Guidelines for Establishing a Case.** There is little consensus about what constitutes established abuse and neglect.

- **Case Confidentiality/Privacy.** In some situations, base personnel are reluctant to refer cases through the Family Advocacy Program because they consider information between the client and themselves as confidential.

- **Staff Credentials for Treatment.** Medical and service professionals often differ about the necessary qualifications for treating victims and perpetrators of abuse and neglect.

- **Response to Dependents/Department of Defense Personnel Overseas.** Because military personnel have limited authority over military dependents and Department of Defense personnel overseas, they often depend upon the host government to exercise jurisdiction in problem situations. Unfortunately, authorities in both Japan and Italy are reluctant to become involved in family disputes involving American citizens.

- **Relationships Between Clinics/Dispensaries and Navy Regional Medical Centers.** In some locations there is little defined

interface between levels of medical facilities in terms of case consultation or reporting procedures.

- **Role of Family Service Centers in Family Advocacy.** At the present time, there is wide variation in the role of Family Service Centers in the Family Advocacy Program. Both medical and Family Service Center personnel express a need for clearer delineations of their respective roles in the Family Advocacy Program.

- **Base Need for Shelters/Safe Houses.** Base and medical personnel often are divided over the merits of base shelters and safe houses.

- **Punishment Versus Rehabilitation.** At present, there is a lack of established criteria about if and when abuse and neglect cases should be handled through punitive rather than treatment rehabilitation channels.

**Keys to Success**

There are a number of prerequisites for developing and maintaining an effective and responsive program. The elements that make up a successful program appear to include:

- **Command Support and Concern.** Both hospital and line commands need to recognize the impact of dysfunctional families on mission readiness and support Family Advocacy Program personnel, the Family Advocacy Representative in particular.

- **Program Clarity.** Programs must establish well defined procedures for case referrals, intake, assessment, and disposition, and continually educate non- Family Advocacy Program personnel about these procedures.

- **Collaborative Team Approach.** Because of the multiple factors involved in abuse situations, intervention strategies call for combined expertise from a number of disciplines or specialities.

- **Family Advocacy Program Leadership.** Energetic and committed Family Advocacy Representatives who view themselves as program managers as well as clinicians provide a focal point needed by other program participants.

- **Effective Liaison with Civilian Child Protection Service Units/ Local Authorities.** Effective communication channels between Family Advocacy Program personnel and personnel in civilian agencies lead to more informed committee decisions and better developed intervention plans.

- **Quality Staff.** The more all program staff are familiar with the dynamics in abusive families and sexual assault/rape situations and the range of treatment alternatives, the better the change of successful outcomes.

- **Family Advocacy Committee Membership.** Those committees which draw their membership from the widest array of individuals and organizations function most effectively.

- **Proactive Focus.** Command and community awareness of family advocacy issues and the family advocacy program are essential for maintaining effective response.

- **Presence of Family Service Centers.** Although Family Service Centers are not the only service resource for family advocacy clients, they are often essential for providing information, referral, and counseling services. They also constitute a primary link with the line community.

- **Availability of Support Facilities.** Because medical facilities do not have the staff resources necessary to meet family advocacy cases, a wide array of alternatives, both civilian and military, must be available and utilized.

- **Training Experiences/Opportunities.** Personnel associated with the Family Advocacy Program and with Family Advocacy Representatives in particular need ongoing training and networking opportunities with other professionals in both case management and the dynamics of family violence.

- **Program Flexibility.** Each individual program must be able to ascertain the full extent of its potential resources and design appropriate procedures for its own locale.

Overall, assessment results suggest that the Family Advocacy Program currently is in a state of transition. Although bases are attempting to refine their policies and procedures and improve service response, program efforts are hampered by lack of program clarity, program staff, and community resources for assessment and intervention.

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# INTRODUCTION

## PROJECT OVERVIEW

This is the second of three planned reports on the Department of the Navy's Family Advocacy Program. The research was sponsored by the Office of Naval Research and was conducted by SRA Technologies, Incorporated. The first report, Reconnaissance, was completed in February 1983. It reviewed the scope and nature of abuse and neglect in the military and examined past responses to the problems as reported in available military and civilian literature.

This report, Assessment, expands on the initial data and examines the structure and operation of Navy Family Advocacy Programs at the command level. The report is based on site visits to 13 Navy and Marine Corps installations and in-person interviews with a broad spectrum of Department of the Navy and civilian personnel at each selected site. The report serves two purposes. First, it describes program conditions observed in the field and identifies major program strengths, concerns, and dilemmas. Second, it identifies program needs and includes recommendations from field representatives for program improvement. By providing descriptive information about current family advocacy program activities at the base level, the report should lead to more effective decisionmaking among Navy and Marine Corps policymakers, program designers, and practitioners who are responsible for family advocacy planning and intervention.

The third report, Conclusions and Recommendations, is scheduled for completion in the fall of 1983. This report will integrate and compare the knowledge bases from the first two reports, identify the gaps between service needs and program responses, and present suggestions for program implementation and recommendations provided by the research data.

## STUDY DESIGN

This report is based on SRA staff observations and interviews with more than 300 Department of the Navy and civilian personnel at 13 Navy and Marine Corps installations: Naval Station, Charleston; Marine Corps Air Station, Cherry Point; Naval Air Station, Brunswick; Naval Air Station, Memphis; San Diego Area Activities; Marine Corps Base, Camp Pendleton; Marine Corps Air Ground Combat Center, Twentynine Palms; Marine Corps Logistics Base, Barstow; Fleet Activities, Yokosuka; Marine Corps Air Station, Iwakuni; Naval Air Facility, Atsugi; Naval Support Activity, Naples and Naval Support Office, LaMaddalena.

The bases chosen for site visits were selected because of variations in command responsibilities, geographic location, base population parameters, and availability and sophistication of support services. Site visits were conducted in March and April, 1983 with an average of five person days devoted to data collection at each site.

All interviews for the study were conducted in person. To ensure diversity of perspective, SRA staff developed interview guides for a number of different groups, including Family Advocacy Representatives, Family Advocacy Committee members, law enforcement and legal personnel, Family Service Center staff, Chaplains, Ombudsmen, and directors of child care facilities. In addition, unstructured interviews were conducted with command leadership and, in a few instances, with civilian child protection personnel. In addition to interviews, SRA project staff attended family advocacy committee meetings and observed base facilities. The guides (located in Appendix B) were designed to structure interviews and observations and to provide data consistency among project staff. The study methodology is described in detail in Appendix A.

## CONTENTS OF THE REPORT

The report is divided into three sections. Section I presents brief descriptions and analyses of the Family Advocacy Programs at each of the 13

sites visited during the course of the study. The aim of this section is to provide an overview of the context, structure, and operation of base responses to abuse and neglect. Recommendations from base personnel for improving service response to family advocacy issues are reported for each site. Section I provides an important foundation for the integrated analysis of base programs in Section II.

Section II synthesizes data and provides a comparative analysis of program responses to abuse and neglect. Using BUMEDINST 6320.57 as a reference point, the aim is to analyze the structure and operation of the Family Advocacy Program across sites and discuss program recommendations from the field particularly as they relate to reducing the gaps between family advocacy service needs and service responses.

The report concludes with an overview of Phase II results and outlines current FAP strengths, concerns, dilemmas, and keys to success. Implications of the report for family advocacy policymakers and practitioners, data strengths and limitations, and a brief outline of the final report in the series, Conclusions and Recommendations, complete the report.

Together, these sections provide a foundation for understanding the current status of the Department of the Navy Family Advocacy Program in the field. Such information is important for refining the existing program and developing new service models and initiatives.

## DATA STRENGTHS AND LIMITATIONS

SRA project staff worked closely with the Research Project Committee--which was composed of representatives from the Office of Naval Research, the Naval Medical Command, and the Navy and Marine Corps Family Support Programs--in selecting sites for the assessment. However, given the restricted number of sites and the nonrandom selection process, we

recommend caution in generalizing study findings to bases other than those sampled.

**ABBREVIATIONS**

The following abbreviations are used in the text:

| | |
|---|---|
| ARS | Alcohol Rehabilitation Service |
| BUMED | Bureau of Medicine (now Naval Medical Command) |
| CAAC | Counseling and Assistance Center |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CID | Criminal Investigative Division |
| CO | Commanding Officer |
| COMFAIRMED | Command Fleet Air Mediterranean |
| CONUS | Continental United States |
| CPS | Child Protective Service |
| DFAR | Duty Family Advocacy Representative |
| DoD | Department of Defense |
| DoDDS | Department of Defense Dependents Schools |
| ER | Emergency Room |
| FAC | Family Advocacy Committee |
| FACT | Family Advocacy Coordinating Team |
| FAP | Family Advocacy Program |
| FAR | Family Advocacy Representative |
| FSC | Family Service Center |
| JAG | Judge Advocate General |
| JCC | Joint Counseling Center |
| MCAS | Marine Corps Air Station |
| MCFSC | Marine Corps Family Service Center |
| MPH | Manpower Human Resources |
| MSW | Master's Degree in Social Work |
| NAVSUPPO | Naval Support Office |
| NCOIC | Noncommissioned Officer in Charge |

| | |
|---|---|
| NIS | Naval Investigative Service |
| NRMC | Naval Regional Medical Center |
| NMPC | Naval Military Personnel Command |
| NSA | Naval Support Activity |
| OB/GYN | Obstetrics/Gynecology |
| OIC | Officer in Charge |
| PMO | Provost Marshall's Office |
| SECNAV | Secretary of the Navy |
| SITREP | Situation Report |
| SOFA | Status of Forces Agreement |
| TAD | Temporary Assignment Duty |
| XO | Executive Officer |

# SECTION I

## FAMILY ADVOCACY PROGRAM DESCRIPTIONS

## Section I

## FAMILY ADVOCACY PROGRAM DESCRIPTIONS

This section provides summary descriptions of th· 13 Family Advocacy Programs visited during the course of the Phase II assessment. Its purpose is to provide a general overview of responses to abuse and neglect across Navy and Marine Corps installations. In highlighting program variations across sites, this section provides an important foundation for discussing the overall structure and operation of the Family Advocacy Program later in the report.

Each program profile contains information organized in the following categories:

- **Introduction:** geographic location and mission of the base or installation, population demographics, stress factors for families, and available support services.
- **Program Context:** the nature of the medical facility, staffing patterns, and history and development of the FAP.
- **Program Structure:** the number and composition of the FACs, frequency of FAC meetings, and role of the FAR.
- **Program Operation:** the number of abuse and neglect cases, the nature and methods of interorganizational cooperation, and the types of referral sources.
- **Current Directions:** new or planned FAP developments, obstacles to effective response, and recommendations of respondents for program improvements.

The intent of this section is to describe rather than evaluate the structure and operation of the FAP at each of the 13 bases. Some base programs are more developed and integrated than others. The implication, however, is not that less-developed programs lack leadership and initiative. Variations in program status often reflect the interplay of a number of forces, including program history and context, the perceived magnitude of abuse and neglect, and the availability of helping resources.

NAVAL STATION, CHARLESTON
SOUTH CAROLINA

## NAVAL STATION, CHARLESTON, SOUTH CAROLINA

The Navy community in Charleston, South Carolina, is home port to approximately 24,000 active duty Navy and Marines. The Charleston area also contains nearly 36,000 dependents and 24,000 retired members and their families. The majority of these families reside in Dorchester, Berkeley, and Charleston Counties. Military housing is available for about 12,000 active duty personnel, primarily in the "Men River" development. In addition to 13 barracks, there are 351 housing units for officer families and 2,329 units for enlisted families.

The Naval Station in Charleston serves a number of important functions. It has both surface and subsurface mission responsibilities, and its major units include the 6th Naval District Headquarters; Naval Weapons Station; Naval Shipyard; Naval Supply Center; Polaris Missile Facility, Atlantic; Cruiser-Destroyer Group 2; Submarine Group 6; and the Mine Warfare Command.

The Charleston area is rich in recreational opportunities with several public beaches nearby. A number of civilian human service agencies and resources complement those in the base community. In addition, the Naval base maintains a close working relationship with Charleston Air Force Base.

### Program Context

The Naval Station has a full complement of facilities and programs to support families. In addition to a 500-bed Navy Regional Medical Center, the base has a fully operational Family Service Center with 11 military, civil service, and contract employees, and a large number of volunteers.

The FAP has been in operation since 1976 and operates under local Instruction NRMCCHASNINST 6320.2A dated 8 July 1981. This Instruction establishes a central committee and three working subcommittees to implement the local program. Detailed guidelines are provided for case management and disposition of family advocacy cases. The Instruction also outlines role descriptions and responsibilities for the NRMC staff in family advocacy cases, including the role of the FAR.

The FAR, a Navy Lieutenant, began his duties as the hospital social worker in July 1980. The previous FAR was the Director of Nursing Services who currently chairs the Family Advocacy Central Committee. The FAR estimates that 40 percent of his duty hours is spent in family advocacy activities. He is also responsible for adoptions and outpatient discharge planning.

The FAP at Charleston is in a state of transition. The subcommitees are attempting to become more efficient in case disposition and management, to increase prevention efforts, and to better coordinate service response in family advocacy cases. The NRMC and the FSC especially are concerned about possible duplication of efforts.

**Program Structure**

The FAP structure consists of a collateral-duty hospital-based FAR, a FAP central committee, and three FAP subcommittees that handle cases of child maltreatment, spouse abuse, and sexual assault and rape. The central committee establishes operational guidelines for the FAP. It meets quarterly and is chaired by the Director of Nursing Services. Membership includes chairpersons of the FAP subcommittees, service agency heads, and the FAR. Currently, no civilian community representatives are members of this committee.

The three FAP subcommittees include fewer representatives and meet once a month. Each subcommittee is chaired by a hospital physician and includes the FAR and representatives from base service agencies. Only the child maltreatment subcommittee has representatives from the civilian community. Child Protection Service (CPS) workers from the three surrounding counties play a key role in the committee's operation.

The subcommittee's primary role is case management. Each month chairpersons present active cases to subcommittee members. As they review cases, they determine case dispositions (unfounded, suspected, and established) and develop coordinated intervention plans. The FAR performs several functions on the committee: he provides information about family history, reports results from case investigations, monitors case dispositions, records committee decisions, provides follow-up services for individual cases, and submits case reports to the Chief of BUMED. In general, the FAR perceives his role primarily as program catalyst and case manager. Because of time limitations, he cannot routinely provide crisis intervention or counseling.

To establish a vehicle for community development and to complement the case management responsibilities of the FAP, the FSC initiated a Family Advocacy Coordinating Team (FACT) in September 1982. The FACT is chaired by the Director of the FSC and includes representatives from the NRMC as well as base and service organizations. A multidisciplinary committee, its stated purpose is to provide a more coordinated service response in the treatment and prevention of abuse and neglect.

**Program Operation**

There were approximately 80 family advocacy cases on active file at Charleston at the time of the site visit: 35 cases of child maltreatment, 40 cases of spouse abuse, and five cases of sexual assault and rape. The majority of family advocacy cases are identified through the hospital

emergency room and through the OB/GYN clinic. Although the FSC is a frequent referral source, its staff only recently began sharing the names of cases with the FAR, because of concerns about case confidentiality. Before releasing information about case reports and dispositions involving Navy personnel to the FAR, the local CPS is required to obtain a signed release of information from the family.

Regardless of the point of initial intake, the FAR or the Duty FAR is notified in many cases of abuse and neglect and in all cases identified through hospital channels. When a case is reported, the FAR's initial responsibility is to provide case consultation to the referring source about FAP policies and procedures. In cases of child abuse and neglect, a referral is made to the appropriate county CPS. Often the FAR will conduct an initial case investigation and, at minimum, work closely with the referring agent to develop a tentative intervention plan. Notification of the sponsor's commanding officer is the exception rather than the rule and usually occurs only when the FAR is unable to enlist the family's cooperation. In general, base personnel are familiar with procedures regarding the intake and disposition of family advocacy cases.

Similiar to many CONUS bases, Charleston has a number of military and civilian treatment resources. On the Navy side, the FSC is an important resource for the clinical management of family advocacy cases. For example, one FSC staff member is a specialist in the treatment of sexually abused children. Community resources include a shelter facility, a community mental health center, child protection specialists, and a number of human service professionals. Effective liaison exists between the Navy and the civilian resources.

Although there are a number of treatment services for family advocacy cases, there are fewer preventive services and programs. However, with the development of the FALT, the FSC is planning to initiate additional prevention efforts.

Follow up of family advocacy cases is the FAR's responsibility. Procedures for follow up, however, appear to be more informal than formal. At best, they consist of calls or letters to the agencies or persons to whom the case was referred. To track established and "high risk" cases, the FAR maintains case files containing treatment recommendations and implementation plans. When a family who is an active family advocacy case receives PCS orders, the FAR forwards an updated status report to NMPC-66.

**Current Directions**

Currently, the NRMC and FSC are attempting to strengthen their working relationships to respond more effectively to family advocacy cases. The FSC, for example, recently initiated the FACT to improve coordination of community responses to family advocacy issues. There is potential, however, for duplication of efforts between the FACT and the FAP central committee.

During the site visit, there were several recommendations made by respondents for strengthening the FAP at Charleston:

- Make the FAR duties a full-time position;
- Increase the prevention focus;
- Improve coordination between base agencies;
- Develop family advocacy training programs;
- Explore the possibility of opening a spouse abuse shelter;
- Clarify FAP priorities and responsibilities; and
- Shift policy and program management functions for family advocacy to the FSC.

Overall, the FAP is functioning very effectively at Charleston. It has the full support of base leadership, a strongly committed FAR, and a powerful combination of base and community resources.

MARINE CORPS AIR STATION, CHERRY POINT
NORTH CAROLINA

## MARINE CORPS AIR STATION, CHERRY POINT, NORTH CAROLINA

Marine Corps Air Station, Cherry Point is located in rural eastern North Carolina, approximately two hours by highway from Camp LeJeune. Surrounded by small coastal towns, the base is a major employer in the region and enjoys a positive relationship with the civilian community. Approximately 15,000 active duty personnel with 10,000 dependents are assigned to the base. More than 7,000 military dependents live in the 2,847 government housing units under the control of the MCAS. The major units include the 2nd Marine Aircraft Wing and the Naval Air Rework Facility.

Although Cherry Point offers a relatively low cost of living for Marine and Navy families, the nature of the mission and location of the base present stress for some families. Family separations are frequent because of routine TADs and recurring deployments to Iwakuni, Japan. Families are left behind in a rural environment, often for extended periods. Family separation is made more difficult by the lack of employment and recreational opportunities for spouses and children.

MCAS Cherry Point provides a number of base services for families. In addition to a 52-bed Naval hospital, the base has chaplains attached to each wing unit, a drug and alcohol center, and an operational Marine Corps Family Services Center with three contract employees. The scope of the MCFSC, however, is restricted to providing information and referral services. A base child care center with a maximum capacity for 225 children is available for families. Recently, a Family Readiness Program (staffed by volunteers) similar to the Navy's Ombudsman Program was initiated by 2nd Marine Aircraft Wing to provide support for families during deployments.

As in many rural communities, there are limited medical and support services for Navy and Marine Corps families in the local area. Some services are available through the Craven and Carteret County Departments of Social Services, which operate CPS units. There is a local mental

health center for military families requiring counseling. Private practitioners in marital and family therapy also are available. In general, the base helping agencies frequently refer members and families to local community resources for assistance.

## Program Context

The FAP at Cherry Point MCAS has been in operation since 1976 and is currently under the auspices of the branch hospital on base. The hospital provides a relatively full complement of staff, including family practitioners. The FAR is a Navy Lieutenant Commander, a clinical psychologist assigned to the hospital staff, who began his duties in 1981. He estimated that less than 10 percent of his time is spent in FAR-related duties.

Although the FAP has the full support of the hospital commanding officer and other medical staff, the FAR has had difficulty establishing effective liaison between base medical annd human service personnel and between military and civilian health professionals. As a consequence, the FAC has been somewhat ineffective, and a number of family advocacy cases circumvent the FAP. Efforts are under way to hire an additional staff member at the hospital to coordinate the FAP.

## Program Structure

The FAP at Cherry Point operates under NAVHOSPINST Instruction 6320.22A and consists of a collateral duty hospital-based FAR and a central FAC. Chaired by the FAR, the FAC includes representatives from the hospital staff, MCFSC, PMO, Judge Advocate, security police, drug and alcohol center, station and wing chaplain services, and the Craven and Carteret County CPS. The FAC meets monthly to discuss family advocacy cases, establish case dispositions, coordinate service responses, and discuss FAP policies and operating procedures. Despite regular monthly

meetings, some committee members are unsure of FAP objectives and functions, and of the roles of the committee and the FAR.

The FAR at Cherry Point performs several functions on the FAC. First, he chairs the meetings and presents new cases to the committee for review and disposition. Second, he monitors case decisions and coordinates service response to the involved member or family. Third, he submits appropriate case reports to the Chief of BUMED in suspected and established cases.

In his role, the FAR has minimal direct contact with family advocacy cases. He views his role as that of a case manager and seldom investigates family advocacy cases directly or provides counseling services. For the most part, counseling responsibilities are assumed by base chaplains who report on case progress at FAC meetings.

Largely because of its information and referral function, the MCFSC plays a limited role in the Cherry Point FAP. It doe operate a base shelter for abused spouses and children, which is located in the female barracks. However, the shelter only can accommodate one family at a time.

**Program Operation**

Despite the lack of program initiative and development, the FAC processed 114 family advocacy cases between January 1982 and February 1983. More than half--59 percent--involved spouse abuse. At the time of the site visit, there were 23 family advocacy cases on active file: 19 cases of spouse abuse, two cases of child abuse, and two cases of sexual abuse involving adult victims. The majority of family advocacy cases are identified through the hospital emergency room and the OB/GYN clinic. Many other cases, however, do not come to the attention of the FAC.

Although chaplains and the FSC receive a number of family advocacy cases through self-referral, they have not routinely channeled these cases through the FAP. Some cases of child maltreatment are referred directly to the county CPS. When the problem involves spouse abuse, the case often is referred directly to the appropriate service resource. Because chaplains are the primary resources for counseling services on base, they frequently maintain contact with the family or receive referrals directly from other service providers. Service providers, especially those who work outside the hospital, have a limited understanding of the function of the FAP and view the program as an administrative detour to providing service to the family. As a consequence, they are reluctant to refer cases to the FAR for case management. To date, this situation has resulted in ineffective case coordination and duplication of service effort. This situation is being discussed by the FAC and efforts are under way to bring more family advocacy cases into FAP review and management.

In all family advocacy cases referred through the FAP, the FAR initiates a case file and provides case management coordination. When a case is reported, the FAR provides case consultation to the referral source about FAP policies and procedures. In cases of child maltreatment, a referral is made to the appropriate CPS. Notification of the sponsor's commanding officer is the exception rather than the rule in family advocacy cases.

Intervention and prevention programs in family advocacy are currently under development at Cherry Point. With the exception of the chaplains on base and some clinical resources in the civilian community, there are few resources for direct intervention into family advocacy cases, particularly since the role of the FSC is limited to information and referral services.

At present, there appears to be more resources directed toward case management and information and referral at Cherry Point than to clinical management of cases. Treatment and prevention efforts have been hampered by the lack of effective liaison and interaction between base service

providers. In addition, relationships between military organizations and civilian helping resources, especially the CPS units, are marginal at best.

Follow up of family advocacy cases is the responsibility of the FAR. Case files are maintained in patient affairs and include an emergency room cover sheet, intake form, case disposition, and treatment and intervention plan. When a family advocacy case receives PCS orders, the FAR copies the case file and forwards it to the FAR at the gaining command.

**Current Directions**

The FAP at Cherry Point was undergoing some significant changes at the time of the site visit. The hospital was about to employ a full-time social worker to handle case management for the FAP, and the MCFSC was about to hire a clinician who would provide counseling support. Given the previous low staff support, these two positions represent potentially major improvements in the ability of the program to identify cases. provide intake and assessment, deliver supportive services, and suppo. interagency linkages and case follow up. If these positions become operational, the program may change radically from the one described above.

Those interviewed made the following recommendations to strengthen the program, as currently operating:

- Clarify role and function of the FAP;
- Make the FAP an effective vehicle for case coordination and service liaison;
- Increase the time available to the FAR for family advocacy case management;
- Improve relationships with the civilian child protection units;

- Increase family advocacy training, especially for hospital staff, sergeant-majors, and commanding officers; and
- Mandate notification of the sponsor's commanding officer in family advocacy cases.

NAVAL AIR STATION, BRUNSWICK
MAINE

NAVAL AIR STATION, BRUNSWICK, MAINE

The Naval Air Station is located 20 miles north of Portland, Maine. Since 1951, it has been a major support base for antisubmarine warfare (ASW) patrol aviation forces of the fleet. At present, these forces consist of six operational squadrons under the Commander of Patrol Wing Five. Both the air station and the patrol wing report to Commander Patrol Wings, U.S. Atlantic Fleet, whose flag headquarters is located at the Topsham Annex of the station. Two squadrons are routinely deployed for a duration of five months.

The Navy population at Brunswick includes approximately 3,800 active duty personnel and more than 5,000 dependents. There is base housing for approximately 168 officer families and 694 enlisted families. Because of the shortage of base housing units and rental units near the station, however, the Navy community at Brunswick is quite dispersed. Some families live as far as 100 miles from the base. The majority of personnel and families assigned to Brunswick live in the Brunswick, Topsham, and Bath areas. Bath is farthest away at 10 miles.

Of the four squadrons remaining at the base, one is the "ready" squadron of the month and is responsible for all taskings. The combination of frequent deployments for some members coupled with geographical separation from the base community creates stress for families. Unfortunately, the families who live the farthest from the base typically are younger and most in need of support. The population dispersion also makes coordination and delivery of support services for families difficult.

There are few recreational and support service resources available for Navy personnel and families on the base. Although an FSC is being developed at Brunswick, it is not yet operational. As a consequence, the station depends heavily on civilian community resources for support of base personnel and families. Fortunately, the local community is rich in natural recreational opportunities and professional services for responding

to the medical, family, and personal needs of Navy personnel and families are available through local hospitals, a community mental health center, and local practitioners. The base and the civilian community enjoy a positive working relationship.

### Program Context

Brunswick established a Family Advocacy Program in 1979. It has always operated from the branch dispensary--an outpatient clinic. The dispensary has no specialists on staff and includes an OIC, two general practitioners, six flight surgeons, two physician assistants, and 30 hospital corpsmen. The flight surgeons and hospital corpsmen assigned to the squadrons may or may not be present physically at the dispensary because of their deployment status.

The OIC of the dispensary chairs the FAC. Since the death of the dispensary psychologist, a Navy physician and a physician assistant have shared collateral duty as the FAR. There is no local instruction to provide family advocacy policy and program guidance.

### Program Structure

The Brunswick FAP lacks formal structure and operating procedures. Although no formal meetings are held, an ad hoc FAC meets perodically to discuss identified cases of abuse and neglect. The committee's composition includes the dispensary OIC, the two part-time FARs, a JAG officer, and a representative from security police.

The informal structure and operation of the FAP has been influenced by three factors. First, few family advocacy cases come to the attention of the FARs. In fact, no established or suspected cases were reported to the BUMED Control Registry for the years 1981-82. Second, hospital personnel generally believe that abuse and neglect are not prevalent problems at

Brunswick. Third, the OIC of the dispensary and the two part-time FARs believe, because of potential violations of case confidentiality and privacy, that few people should be involved in family advocacy case decisions. The aviation community is seen as tightly knit; inappropriate discussion of family advocacy cases is viewed as potentially damaging to the reputation of the member and family.

Currently, the medical community is totally in charge of the program. Although the two FARs, the JAG, and a security officer recently attended the OP-156 family advocacy training program, they had not yet implemented the action plan for family advocacy that they had developed at the training program.

**Program Operation**

Brunswick averages fewer than 12 family advocacy cases per year. Of these, the majority involve child abuse and neglect. In 1981, only one case of spouse abuse came to the attention of the hospital. Although most family advocacy cases are self-referred to the dispensary through the emergency room, some are reported by security police, the JAG officer, and Navy and civilian community members. Overall, intake procedures and protocol for family advocacy cases are poorly understood by base and community service providers. The base child case director, for example, had little knowledge of reporting requirements in child abuse and neglect cases.

If the victim comes to the hospital, he or she is given a physical examination and treatment. The duty FAR interviews the victim and family, establishes a case file, and initiates the necessary referrals. In child abuse and neglect cases, the duty FAR notifies the local CPS, which assumes case responsibility. In cases of spouse abuse, the duty FAR meets with the abused spouse and discusses available options for dealing with the situation. If the abuser is a Navy member, the duty FAR notifies the member's CO.

In both child maltreatment and spouse abuse cases, the FARs depend largely on local civilian community resources for support. Many base representatives believe that the civilian community is not well educated about Navy life and its potential impact on families. As a consequence, base representatives question the effectiveness of civilian treatment and intervention resources in cases of abuse and neglect. They also question whether Navy referrals are given proper attention by civilian resources, despite the good relationship between the Navy and civilian community.

Currently, there are few programs or activities to reduce family stress and the occurrence of abuse and neglect. Although base representatives view prevention of family problems as important, their efforts are hampered by the shortage of base resources and lack of service direction and coordination.

Although the FARs are maintaining family advocacy files, follow-up procedures for identified cases are rudimentary at best. However, the need for case follow up is recognized by family advocacy personnel as a key to program success.

**Current Status**

Base personnel are waiting eagerly for the opening of their FSC. The dispensary OIC and the FARs believe that the FSC will assist the dispensary OIC and augment civilian resources. The fully operating FSC is the key, they believe, to implementing the Brunswick FAP more effectively.

At present, the program lacks development and initiative. Shortages of professional staff at the dispensary to address family advocacy issues and the lack of base service resources seriously impede the development of an effective identification and response system. Although the FSC will provide an important new helping resource in the base community, its anticipation is serving to delay program initiative.

Several recommendations were made by base personnel in the course of the site visit:

- Make family advocacy program development a priority;
- Initiate a family advocacy implementation plan;
- Create proactive prevention programs;
- Increase community outreach efforts;
- Develop family advocacy training program;
- Better publicize family advocacy referral and intake procedures;
- Involve the base commanding officer in family advocacy initiatives; and
- Emphasize the importance of confidentiality and privacy in family advocacy cases.

NAVAL AIR STATION, MEMPHIS

TENNESSEE

## NAVAL AIR STATION, MEMPHIS, TENNESSEE

The Naval Air Station is located 20 miles north of Memphis in Millington, Tennessee. It is a primary training center for both Navy and Marine Corps aviation activities. The Chief of Naval Technical Training is a major command as is the Marine Aviation Training Support Group. Between 13,000 and 16,000 active duty members with approximately 10,000 dependents are stationed at Memphis. Because the training schools often are the first assignment after boot camp, trainees are typically young and new to the Navy. Many married trainees are newlyweds. The demographic composition of the base, the transient nature of the trainee population, and the demands of training can create stressful situations. Trainees constitute 70 percent of the active duty population. Although they are encouraged not to bring their families, many of them do.

### Program Context

Since October 1982, the NRMC at Memphis has had a full-time FAR, a civilian and the first social worker to be assigned there. Between 1979 and 1982, the FAR position was collateral duty for two successive chiefs of outpatient administrative support services. With 230 beds, the NRMC is a relatively large facility with a full complex of medical services. In addition to the NRMC, there is a medical clinic on base for active duty personnel. The current local family advocacy instruction, NRMCMFSINST 6320.24N dated 17 July 1981, establishes a central standing committee and three working subcommittees. The instruction creates a system for prevention and intervention that is more elaborate and complex than the actual program. For example, it includes a referral form to be used by medical officers to direct an active duty suspected spouse abuser to screening and counseling at the counseling and assistance center.

**Program Structure**

Composed of 19 representatives assigned either to the hospital or clinic, the central FAC has met once in the past two years and has no chair at present. The child and spouse abuse subcommittees meet monthly and are chaired by a pediatrician and a primary care nurse practitioner, respectively. Both chairs are Lieutenant Commanders. To strengthen base and civilian community liaison, the child abuse subcommittee recently added a representative from the civilian CPS unit. The NRMC chaplain, chief of hospital security, hospital psychologist, and the charge nurse of the emergency room all are members of the three subcommittees.

The chair of the sexual assault subcommittee is a Commander from the OB/GYN staff. Although the subcommittee did not function until recently, the chair has created a new impetus for activity by stressing the subcommittee's education and prevention functions.

The previous FAR perceived her responsibilities primarily as coordination with the subcommittees, intake and assessment, and liaison with the commands. The present FAR sees an expanded role, perhaps because of his experience with the Army Family Advocacy Program. The FAR sees his role as including coordination with civilian referral sources and follow up of family advocacy cases. In addition, he believes that the FAR should offer some short-term counseling in family advocacy cases and serve as an advocate for social as well as medical family needs on the base.

**Program Operation**

Since October 1982, the FAR has presented approximately 30 abuse, neglect, and assault cases to the committees. The previous FAR estimated that there were between five to seven new suspected cases of child abuse per month and between seven and ten cases of spouse abuse per month. Only three rape cases were reported to the hospital between 1981 and 1982. A base security officer, however, estimated that his office routinely handled

at least 15 cases of rape per month involving active duty personnel during the same time period. The underreporting of rape cases through the FAP is attributed both to the reluctance of victims to report rape and the presence of a rape crisis center in the civilian community. The chair of the sexual assault and rape subcommittee is aware of the discrepancy between incidence and case reporting. He attributes this discrepancy in part to the previously poor response from OB/GYN to FAP protocol.

When child abuse cases come through the base hospital, they are evaluated by the chair of the child abuse subcommittee and the FAR. The FAR then notifies the CPS unit. The CPS representative conducts a case evaluation and provide the subcommittee with feedback on case findings. Spouse abuse cases are referred to the FAR by the emergency room, base chaplains, or security police. The FAR conducts an initial screening and brings the cases to the subcommittee for case disposition. To protect the privacy of the member and family, cases are assigned numbers before presentation to the subcommittees.

Treatment resources include referral to civilian therapists, supportive counseling by the FAR, and referral to chaplain-sponsored abuse groups. There is no FSC, although one is planned to come on line in 1983. All the individuals involved in the FAP were looking forward to its opening. They consider it an essential resource for therapy and education.

The FAR is the primary link between the FAP and base and community agencies. Although the subcommittees review general case progress on a regular basis, the FAR is responsible for follow up of cases referred to both base and civilian treatment resources. He also is responsible for coordinating closely with CPS case workers. The FAR maintains records of working files. In suspected and established cases of abuse and neglect, the FAR forwards the appropriate case reports to the Chief of BUMED. In the event of PCS orders, the FAR will contact the FAR at the gaining command in established family advocacy cases. He reports infrequent notification from other commands of incoming family advocacy cases.

## Current Directions

The appointment of a medical social worker who can devote a significant proportion of his time to family advocacy issues has strengthened both family advocacy case investigation and follow-up procedures. In addition, a hospital-based psychologist who has previous FAP experience at Camp LeJeune has contributed to a tightening of procedural guidelines. His knowledge of sexual assault and abuse issues also has stimulated educational activities in this area.

At present, the FAP at Memphis is hospital-dominated. Except for one representative on the child abuse subcommittee, all three subcommittees and the central FAC are restricted to hospital-based personnel. Program members expressed concern about the hospital commitment to the FAP. The outgoing hospital CO indicated, for instance, that the lack of staff resources precluded the FAP from receiving higher priority in hospital activities. Although no staff members have yet been hired, the proposed FSC is regarded by base personnel as a major future component of the FAP. Many recommendations centered around developing the FSC, but others included:

- Expand the FAC to include nonmedical personnel such as base security, child care, housing, and command representatives;
- Expand the proactive, educational aspects of the FAP;
- Brief commands on the function of the FAP and encourage their support in the treatment of abusers;
- Mandate treatment in cases of family abuse and neglect;
- Provide training to chaplains and other base personnel in family advocacy areas; and
- Emphasize the success stories of families of abuse or neglect who were helped by treatment.

# San Diego Area Activities

## California

## SAN DIEGO AREA ACTIVITIES, CALIFORNIA

The Navy community in the San Diego area includes more than 96,000 active duty members and 100,000 dependents. There are also approximately 40,000 retired members and 100,000 dependents of retired or deceased military personnel. SRA project staff interviewed Navy personnel for this study at five locations: the Naval Regional Medical Center at Balboa, the Area Coordinator's Office at COMNAVBASE, and Family Service Centers at the 32nd Street Naval Station, Naval Air Station North Island, and Naval Air Station Miramar.

Many families in San Diego are faced with long and frequent deployment cycles associated with WestPac activities. San Diego also has many training facilities and a number of families in the area are young and experiencing their first deployments. Because of San Diego's size, numerous service facilities are widely dispersed throughout the area. As a consequence, service accessibility often depends on having available transportation; coping with the high cost of living in the area is also an issue.

The large Navy population, the diversity of the mission, and the dispersed location of the population create pressures for coordination of support programs and activities. Compared to many Navy and Marine Corps installations, however, San Diego is rich in both base and community resources.

### Program Context

The FAP at San Diego is headed by a full-time FAR, the third to hold that position. As a civilian social worker, he is part of a larger social work department headed by a Navy Lieutenant from the Medical Service Corps. The social work staff at the NRMC includes two additional staff members, one of whom takes primary responsibility for child abuse cases.

The FAR expressed the need to develop a more preventive focus in family advocacy programming, as well as to establish closer linkages with civilian agencies.

The NRMC in San Diego is a large and sprawling complex of buildings with a potential caseload of approximately 360,000 active duty, dependent, and retired military patients. The estimated caseload for the emergency room alone is 70,000 per year. The hospital provides a full complement of medical and support services, including resident training. In many ways, the Balboa NMRC is its own community. It has a large population of employees, patients, and its own security force. There are several different jurisdictions within its boundaries. To make medical services more accessible to the Navy population in San Diego, branch clinics and dispensaries also exist at 32nd Street, North Island, and Miramar.

The 32nd Street Family Service Center was one of the first established by the Navy. It has approximately 20 staff members in addition to volunteers. The FSCs at North Island and Miramar have fewer staff. In addition to Navy support activities, the civilian community in San Diego County contains a wide range of human services, including rape crisis centers, shelters for battered women, and organized support groups for both physical and sexual abusers and victims.

**Program Structure**

Operating under NAVREGMEDCEN SDIEGO Instruction dated 19 December 1979, the FAP at San Diego consists of a central committee and three subcommittees for child abuse, spouse abuse, and sexual assault and rape. With the exception of the child abuse subcommittee, committee meetings are held irregularly. Because of the number of child maltreatment cases and the potential seriousness of this problem, the child abuse subcommittee meets weekly. Although the spouse abuse and sexual assault and rape subcommittees currently have no civilian community members, a represen-

tative from the San Diego CPS plays an active role on the child abuse subcommittee. At present, only the child abuse and sexual assault and rape subcommittees review cases and focus on case management and service delivery. The spouse abuse subcommittee offers policy guidance to the FAR, but does not review cases.

The FAR has had previous experience working with family advocacy cases in both the Navy and the Army. Playing primarily an administrative role, he sees his most important functions as case management and coordination. In this role, he tracks the progress of the subcommittees in responding to abuse and neglect cases and he handles the reporting requirements mandated by the program. Although he occasionally does some clinical counseling in abuse and neglect cases, especially in spouse abuse cases, other base and community resources frequently handle the clinical management of cases.

Since September 1982 and partly as a response to the training sessions sponsored by NMPC-66, the FSCs at 32nd Street, North Island, and Miramar have begun developing base advocacy teams in conjunction with the Area Coordinator's Office at COMNAVBASE. Although in different stages of development, these teams set local base procedures for handling family advocacy cases and develop prevention and awareness programs. Members of the base advocacy teams include representatives from the base security and legal offices, the FSC, the base child care center, the chaplain community, ombudsman councils, and in some cases, personnel from the dispensary or branch clinic.

In addition to the development of base advocacy teams, the COMNAV Base Area Coordinator's Office now is assuming a major role in consolidating family advocacy activities in the San Diego area. Plans include developing a centralized system for case documentation and reporting and conducting training and educational briefings for the Navy and civilian communities. There is also a proposal to create a San Diego Navy Family Advocacy Advisory Council to coordinate community response to abuse and neglect. Plans are under way to involve both Navy and civilian medical, legal, and social work staffs on this council. In general, the council is seen as a

vehicle for augmenting and broadening the function of the FAC at NRMC Balboa, ra ıer than duplicating its function.

### Program Operation

In 1982, the Naval Hospital at Balboa handled 133 cases of child abuse, 144 cases of spouse abuse, and 30 cases of rape and sexual assault. The FSC at 32nd Street reported 51 child abuse cases, 66 spouse abuse cases, and three rape and sexual assault cases. It is not clear how frequently or routinely FSCs reported to the FAR those cases that had originated through their clientele. In some instances, FSCs reported child abuse directly to the civilian authorities. They sent periodic reports of family advocacy caseloads to the FAR, while dealing directly with those not needing medical treatment or supervision.

Most FAP cases that are handled by the FAR and hospital committees have come through hospital channels, primarily through the emergency room and pediatrics. In spouse abuse situations, the FAR will do initial counseling and referral, usually to an FSC or civilian resources. If emergency shelter is required, the FAR will work with the victim to find appropriate placement.

When adult victims of rape come to the emergency room they usually are referred to civilian hospitals that have contracted with the San Diego Police Department to handle the collection of medical evidence for court presentation. Subsequently, the FAR telephones the victim to offer referrals for counseling.

Several other intake alternatives also exist, such as the FSC and civilian hospitals. Most personnel at Balboa agree that their primary focus is on child abuse. Thus, treatment and counseling of other victims who do not come to the hospital or need medical intervention are frequently handled by the FSCs or referred to civilian resources.

Regardless of the initial point of contact, suspected cases of child maltreatment are referred to CPS in the San Diego area. If the referral is initiated through hospital channels, the CPS worker will report the results of the case investigation to the child abuse subcommittee. This subcommittee functions as both a case management and a quality assurance tool. Cases are presented by the attending physician who describes the case history, the presenting problem, and the treatment response. The subcommittee makes case dispositions and discusses intervention plans. The FAR's staff is responsible for initiating committee decisions, making appropriate case referrals and follow up, and coordinating the overall treatment plan.

Compared to the child abuse subcommittee, the spouse abuse subcommittee has a more limited focus. The subcommittee does not review specific spouse abuse cases but focuses more on procedural issues, such as drafting form letters to commands to encourage abusive families to keep appointments with the FAR. It is not clear why case management responsibilities are not handled by the subcommittee, other than the fact that the FAR takes on these responsibilities.

All family advocacy cases from area clinics and dispensaries are reported to the FAR at Balboa who sends them into BUMED. Follow up of cases is considered problematic, particularly in those cases referred to the civilian community for treatment.

### Current Directions

Although the proposed formation of a San Diego Navy Family Advocacy Advisory Council through the COMNAV Base Coordinator's Office may lead to a higher level of interagency cooperation, the FAP now is hospital based. The prior involvement of NIS, the Red Cross, and the ARS has diminished. Even if the FSC reported all its family advocacy cases to the FAR, the social work staff at the NRMC has few resources to conduct the initial treatment and referral for other than child abuse cases. This has the

effect of diminishing cooperation. Further, the relationship among the FSC, the base teams, and the Area Coordinator's Office vis-a-vis the medical program is unclear and currently under discussion.

To date, hospital personnel have focused primarily on child abuse cases. Little outreach has occurred beyond hospital-identified cases. If the formation of the base advocacy teams leads only to a higher referral rate to the hospital but no additional resources for intervention, cases may be reported but receive little in the way of treatment.

Recommendations from San Diego personnel emphasized the need for line support for the program, including a SECNAV Instruction that clearly delineates both line and medical responsibilities. Other suggestions included:

- Emphasize prevention activities;
- Provide training and assessment in case management to FSC staffs;
- Develop spouse abuse shelter and emergency respite care to supplement civilian resources;
- Educate COs, XOs, and command master chiefs on family advocacy issues and the importance of command involvement;
- Provide forums for information sharing among family advocacy service providers in the San Diego area; and
- Provide training for FSC staff, such as short-term counseling.

MARINE CORPS BASE, CAMP PENDLETON

CALIFORNIA

## MARINE CORPS BASE, CAMP PENDLETON, CALIFORNIA

Located in San Diego County about 30 miles north of downtown San Diego, Camp Pendleton is a 125,000 acre site designated as the primary West Coast base for combat training of Marines. The base community includes 44,000 people: 33,000 active duty military members and 9,700 dependents. Composed of more than 1,500 military personnel, the headquarters and service battalion is the host command. The base provides 3,819 housing units, a 600 bed Naval Regional Medical Center, training facilities, logistical support for the Fleet Marine Force, and a number of specialized schools. Because of short-term training cycles and the unavailability of temporary quarters, married student personnel are advised not to bring their family members.

The installation provides a full range of support services, including one of the largest Marine Corps Family Service Centers. The FSC handles a toll-free "hot line" calls for all Marine Corp families west of the Mississippi who have limited access to an FSC. Nearby civilian communities such as Oceanside, California, provide additional service resources, including a respite care center and a shelter for battered women.

### Program Context

The FAP currently operates under three local Instructions. The Child Abuse Instruction was issued in November 1979 and the spouse abuse instruction was issued the following month. In November 1982, an Instruction was issued on the management and care of alleged sexual assault, including rape. Camp Pendleton has had an active child abuse committee since 1977.

The NRMC is fully staffed and includes family practice, primary care, and adolescent clinics. Thirteen branch clinics are located across the base. The medical facilities at Barstow and Twentynine Palms report family advocacy cases directly to Camp Pendleton. Since 1970, the PMO at Camp

Pendleton has included a family protection unit specifically trained to deal with domestic disturbances. Presently, the FSC is developing a greater role in family advocacy issues.

## Program Structure

In addition to a central FAC, chaired by the chief of pediatrics, there are three clinical subcommittees. Focusing on child abuse, spouse abuse, and sexual abuse and rape, these subcommittees handle case disposition and treatment planning. The hospital also sponsors two proactive committees: one for high risk cases and the other for education. Membership on subcommittees includes hospital personnel, FSC staff, and human affairs representatives from the various commands. In addition, representatives from the public health nurse service attend child abuse subcommittee meetings.

The FAR is a civilian social worker (MSW) and chief of social services. She has been involved with the program since its inception and sees her role as counseling patients for referral to treatment resources, coordinating with civilian social services, and conducting follow up of family advocacy cases. There are two social workers under the supervision of the FAR. One spends about 75 percent of her time with family advocacy cases, while the other is involved primarily with discharge planning.

## Program Operation

In 1982, 248 family advocacy cases were handled through the family advocacy subcommittees: 131 high risk, 121 spouse abuse, 116 child abuse, and 11 sexual assault and rape cases. The high risk referrals came primarily from hospital staff, but other cases were referred by public health nurses. Spouse abuse cases were identified primarily through the emergency room staff and the PMO family protection unit. Pediatricians and family practice physicians referred most child abuse cases. The remainder

were self-referred or reported from the PMO family protection unit. The emergency room identified the majority of sexual assault/rape cases.

The child care subcommittee handles cases involving child abuse and neglect and reports them to the CPS. If the sucommittee fails to agree with the results of the CPS investigation, it may initiate its own action. Although spouse abuse cases may be referred to the psychiatric unit which runs group sessions for abusers, cases usually are referred to civilian resources. According to the FAR, the primary purpose of the subcommittees is quality assurance, making sure that cases are staffed and handled properly through referral and treatment resources. The sexual assault subcommittee is particularly geared toward assessing the quality of medical care provided in individual cases.

Because of the scarcity of hospital-based resources, adequate response to abuse and neglect cases is sometimes difficult. Follow up of cases becomes complex if individuals are referred to resources off the base. To many participants, the focus of the Family Advocacy Program is geared more to case identification and reporting than to treatment services.

At this stage in the program, interagency cooperation involves three agencies: the FAR and her staff, the PMO, and the FSC. Overall, the base enjoys a positive working relationship with civilian authorities and agencies. Two counseling and education staff members from the FSC and the head of the PMO family protection unit sit in on FAP subcommittee meetings. The FSC director proposes taking on a larger role in family advocacy and proposes designating the FSC as the coordinating agency for spouse and child abuse cases. The FSC would prefer more involvement by the sponsor's commanding officers in family advocacy cases. The FSC also proposes taking a leading role in case follow up and providing administrative and judicial recommendations to the sponsor'scommanding officer if treatment progress is unsatisfactory.

FSC staff expressed concern over the presence of the command enlisted human affairs representatives in subcommittee meetings because they lack

the professional credentials of the other subcommittee members. At the same time, the hospital staff expressed concern that the FSC lacks quality control because no committee or individual oversees its family advocacy case review and management procedures. The PMO at the time of the site visit was reacting to the changing roles of the FSC in family advocacy cases. The PMO felt caught in the middle in terms of which agency to notify first in family advocacy cases and how to report domestic disturbance incidents. The PMO expressed a need for clearer guidelines about role responsibilities of the FSC and the FAR.

**Current Directions**

Camp Pendleton created an early model program for responding to child abuse cases. It has maintained a high level of experienced staff and has intitutionalized Family Advocacy Program procedures among hospital staff. The dynamic nature of the program is illustrated by the ongoing discussions between the FSC and the hospital in terms of role responsibilities and capabilities. Such discussions indicate a great deal of interest in addressing and responding to abusers and victims.

Camp Pendleton personnel indicated the need for a clear SECNAV Instruction that clarifies responsibilities between the hospital and the line community and that offers program guidance. Other suggestions included:

- Emphasize the role of family advocates and how they support the mission;
- Emphasize a holistic approach to domestic violence in which the abuser and the victim are both involved in counseling;
- Educate battalion commanders in family advocacy and the importance of treatment;
- Train medical personnel who are assigned to chair committees, especially those with no previous experience in family advocacy;

- Strengthen ties with civilian police to enhance case identification outside the base housing area; and

- Add more social workers to work in the pediatric field to identify new mothers with poor parent-child bonding.

MARINE CORPS AIR GROUND COMBAT CENTER,
TWENTYNINE PALMS, CALIFORNIA

## MARINE CORPS AIR GROUND COMBAT CENTER, TWENTYNINE PALMS, CALIFORNIA

Twentynine Palms is a moderate size, multi-mission Marine Corps installation located in the California desert approximately 115 miles east of Los Angeles and 60 miles north of Palm Springs. Although it is the largest Marine Corps installation in land area, its population includes only 6,500 active duty Marines and 6,000 dependents. The base is relatively isolated with a small community located off base. Few recreational outlets and support services exist for families and the nearest large city is more than an hour away. Most Marine families live on base. This housing situation facilitates community involvement as well as knowledge of the stresses and dissatisfactions of neighbors. The combined impact of social isolation, high mission demands, and lack of recreation and support services makes some Marine families vulnerable to stress.

### Program Context

The FAP at Twentynine Palms is managed by the FAR at the 40-bed branch hospital. Family advocacy case reports are forwarded to the NRMC at Camp Pendleton from which the FAR receives program direction. A civilian, the FAR was hired in 1981 and is the only social worker on the hospital staff. Besides FAR-related responsibilities, she also has collateral duties in the hospital.

The FSC plays an important role in the FAP at Twentynine Palms. The staff is involved in the FAP and interacts cooperatively and functionally with the FAR. The FSC staff includes specialists in child and family advocacy who are experienced in clinical response to family stress. Especially notable is the recent development of the FSC Family Violence Containment Program, a proactive program aimed at preventing abuse and neglect through community and outreach education.

Although the local community is small, the FAR has been able to effectively coordinate with community organizations and provide safe houses

for abused families, a community shelter for battered wives, a rape crisis hotline, and a education program for parents. A good working relationship exists between the FAR and personnel from the CPS.

**Program Structure**

The FAC at Twentynine Palms meets monthly and is chaired by the chief of medical services for the hospital, a pediatrician. The membership includes the FAR, the school nurse, and representatives from the FSC, NIS, PMO, Navy Relief, chaplain services, CPS, and day care center. FAC meetings provide a linkage between service providers and a forum for exchange of information on new family advocacy developments. Individual cases are reviewed for disposition and coordination of intervention.

Although no FAC subcommittees exist, two base committees have emerged to deal with family advocacy problems. First, a high risk subcommittee meets monthly to track families considered to be at high risk for child abuse. This committee views itself as prevention oriented and includes the FAR and representatives from Navy Relief, the FSC, and other community care providers as appropriate. Second, the FSC conducts weekly committee reviews of all family cases, including those involving abuse and neglect. Since the FSC is largely responsible for family advocacy case management, most cases are reviewed at these weekly meetings. The case management meetings include the clinical staff of the FSC, the FAR, a chaplain, a CPS representative, and others as needed.

The FAR participates in all meetings and activities related to family advocacy on the base. Her responsibilities include providing intake for all abuse and neglect cases, conducting case assessments, providing recommendations for treatment, making referrals to the FSC or other service providers, and submitting appropriate reports to the CPS, local law enforcement authorities, and Chief of BUMED. In addition, she conducts some counseling at the hospital in family advocacy cases and provides some outreach education.

## Program Operation

Over the past six months, the FAR documented 68 abuse, neglect, and assault cases. The number of family advocacy cases has remained fairly steady over the past two years. The FSC reports that approximately one out of four cases are self-referred while the remainder come from the hospital, PMO, and other sources. All cases referred to the FAR are entered in the incidence blotter which results in notification of the sponsor's CO. For active family advocacy cases, the FSC provides status updates to the sponsor's CO. Cases that are self-referred to the FSC are not routinely reported to the FAR or to the sponsor's CO.

The FAR is notified when cases of child abuse are identified or reported through hospital channels. She interviews the parents of the child, observes their interaction, records the psycho-social history, initiates a case report, and notifies the PMO. The PMO files a separate report of the incident. After stabilizing the situation, the FAR refers the case with treatment recommendations to the FSC. Spouse abuse and sexual assault and rape cases are handled in the same way as child abuse cases when they are referred or self-referred through the hospital. The FAR is called in immediately to provide crisis intervention, initiate a case report, and make appropriate referrals. In incidents of spouse abuse, sexual assault, or rape, the PMO is informed, an entry is made on the command blotter, and the FAR initiates case reports.

Although base organizations cooperate in prevention strategies for family violence, base programs still are quite limited. Local community crisis lines, parent education programs, and other efforts attempt to defuse potential family problems. The high risk committee on children also serves as an effective abuse-prevention strategy. Relatively new, the Family Violence Containment Program initiated by the FSC appears to have excellent prevention potential.

Interorganizational cooperation on family advocacy cases was reported to be quite good on the base and in the civilian community. The local community has contributed significant resources to the family advocacy effort and the CPS is actively involved on base committees and programs. Cooperation and respect between the FAR and FSC staff is particularly noteworthy in facilitating service delivery to families under stress. Cooperation with legal personnel, NIS, PMO, chaplains, and other organizations is somewhat strained but workable.

Follow up of family advocacy cases is performed by the FSC staff. After the cases are referred to the FSC or self-referred, monthly follow up is conducted and continues for approximately one year, unless the Marine is discharged or transferred. In the case of a transfer, the FSC staff notifies the FSC at the new command and mails the case file. The FSC also reports receiving notification from other FSCs in family advocacy cases. The FAR reports all confirmed cases to the Central Registry and forwards the medical file to the gaining command when a family advocacy case is transferred to a new location.

Jurisdictional concerns have somewhat complicated the relationship between the FAR and the CPS. Currently, the FAR reports cases to the PMO. The PMO then notifies the sheriff and the CPS after an investigation and consultation with the staff judge advocate. Unfortunately, this slows the response time of CPS and can cause problems when CPS needs to remove the child from a dangerous situation. Negotiation on these relationships is under way.

**Current Directions**

Largely due to the good working relationship between the FSC and the FAR, the FAP at Twentynine Palms is functioning quite well. The number of abuse and neglect cases being reported through self-referral is increasing and prevention efforts are currently being expanded. The FAR is about to

initiate a new clinical subcommittee following the guidelines of the BUMED Instruction.

The following recommendations were made by those interviewed during the site visit:

- Finalize the Marine Corps Family Advocacy Order;
- Develop standard forms and procedures for family advocacy case management and reporting;
- Expand training in family advocacy cases for FSC directors and NCOICs;
- Upgrade information and skills of FSC staff in family advocacy by providing more opportunities to attend professional meetings and read professional publications;
- Reduce the case management responsibilities of the FAC and emphasize responsibilities for policy development, planning, and coordination of services;
- Increase support for the FAR, particularly in the form of secretarial assistance and reimbursement for local transportation cost;
- Expand efforts in family advocacy prevention and education; and
- Increase continuity of FSC staff through longer-term contracts.

MARINE CORPS LOGISTICS BASE, BARSTOW

CALIFORNIA

## MARINE CORPS LOGISTICS BASE, BARSTOW, CALIFORNIA

Barstow is a small Marine Corps Logistics Command comprised of a single battalion headed by a Commanding General. It is located in the desert approximately two hours east of Los Angeles. The small town of Barstow serves as a support community for nearly 900 active duty Marines and 1,700 dependents. Most Marine families live on the installation. People at the base report a good sense of community because the small size, permits active duty members as well as families to know each other quickly. Still, there is social isolation and limited recreational and cultural opportunities. Few spouses can find jobs in the local economy and support for spouses during field exercises and deployments is limited.

Support for Marine families at Barstow is shared by base and community organizations. The small FSC has a limited staff and offers information and referral services, but no counseling. The FSC counseling position has been vacant for eight months. Although chaplain support is available to families on base, most referrals for professional counseling are made to the community mental health clinic, or to private psychological services. The base enjoys a positive relationship with the local CPS unit.

### Program Context

The FAP is managed within a tenant Navy clinic which also services Army personnel stationed at Ft. Irwin. There are no social workers or medical specialists at the clinic. The FAR is the senior nurse corps officer. He has collateral responsibilities for clinic patient care and clinic personnel training. The FAC is supervised by the FAR and has been operational since the fall of 1980.

## Program Structure

The FAC is composed of the FAR, the FSC Director, a base chaplain, the base inspector, and representatives from the Headquarters Battalion and the PMO. Chaired by the FAR, the FAC meets bimonthly because of the small number of family advocacy cases. There are no family advocacy subcommittees at the present time.

The FAR conducts intake and case assessment, provides crisis counseling in family advocacy cases, coordinates service response, and serves as an advocate for victims. In all family advocacy cases, the FAR is responsible for case reporting to sponsor's commanding officer and to the Chief of BUMED through the NRMC at Camp Pendleton. Before assignment at Barstow, the FAR had been an emergency room nurse at an NRMC for eight months and served as a pediatric nurse where he had training and experience in child abuse cases.

## Program Operation

Over the past two years, the FAC has reviewed five cases of substantiated child abuse and one rape case. Spouse abuse cases are more common, averaging four a month. Although child maltreatment cases usually are identified at the hospital or by the PMO, spouse abuse cases more often result from the response of military police to domestic violence incidents. In the latter cases, the abuser normally is taken to detention and the victim to the clinic.

The FAR is notified in all cases involving abuse and neglect. He conducts an intake assessment and reviews the facts of the case. Some cases reviewed by the FAC are initiated by the FSC as well. The FSC Director reviews the military police blotter daily for abuse and neglect incidents and works with the FAR in providing referral services in these cases.

Basic information about abuse and neglect incidents is routinely reported by the PMO to the sponsor's CO, the division, the FAR, the MCFSC, and the drug and alcohol program. The civilian CPS is informed in cases of child abuse and neglect. No reports are filed with the sponsor's CO in cases of spouse abuse when they are self-referred. Confidentiality in these cases is seen as necessary to encourage Marine families to seek services voluntarily.

At present, no professional counseling services are available on base for intervening in family advocacy cases. As a consequence, referrals for counseling are made to community resources even though these services are limited. Although the command would prefer to have more in-house resources, a counseling position in the FSC has remained vacant for a number of months, awaiting hiring clearance. Most FAC members believe that this counseling position is critical to the program's success.

To date, family violence prevention efforts have focused on base education, welcome aboard orientations, and classes on child abuse identification. The FSC also facilitates prevention through family life education in parenting and family skills. The FSC director sees the development of quality counseling services as a prevention strategy. Once Marine families realize that help is available on base, he hopes they will come in for counseling before a problem reaches the point of abuse or neglect.

In most cases, cooperation between military and civilian human service organizations is quite good at Barstow. Lack of resources is the principal problem in the local community. The number of organizations on base supporting human services is small. Several organizations are linked by the collateral duties of the same personnel. CPS is considered to provide excellent base support, but local mental health services receive mixed reviews.

Case follow up is limited at the present time. The FSC checks on progress with referral sources when the likelihood of future abuse and

neglect is high. The FAR maintains separate case files and transfers child abuse records to the gaining command when a family advocacy case changes stations. Spouse abuse records also are forwarded to the gaining command when the case is particularly severe.

## Current Directions

At the time of the site visit, the FAP at Barstow was in transition. The FAR was being replaced and the FAC was applying pressure to the MCFSC to fill the counseling position. Filling this position with a qualified clinician was seen as important to providing more responsive case management and prevention of abuse and neglect. The following recommendations were made by those interviewed during the site visit:

- Direct family advocacy training to COs and XOs as well as MPs and chaplains;

- Increase stability and continuity within the Family Advocacy Program. Develop more proactive programs, especially in single parenting, stress management, relational communication, and preparation for marriage; and

- Share information about successful programs at other installations and how these programs have been implemented.

FLEET ACTIVITIES, YOKOSUKA

JAPAN

## FLEET ACTIVITIES, YOKOSUKA, JAPAN

Fleet Activities, Yokosuka, is the largest U.S. Naval Shore Facility in the Far East. Located in the Kanto Plains area, it is an hour's train ride from Tokyo. The base serves as the home port for the USS Midway and several smaller ships. Under the Status of Forces Agreement, the USS Midway is not permitted to stay in port longer than 30 days. Military families thus are subjected to continual deployment cycles of short duration when ships are in port and for indefinite periods when ships are out of port.

There are approximately 3,000 families stationed in the area. Half live in base housing units in Yokosuka, Yokohama, and Nagai. The remainder live on the local Japanese economy. Under the Status of Forces Agreement, the Japanese government has both civil and criminal jurisdiction over off-duty Navy personnel stationed in Japan, and authority over dependents at all times. According to the legal officer, Japanese law enforcement centers around drunk driving, drug offenses, and possession of weapons. Little focus has been directed in Japanese law to child or spouse abuse and neglect.

The Yokosuka base provides the most extensive support services for Naval personnel found in Japan. In addition to the NRMC there is a fully staffed FSC as well as Dependents' Assistance Teams for the USS Midway and other ships. There is also a well-organized Ombudsman Council.

### Program Context

Under the auspices of the NRMC in Yokosuka, a FAC was established in 1977. It has been chaired continuously by the same chief of pediatrics. In January 1983, the NRMC hired a full-time FAR to provide case management and coordination of family advocacy cases.

The NRMC is designated as an acute care facility. Its staff includes specialists in medicine and surgery. There is a branch hospital at MCAS Iwakuni and branch clinics at NAF Atsugi and COMFLEAC Detachment, Yokohama. At each branch medical facility, a part-time FAR is responsible for reporting cases to the Yokosuka FAC. The hospital has the only Navy psychiatrist in Japan as well as an alcohol rehabilitation service headed by a psychologist with a background in family therapy and public health.

## Program Structure

The Yokosuka FAP consists of one FAC which meets monthly. Chaired by the head of the pediatric branch of the NRMC, FAC members include a Naval Legal Services Officer, two pediatricians, a chaplain, the head of the Alcohol Rehabilitation Service, and representatives from the dental center and nursing service. The director of the FSC and a security officer represent the line side.

A representative of the Yokohama Detachment also attends committee meetings as do representatives from the Dependents' Assistance Teams from the USS Midway and NAVSURFPAC. The number of FAC numbers was reduced in the fall of 1982 at the recommendation of the Naval Legal Services Officer. Given the relatively small size of the military community at Yokosuka, he felt the large-sized committee jeopardized client privacy.

The FAR is responsible for the background investigation of all family advocacy cases brought to the FAC and provides crisis intervention in many instances. In addition, she is the primary link with the FARs and FSC personnel in Atsugi and Iwakuni. The current full-time FAR is a civilian social worker (BSW) and former chair of the Ombudsman Council. She replaced an MSW who was a part-time volunteer, in January 1983. Since her appointment as FAR, the liaison has improved between the NRMC and the branch medical units at Atsugi and Iwakuni.

**Program Operation**

Between December 1982 and February 1983, the FAR reported eight cases of suspected child abuse and 18 cases of spouse abuse. This is double the number of cases the FAC had reported in any previous year. In a February 1983 SITREP, the FAC chair noted that few of the reports presented to the committee were unfounded. The majority were either strongly suspected or confirmed. Rape or sexual assault is reported very rarely, only one or two cases per year.

Child abuse cases are primarily identified by pediatricians and other hospital personnel; DoDDS school social workers and counselors also are a frequent referral source. Spouse abuse cases usually are identified by the shore patrol. Other sources for spouse abuse cases include the ombudsmen, the housing officer, and the Dependents' Assistance Team.

Cases initially are investigated and counselled by the FAR. They are subsequently brought to the attention of the FAC for case disposition and intervention planning. Investigations may be conducted by the NIS, but only if the command initiates the investigation and if the level of abuse indicated is a felony, such as aggravated assault.

Each family advocacy case is recorded by number and staffed by the FAC. Although the minutes of FAC meetings contain brief case histories and treatment recommendations, they do not routinely report whether cases are established or suspected. In some instances, spouse abuse is documented and established by the shore patrol.

Intervention strategies include referrals to the ARS and FSC for counseling services or recommendations for an early return of the entire family or particular family members to CONUS. If needed, inpatient psychological treatment for adolescents is available on a limited basis at Yokota Air Base.

Since overseas bases lack community support services for military families, the interagency linkages at Yokosuka are military ones. The agencies that interact most often in family advocacy cases include the hospital, FSC, Shore Patrol, and DoDDS schools. Commands become involved if early returns are suggested, or if active duty personnel refuse to enter recommended counseling. The FAR, other FAC members, or the hospital CO may be involved in case discussions with commands.

In early return situations, case follow up usually includes notification of CONUS authorities, both receiving commands and civilian agencies such as CPS. This procedure helps ensure that the family receives the necessary help and support upon return to CONUS.

Case reporting procedures are outlined in NAVREGMEDCENJAINST 6320.57 dated 15 June 1982. The FAR is responsible for maintaining all abuse and neglect reports. These reports are appended to medical charts, which are forwarded directly to the CO or OIC of the medical facility of the receiving command in PCS moves. The FAR reports that she does not routinely receive records of incoming cases from other bases.

In a briefing last February, the Chair of the FAC reported several difficulties that the FAP faces at Yokosuka:

- Lack of legal authority: under the Status of Forces Agreement (SOFA), the Japanese government has jurisdiction in family disputes involving military personnel but, in fact, does not intervene in these cases. The military has no legal authority over dependents or DoD civilian employees or their families.

- Liability of safe homes and shelters: both the medical center and privately volunteered safe homes are open to charges of kidnapping should they remove a child for protective custody and the parent opposes the decision.

- Lack of clinical resources: because of the shortage of adequate counseling and support services at Yokosuka, families involved in abuse and neglect often must be transferred to CONUS for treatment.

* Lack of command support: at present, local command leadership lacks understanding of the seriousness of abuse and neglect and its potential negative impact on the Navy mission.

**Current Directions**

Yokosuka personnel involved in the Family Advocacy Program cite jurisdictional issues and lack of treatment alternatives as the major program handicaps. The high number of American-Japanese and American-Philippino marriages leads to complex questions about culture-bound definitions of child and spouse abuse. The lack of adequate screening of families for overseas assignment contributes to the problems faced by the small number of services providers.

The FAP receives strong support from the hospital command, but a higher degree of awareness on the part of local commands is seen as vital to successful program operations.

FAP personnel indicated a number of recommendations for strengthening the Family Advocacy Program at Yokosuka:

* Include representatives from COMNAVFORCESJAPAN and NIS to aid in command and legal intervention in family advocacy cases;

* Add billets to the medical center of the FSC to increase clinical resources for abuse and neglect cases;

* Improve screening mechanisms both prior to overseas duty and between different overseas duty stations; and

* Develop a base action plan authorized by COMNAVFORCESJAPAN that clearly delineates Family Advocacy Program responsibilities.

MARINE CORPS AIR STATION, IWAKUNI

JAPAN

## MARINE CORPS AIR STATION, IWAKUNI, JAPAN

The U.S. Marine Corps Air Station at Iwakuni is the only Marine Corps base on mainland Japan. Located in the extreme western portion of the island of Honshu, it is a day's train ride from Yokosuka Naval Base. Iwakuni's mission includes support of Marine Corps operations in Asia and maintenance and supply of tenant units in the Pacific such as the 1st Marine Aircraft Wing headquartered on Okinawa. Transport planes and search and rescue helicopters also are assigned to the air station.

Although Iwakuni has a fluctuating population of 700 families, almost one-half are not command sponsored. The growing number of families deciding to accompany the active duty member has strained housing and school resources. The six-month rotation pattern of squadrons means a constant turnover of commanding officers and personnel. This turnover demands continual efforts on the part of family advocacy personnel to justify their role to new command personnel.

Families at Iwakuni are faced with frequent separations because of deployment of active duty members to Okinawa, the Philippines, and South Korea. Support services for families are available, however, through the FSC, branch hospital, Red Cross, and Navy Relief.

### Program Context

Staffed by general physicians, physician assistants, and nurses, the branch hospital provides pediatric, obstetrical, and general medical care. Specialists from Yokosuka fly down periodically and serious cases are referred to the NRMC in Yokosuka. Most medical personnel serve only a one-year tour of duty at Iwakuni before returning to CONUS. The present FAR, a charge nurse and Navy Lieutenant, began her duties in October 1982. She is the third appointed FAR and replaced a physician who now chairs the FAC.

## Program Structure

The FAC at Iwakuni meets once a month and is composed of representatives from the NIS, PMO, the dental clinic, chaplain service, Red Cross, and Navy Relief. Other members include the FAR, a school nurse and counselor, FSC Director, NCOIC of the joint counseling center for alcohol and drug abusers, and two physicians. One of the physicians serves as the committee's chair.

To maximize its function, the FAC divides itself into task groups. A recently established "core committee" meets weekly to screen advocacy cases before they come to the full committee for review. Its objectives are to guide initial treatment response to victims and carry recommendations to the base CO or XO about particular abuse situations. This group is composed of the FAC chair, the FAR, and the director and social worker of the FSC. Another group recently developed a proposal for dealing with foster home issues.

The FAR perceives her primary responsibilities as intake and case management. She is the initial medical contact person for most victims and coordinates service response to their needs.

## Program Operation

In the past year the FAC has dealt with 26 abuse and neglect cases: three cases of physical child abuse, four cases of sexual child abuse, 15 cases of spouse abuse, and four cases of adult sexual assault and rape. The FSC is the primary source of case identification. The clinic and concerned citizens are secondary sources. In all cases, the FAR interviews the victim and the family and coordinates case investigation and service response with the core committee. The larger FAC operates essentially as a quality control agent to review service response.

Treatment resources are scarce in Iwakuni. Counseling services are provided by the FSC social worker, who has a background in the Department of Army family advocacy program, base chaplains, and the joint counseling center in some spouse abuse cases involving alcohol.

There is a civilian community church-sponsored "Serendipity House" operated by an American-born Japanese couple. Used as a support center primarily by Japanese wives, the staff of this community center makes and receives referrals from the FSC, branch clinic, and base chaplains.

Case follow up is provided by the FAC and includes contacts with receiving commands in early return situations. Case reporting is handled by the FAR who sends materials to the Yokosuka NRMC for forwarding to Washington, D.C.

**Current Directions**

In the past few months, the program at Iwakuni has gained impetus from two sources: the physician who chairs the FAP committee and the growing participation in the FAP by the FSC. Because of the size of the FAC and concerns over case confidentiality, the core committee was established to expedite service response and case privacy. At present, the separate chain of command between the clinic staff and the FSC staff creates tension about correct procedures for notifying commands and working through necessary procedures for early returns of families. The transient nature of many squadron personnel may encourage commands to believe that many domestic problems will resolve themselves without professional intervention simply upon rotation back to the United States.

A number of recommendations were made by the respondents involved in the FAP at Iwakuni:

- Develop standard operating procedures for handling family advocacy cases that demonstrate command support and provide program continuity;

- Train committees in case identification and FAP procedures;

- Schedule regular FAC meetings so that committees learn how to operate when not in a crisis situation;

- Periodically review case management tactics to discover interventions that had the most positive effects; and

- Develop and distribute educational materials at the clinic, chapel, child care center, and FSC to demonstrate command support for family advocacy issues.

# NAVAL AIR FACILITY, ATSUGI

JAPAN

## NAVAL AIR FACILITY, ATSUGI, JAPAN

Located about 35 miles southwest of Tokyo, the Naval Air Facility at Atsugi is headquarters of the Commander Fleet Air, Western Pacific. Sharing facilities with the Japan Maritime Self Defense Force, it provides aviation support functions for tenant commands and transient units. Since 1973, aircraft assigned to the USS Midway fly to Atsugi as the ship reaches port. Although the population fluctuates greatly, an estimated 900 military members and up to 2,500 dependents and civilian personnel live on or near the base. There is a two-year waiting period for on-base housing. Camp Zama, a nearby Army installation, provides school facilities for grades 6-12 and augments other support services for the Navy population, including parenting education classes.

Although Atsugi is only 26 miles from Yokosuka, the perceived distance is much greater because of complex train connections and extremely crowded highways. At the same time, Atsugi provides neither a full complement of medical nor social services to its personnel. Since the ratio of support personnel is based on the number of active duty members, the allocation of services depends on whether the members are counted as part of Yokosuka (because they are assigned to the USS Midway) or as part of Atsugi (because they fly there).

The base has an exchange and a small commissary. In addition, Red Cross and Navy Relief offices are open a few days a week. A FSC was opened in February 1983 with a Deputy Director and one staff member.

Many families in Atsugi feel isolated and dependent upon Yokosuka for support. For many, lives are tied to the schedule of the USS Midway and its frequent movements in and out of port. For those unaccustomed to living in a foreign environment, the long wait for housing and Japan's high cost of living can cause significant levels of stress.

## Program Context

Staffed by two physicians and two physician assistants, the medical clinic at Atsugi provides emergency and ambulatory care. There has been a part-time FAR for three years. The present FAR is a medical resident and Navy Lieutenant who began his duties in 1983. The former FAR was the OIC of the medical clinic.

## Program Structure

Currently, there are no family advocacy committees at Atsugi. Family advocacy cases are discussed by the FAR and the OIC of the medical clinic. Case reports are submitted to Yokosuka. The present FAR has handled no family advocacy cases. Before he assumed responsibility, however, two suspected child abuse cases and three or four spouse abuse cases had been identified in the previous eight months. One suspected rape case had been dropped because the alleged victim would not pursue it. With the changing population and stressful nature of the Navy mission at Atsugi, the FAR suggested that incidence rates should be higher, but cases simply were not surfacing at the clinic.

## Program Operation

Since the appointment in December 1982 of a deputy director for the FSC in February 1983, base service linkages have improved. In conjunction with the FAR and a pediatrician at Yokosuka, the FSC deputy director is monitoring a "high risk" family until it returns to CONUS. In addition, she has worked with another family to arrange for treatment for alcoholism in the Yokosuka ARS. Security police have been alerted to inform both the FSC deputy director and the FAR of domestic disturbance incidents on base.

Although there is some uneasiness about abuse cases not coming to the attention of medical or other personnel, a number of nonmedical

professionals interviewed admit their ignorance of family violence issues and compare Atsugi to a small town where such things are not brought out in the open. Respondents interviewed also expressed concern about the lack of available resources to handle abuse and neglect cases should they begin to surface.

## Current Directions

Atsugi is currently developing base resources to become less dependent upon Yokosuka. For example, the acquisition of a deputy director to initiate an FSC and the recent establishment of an Ombudsman Council at Atsugi undoubtedly will lead to a greater community awareness of family advocacy issues and better service response. At the present time, however, the FAP is embryonic, both in terms of identification and treatment.

In the course of the site visits, base respondents made several recommendations for improving the FAP at Atsugi:

- Develop educational programs about the nature and causes of domestic violence and the impact of sexual assault;

- Develop day-to-day guidelines in terms of intervention and notification of professionals in suspected cases;

- Educate dependents about the impact of referring abuse cases;

- Develop screening procedures for families that assess both medical conditions and social skills for living overseas; and

- Conduct area-specific training for family advocacy personnel in Japan.

# NAVAL SUPPORT ACTIVITIES, NAPLES

## ITALY

## NAVAL SUPPORT ACTIVITIES, NAPLES, ITALY

The military community in Naples numbers approximately 8,000 Navy, Army, Air Force, Marine, and Coast Guard personnel and family members in addition to civilian DoD personnel and dependents. The military presence includes such commands as Headquarters Allied Forces in Southern Europe, Naval Supply Activity, Naval Air Facility, and Fleet Air Mediterranean (COMFAIRMED). There also are 2,000 Navy active duty personnel and dependents in Gaeta, the home port for the U.S. Sixth Fleet, 60 miles north of Naples.

Although government-contracted quarters are available for approximately 300 enlisted families in Pinetamere, approximately 20 miles from the Naval Support Activity, the majority of families are dispersed throughout the area, usually at some distance from the NSA. Travel distances are compounded by transportation and communication difficulties. Public transportation is seen as unreliable and inconvenient, and the use of private transportation may be frightening to those unaccustomed to the Neapolitan driving style. In addition, few families have telephones because of the expense and long installation delays. Cultural and language barriers, few employment opportunities for dependents, and frequent absences of Navy members because of deployments often strain the coping resources of families.

The Neapolitan area is rich in natural and cultural resources. However, unlike many CONUS installations, it lacks services for families. NSA provides a number of important support services, including a U.S. Navy exchange and commissary, NRMC and Naval FSC. However, base recreational services are limited, and there is no child care center.

### Program Context

The Naples FAP was established in 1979 under COMFAIRMED Instruction 6320.1B. It was reorganized early in 1982 by the Chief of Psychiatry at

the NRMC in Naples. Before assignment to Naples, the Chief of Psychiatry, a Navy Commander, had successfully established a FAP in Subic Bay and was asked by the hospital's commanding officer at Naples to initiate a similar effort. In the reorganization, the Chief of Psychiatry prepared a new COMFAIRMED Instruction (6320.1C) dated 7 April 1982 which established policies and procedures for an ongoing FAP under coordination of the Commander, Fleet Air Mediterranean, Naples, Italy. Cancelling the earlier COMFAIRMED Instruction, the new Instruction is applicable to all commands within the area served by the NRMC.

In response to the new Instruction, a FAC was formed in April 1982 to review reported cases of abuse and neglect and to administer program operations. Approximately ten months after the first FAC meeting, a full-time hospital based civilian social worker was hired as the FAR. Through the family advocacy instruction and before the arrival of the hospital based FAR, the FAC requested all CO's and OIC's to designate a command family advocacy representative. They assisted the FAC in investigating and coordinating abuse and neglect cases. Although command family advocacy representatives continue to exist, their role has diminished since the hiring of the full-time hospital based FAR.

**Program Structure**

Naples presently has a single FAC made up of eight members: the FAR, the Chief of Staff-COMFAIRMED, the Staff Judge Advocate, the Senior Chaplain-COMFAIRMED, a Security Officer, an FSC staff representative, the Chief of Pediatrics, and a DoDDs counselor. Augmented periodically by additional hospital and base leadership, the FAC meets monthly to discuss family advocacy cases, establish case dispositions, coordinate service response, and establish FAP policy and operating procedures. Chaired by the Chief of Staff for COMFAIRMED, the FAC reviews cases from Gaeta, Sigonella, LaMaddalena, and Naples. Only the cases from Naples receive extensive review by the committee. Diagnoses and dispositions for cases from areas other than Naples are established by FACs at local levels. The

FAC at the NRMC provides brief reviews of these cases before forwarding them to the Chief of BUMED. If there are questions about case diagnosis or treatment, the FAC will request additional information from the local command.

The FAR performs several important functions in the Naples FAP. First, he is the conduit for all family advocacy case reports. When the FAR is notified about a family advocacy case, he is responsible for conducting an investigation and presenting the findings from the investigation to the FAC. The FAR then monitors the disposition of the case, provides follow-up services, and forwards case reports to the Chief of BUMED. The FAR also coordinates the operation of the FAP between the NRMC and the branch clinics in Gaeta, Sigonella, and LaMaddalena. He also has been instrumental in establishing local family advocacy programs at these bases.

In his role, the FAR is assisted by an FSC social worker who is the Family Advocacy Coordinator of the center. She works with the FAR in investigating family advocacy case reports and provides consultation to the FAR on a weekly basis. In general, the FSC plays an important role in the FAP. Composed of professional staff, including psychologists, social workers, and information specialists, the FSC provides both prevention and treatment programs for dealing with the problems of abuse and neglect.

**Program Operation**

Since the initiation of the FAC at Naples and especially since the hiring of the FAR, the number of family advocacy cases has increased dramatically. At the time of the site visit, approximately 66 cases were on active file, more cases than reported for the three year period of 1980 through 1982. The majority of advocacy cases are identified through the emergency room, but others are reported to the FAR by base chaplains, security police, the shore patrol, the JAG officer, the FSC, and local Navy

community residents. In general, Navy and civilian personnel on base are familiar with case reporting procedures, especially the hospital staff.

Regardless of who identifies the case, the FAR is notified routinely and a case file is initiated. After a case is reported to the FAR, he formulates a tentative intervention plan and coordinates a case investigation with the FSC. Normally, the FAR works closely with the sponsor's command in all cases of abuse and neglect. The working relationship between the FAR and the command is facilitated by the presence of a command family advocacy representative in each command.

Protection for victims of child and spouse maltreatment often is a problem for families residing in the local community. Base security has no authority over dependents and the Italian police are hesitant to become involved in family disputes in Navy households. In cases that present jurisdictional issues, the FAR is instructed to contact the Chief of Staff-COMFAIRMED for resolution.

With the exception of the FSC and chaplains on base, there are limited treatment resources for intervention into family advocacy cases. Although the FAR is a trained social worker (MSW), he has been reluctant to accept cases clinically because of his case management and area coordinating responsibilities. Because of inadequate resources, early returns for family members involved in abuse and neglect are necessary in approximately 25 percent of family advocacy cases. If transfer to CONUS is recommended by the FAC and the decision is supported by the sponsor's command, the program instruction suggests that the family be moved to the vicinity of an NRMC having available family counseling and therapy resources.

Despite limited treatment resources, referral and case coordination between base service providers are quite effective in cases of abuse and neglect. The FAR has done an excellent job in briefing service providers and hospital personnel about family advocacy case procedures so that effective communication and liaison exist between the FAR and the staff of the FSC. Having a line instruction guide the family advocacy program and

the Chief of Staff-COMFAIRMED chair the FAC provides the FAP with command support and credibility among base leadership.

Follow up of family advocacy cases is the responsibility of the FAR. Currently, the FAR maintains "working files" on each family advocacy case. These case files can originate from Naples, Gaeta, Sigonella, and LaMaddalena. Although suspected and established cases of abuse and neglect are forwarded by the FAR to the Chief of BUMED, the FAR does not routinely forward case files to the receiving command when a family advocacy case receives PSC orders, nor does the FAR receive case files from other commands when a family advocacy case is transferred to Naples.

**Current Directions**

Through the initiative of the Chief of Psychiatry at the NRMC, Naples has implemented an effective FAP. There are procedures for case management and base service agencies are working cooperatively to maximize available resources. In addition, the FAR at the NRMC has successfully assisted Gaeta, Sigonella, and LaMaddalena in establishing FAPs in their branch clinics.

As base personnel have become more sensitive to abuse and neglect, the numbers of family advocacy reports have increased dramatically. This situation is straining the human services delivery system on base and resulting in a backlog of family advocacy cases for investigation and disposition. If more staff resources are not made available, the FAR and members of the FAC believe that an increasing number of family advocacy cases will have to be returned to CONUS for treatment.

Because of increasing numbers of cases, the FAC is initiating a clinical subcommittee to assume case management of family advocacy cases. Composed mainly of agency heads and representatives and chaired by the FAR, the subcommittee will meet monthly. The larger FAC will continue to meet monthly, but will focus primarily on FAP policy and procedural issues.

In the course of the site visits, several recommendations were made for strengthening the FAP at Naples:

- Tighten screening procedures for assigning families to overseas duty;
- Increase FAP program staff at the NRMC;
- Hire a visiting nurse to conduct home investigations in child abuse and neglect cases;
- Increase community helping resources;
- Construct a child care center to provide an outlet for parents;
- Conduct training in abuse and neglect treatment and prevention;
- Increase the prevention focus;
- Provide better outreach to base families who are "high risk" for abuse and neglect;
- Clarify reporting procedures when family advocacy cases transfer; and
- Provide clear definitions of abuse and neglect.

NAVAL SUPPORT OFFICE, LAMADDALENA

SARDINIA

## NAVAL SUPPORT OFFICE, LaMADDALENA, SARDINIA

The island of LaMaddalena is the largest of 14 islands in the archipelago of the same name. It is located northeast of Sardinia in the western Mediterranean Sea. Part of the Republic of Italy, its people are primarily Sardinian and of mainland Italian origin. The island's primary economic support comes from tourism. The population swells from approximately 11,000 in winter to 70,000 in summer. The population normally includes U.S. Navy, Italian Navy, military familes, and local civilians. The Navy population of LaMaddalena includes approximately 2,000 active duty members and 750 dependents. An 18-month unaccompanied tour, LaMadalena is a 24-month assignment for Navy members with command-sponsored dependents.

LaMaddalena serves a number of important functions for the U.S. Navy. Its commands include the Commander Submarine Refit and Training Group, the site component (port services), the USS Orion, and the U.S. Naval Support Office (NAVSUPPO). Of these commands, the USS Orion is the largest witn a crew of approximately 1,000. A submarine tender, the USS Orion is anchored off the island of Santo Stefano, a 20-minute ferry ride from the island of LaMaddalena.

Few base housing units exist for families. As a consequence, the Navy population at LaMaddalena is quite dispersed over the mainland of Sardinia and the island of LaMaddalena. Many families spend months living in local hotels until base or local community housing is secured. Families are sometimes evicted from local rental units during the summer tourist season.

Besides the shortage of housing, other stresses affect military families at LaMaddalena. Slow ferry services between the mainland and the islands, lack of public transportation, and almost total unavailability of telephone service isolate many families from community support and results in loneliness and boredom. Although most families live on the island of LaMaddalena, the commissary and exchange are located on Santo Stefano

island, a ferry ride away. Lack of familiarity with the local culture, language barriers, frequent loss of electricity, and geographic isolation from major European cities create daily frustrations.

There are limited recreation and support services for Navy personnel and families in LaMaddalena. Although an FSC is being developed, it is not yet operational. In addition, there is no secondary school for adolescents on base. As a result, students in grades 10-12 are sent to a boarding school at Torregon Air Force Base near Madrid, Spain. Also, despite the presence of a child care center, child care services are unavailable to many families because of limited space. The high stress at LaMaddalena and the lack of recreation and support services challenges the coping resources of even the strongest families.

**Program Context**

The FAP at LaMaddalena was established in the fall of 1982 by medical personnel at the branch clinic and operates under local Instruction 4320.1 dated 03 January 1983. The Instruction establishes the OIC, NRMC branch clinic, or his designee as the FAR for the LaMaddalena area. The FAR is responsible for investigating and handling all reported instances of child maltreatment, spouse abuse, and sexual assault and rape. A civilian social worker (MSW) was hired as FAR, after a billet was transferred from the NRMC to the branch clinic. A part-time position, the FAR chairs an ad hoc family advocacy committee.

Prior to the initiation of the FAP at LaMaddalena, the NRMC Naples had total responsibility for diagnoses and coordination of identified cases of abuse and neglect at LaMaddalena. Although case reports at LaMaddalena continue to be filed with the Chief of BUMED through Naples, the FAR at Naples strongly supports the investigation, diagnosis, and service coordination of family advocacy cases by base personnel in LaMaddalena.

Like many of the sites visited, the FAP at LaMaddalena is in transition. Several family advocacy committee members will be changing duty stations in the near future. Among those leaving is the FAR, a Navy spouse, whose husband has received PCS orders to a CONUS installation.

**Program Structure**

LaMaddalena has a single FAC composed of ten members: the FAR, the JAG officer, two physicians from the branch clinic, two physicians and the chaplain from the USS Orion, and two chaplains and the CO of the Navy Support Office. Chaired by the FAR, the FAC meets monthly to discuss family advocacy cases, establish case dispositions, and coordinate service response.

The FAR is the conduit for all family advocacy case reports. She is responsible for investigating reported cases, presenting findings from the investigation to the committee, monitoring case decisions, providing and conducting follow-up services, and forwarding case reports to the NRMC in Naples. In general, the FAR perceives herself as the primary interface between the involved member or family and the FAC. Because of shortages in counseling resources, the FAR also provides counseling and direct support in many family advocacy cases.

**Program Operation**

In the past year, LaMaddalena had approximately 30 family advocacy cases. At the time of the site visit there were eight cases on active file: five established and two suspected cases of spouse abuse and one established case of child maltreatment. The majority of family advocacy cases are identified by medical personnel, chaplains, and the JAG officer. Some cases are self-referred to the FAR.

In all cases, the FAR is notified and a case file is initiated. When a case is reported, the FAR conducts an investigation, provides crisis intervention or works with the referring agent in formulating a short-term intervention plan, and presents the findings to the committee for case review and disposition.

Until the FAC decides to open or to drop a reported family advocacy case, the FAR maintains "working files." When a case is opened, a copy of the file is forwarded to the FAR at the NRMC in Naples for review and possible consultation. If the FAR at the NRMC has questions about the case, he will seek clarification from the FAR at LaMaddalena before forwarding the case report to the Chief of BUMED.

Local follow up of cases is the responsibility of the FAR. The small size of the base and the coordination between base service providers facilitates tracking of family advocacy cases. In the event of PCS orders in family advocacy cases, the FAR notifies the medical command at the receiving installation.

Notification of the sponsor's CO occurs only when the FAR is unable to enlist the cooperation of the member or the member's family. In general, base personnel are well acquainted with procedures for handling family advocacy cases. The cohesion of the professional helping community facilitates case referral and liaison.

With the exception of chaplains and the FAR, few professional resources exist at LaMaddalena for intervention into family advocacy cases. In serious cases, the member or family will be sent to the NRMC in Naples for a psychiatric evaluation or return to the States. Currently, the development of preventive programs and activities to reduce stress and the occurrence of abuse and neglect are hampered by the shortage of base resources and facilities.

Perhaps because of the shortage of resources, base professionals at LaMaddalena attempt to coordinate their service response to family advocacy

cases through effective communication and l'aison. Although chaired by the clinic FAR, the FAP is seen as a base, not a clinic, program.

## Current Directions

LaMaddalena has successfully provided the foundation for the continued refinement of an effective FAP. Despite limitations of professional resources, base personnel work together to improve service response in family advocacy cases.

Currently, the FAR at the NRMC in Naples is reinforcing the LaMaddalena FAP with increased support. The FAR position at LaMaddalena, for example, was provided through the NRMC. The FAR in Naples believes that case coordination of family advocacy cases best occurs at the local level. Close working relationships between the NRMC in Naples and the branch clinic in LaMaddalena strengthens service response in family advocacy cases.

The FSC in LaMaddalena will open in the fall 1983. The FAP has already appointed the new deputy director of the FSC to the FAC. Given the upcoming staff transition among family advocacy program initiators, the FSC may become an important source of continuity for the family advocacy programs. The FSC certainly will provide new helping resources in the base community and strengthen operation of the FAP.

In the course of the site visit, several recommendations were made by base personnel for strengthening the FAP at LaMaddalena:

- Make the FAR a full-time position;
- Tighten screening procedures for assigning families overseas;
- Develop family advocacy training programs;

- Clarify requirements for maintaining and forwarding case files;
- Increase community helping resources;
- Increase support for base families through better outreach services; and
- Better prepare families for anticipating the "real" situation for family life at LaMaddalena.

# Section II

## Program Overview

## Section II

### PROGRAM OVERVIEW

The 13 Family Advocacy Programs assessed during the site visits exhibit both similarities and differences in program structure and operations. Although some Family Advocacy Programs closely follow the program guidelines set forth in BUMED Instruction 6320.57, those at other sites are more rudimentary. Differences between programs more often result from variations in available resources and program history than from lack of concern and initiative for program development.

This section of the report discusses distinctive program variations, provides explanations for these differences, and presents program issues raised by respondents and observed by research teams during the site visits. The issues chosen for discussion reflect general program concerns and are not specific to any particular location. The section concludes by outlining current program strengths, concerns, and dilemmas and by including specific recommendations (from base respondents) for increasing program effectiveness.

### PROGRAM CONTEXT

Sites chosen for the study represent the heterogenous character of Navy and Marine Corps locations and functions. The aim was to assess the development, structure, and operation of the Family Advocacy Program across a number of demographic, mission, and support service variables. These variables include different missions, locations, and sizes of Navy and Marine Corps installations operating under distinctive State laws and Status of Forces Agreements; and a variety of military and civilian medical and other support services and facilities operating in both transient and relatively stable military communities.

The range of site contexts alone provided several straightforward explanations for Family Advocacy Program variations:

- Smaller bases and hospital facilities usually have one rather than three working subcommittees; otherwise the same personnel would be assigned to all three.

- Overseas installations are dependent on base resources for family advocacy case investigation and intervention because civilian resources are unavailable.

- At smaller CONUS bases with limited hospital and base facilities and personnel, family cases requiring treatment services often are referred to civilian resources.

- Unlike CONUS installations, overseas FAC discussions often focus on the merits of the "early return" of families involved in abuse and neglect.

- Bases with an entry-level technical training mission have less well developed Family Advocacy Programs because of the transient nature of the population.

- Navy FARs are more likely than civilian FARs to have additional collateral duty responsibilities.

All the Family Advocacy Programs examined share one element in common: the evolution of greater specification and refinement in program structure and operation. The development of line-based activities in family advocacy areas is a reason for program change. Stimulated by the forthcoming SECNAV Instruction, training sessions sponsored by NMPC-66 and MPH-25, and the recently issued Marine Corps Family Advocacy Order, the awareness of advocacy issues is spreading throughout the Navy and Marine Corps Communities. One example of this development is the initiation of line-based committees, such as the Family Advocacy Coordinating Team (FACT), operated by the Family Service Center at Charleston Naval Base. The FACT is designed to educate base support service personnel about family advocacy issues and reporting procedures, and improve community service response to abuse and neglect.

Another influence on the Family Advocacy Program, especially at smaller installations, is the introduction of military and civilian social workers into Navy medical settings. Trained hospital social workers expedite the work of the FACs by assuming investigative and coordinating responsibilities in abuse and neglect cases. Depending on their available time, these persons are able to stimulate the development of programs in smaller, more isolated facilities and refine procedures for case identification, intake, and coordination. Also, medical personnel involved with FACs at other locations bring their knowledge and experience to their new duty stations and act as catalysts to less developed programs.

**PROGRAM STRUCTURE**

The BUMED Instruction creating the FAP is a policy rather than a program statement. It outlines a program structure but is less specific about how this structure should operate. The Instruction specifies the number and composition of family advocacy committees, meeting frequency, position and role of the FAR and DFAR, and procedures for case reporting. It also directs hospital personnel to perform a number of functions: case identification, assessment, treatment, prevention, education, and reporting.

The Instruction stresses the importance of cooperation between base agencies and base and civilian resources, but does not provide detailed guidance about developing and maintaining this cooperation. Given the importance of community response to family advocacy and the need for effective interface between hospital, civilian, and line personnel, this lack of guidance is seen as a serious problem, especially by inexperienced FAP staff.

In general, the Instruction does not have detailed program goals and parameters for program evaluation. Instead, the emphasis is on statistical reporting requirements of family advocacy cases. In addition, the case procedures outlined by the Instruction for handling abuse and neglect cases

are more applicable to cases of child maltreatment than to spouse abuse, sexual assault or rape. Frequently, the Instruction combines the problems of child maltreatment and abuse between adults.

The Instruction's emphasis on child maltreatment is reflected in many local programs. Child maltreatment subcommittees usually meet more frequently and regularly than do the other subcommittees. There are no spouse abuse or sexual assault/rape subcommittees at some bases. The focus of the Instruction and local programs on child maltreatment stems from historical factors and the perceived seriousness of the offense. In 1976 BUMED initiated a child advocacy Instruction. Three years passed before this Instruction was expanded to include adult abuse and neglect. The policy and base program emphasis on child maltreatment, however, does not reflect the relative magnitude of reported abuse and neglect among military families. Although there are few reported cases of sexual assault and rape, the incidence of spouse abuse at most visited bases equals or exceeds the number of reported child maltreatment cases.

### Role of the FAR

The FAR plays a key role in the program. According to the Instruction, the FAR's primary duties are to implement and manage the local FAP. In this role, the FAR:

- Represents and advises the CO of the medical facility in all areas pertaining to family advocacy;
- Assists the medical CO in establishing local policies and directives necessary to implement the FAP at the local level;
- Helps Naval regional dental centers and other dental activities establish local policies and directives;
- Establishes a continuing educational effort for all command personnel;

- Establishes internal reporting, follow-up and management procedures for advocacy cases;
- Serves as the referral point for each command to report incidents;
- Establishes working files for each reported case to determine the course of action;
- Develops knowledge of all available military and civilian treatment resources;
- Notifies civilian agencies of abuse and neglect cases as required by State and local laws;
- Evaluates, reports, and secures treatment for abuse and neglect victims;
- Works on a collaborative basis with community agencies to provide services;
- Expeditiously processes, reviews, and reports each family advocacy incident;
- Involves the parent or sponsor in the treatment process;
- Works with judicial systems to establish jurisdictional agreements;
- Evaluates the impact of legal intervention on therapeutic efforts;
- Develops through the FAC a realistic treatment plan that maintains the family unit;
- Conducts social history interviews with community agency staff;
- Maintains family advocacy incident log;
- Maintains custody of all FAP records;

- Forwards copies of FAP files to the gaining medical facility;

- Provides follow up for missed medical appointments; and

- Reviews case files following medical treatement or when abuse or neglect is suspected.

Although the FAR shares some of these responsibilities with the FAC, the BUMED Instruction clearly designates the FAR as program manager.

On the bases the research team visited, the proportion of time spent by FARs in FAR related duties ranges from 10 to 80 percent. Only at Naples is the FAR position considered to be full time. Most FARs have responsibility not only for the FAP, but also for such duties as outpatient and discharge planning, adoption coordination, weight control programs, social work administration, and medical caseloads. Most FARs interviewed either are Navy or civilian social workers or psychologists; others are nurse practitioners, physicians and physician assistants. Most have been in their roles for less than one year.

To determine how they implement their management responsibilities, SRA staff asked the FARs to describe their primary duties and responsibilities. Results indicate little consensus among FARs about their primary duties. Most see their roles as primarily administrative with responsibilities in the areas of case reporting, case management, and program coordination. A few focus as well on clinical practice and perform direct crisis intervention, family mediation, and case investigation.

FARs differ considerably in the proportion of time spent in providing counseling in abuse and neglect cases. Although some FARs have an active caseload of family advocacy cases, others do not have the training, the willingness, or the time for counseling. Where FARs provide counseling, they sometimes experience the dilemma of being both investigator and counselor. This situation occurs most often overseas where FARs must assume investigative roles in the absence of CPS and other agencies. It

also occurs in CONUS when base security or civilian reports lack sufficient detail for case disposition. Because of possible career implications to clients, a FAR's investigative role can be seen as threatening and counterproductive to building a therapeutic relationship.

The FAR's responsibilty for developing and maintaining interorganizational relationships with nonmedical military and civilian systems is an important part of the job. When the missions of such organizations conflict, the FAR's role can be a source of controversy. Although FARs in CONUS are mandated by the BUMED Instruction to contact the CPS directly if child abuse is suspected, some representatives from military legal agencies insist that both preliminary investigation and contact with CPS is their responsibility. Another example of organizational conflict can occur when alcoholism is detected during a home investigation by a CPS worker. In a case encountered during a site visit, the FAR felt obligated to notify the sponsor's CO even though there was no substantiation of the abuse or neglect allegation by CPS. This makes some CPS workers wary of including details in their reports to the FAR or FAC.

Another example of potential controversy exists between FARs and the NIS. The Instruction mandates a treatment approach to abusers, at least initially. The involvement of NIS sometimes causes concern to FARs because its primary mission is to investigate for prosecution. Thus, FARs are expected to deal with the contradictory needs of military and civilian organizations and of medical and line organizations. In situations where the medical and line personnel belong to different services, appropriate procedures for responding to advocacy cases are debated. For example, in one overseas community, the FAR was criticized for advocating an early return to CONUS for a family through the medical chain of command when the line command disagreed with the medical recommendation.

Study respondents disagree about whether civilian or military FARs are more effective in the FAP. Some argue that a uniform ensures higher credibility with abusers, commands, and FAC members. Others believe that civilians often have more experience in family advocacy matters and more

potential to provide program continuity. The transfer of a Navy FAR often is quite disruptive to FAP continuity and case follow up.

The site visits demonstrated that the FAR is central to the functioning of the FAP: a good one can turn "a paper program" into an actual one. On the other hand, the simple designation of a FAR without the ingredients of time, treatment resources, command support, and interest in abuse and neglect problems is insufficient for success.

**Role of Committees**

The BUMED Instruction mandates a minimum of four types of local family advocacy committees for medical centers, regional medical centers, and hospitals. These include a standing Family Advocacy Committee and three working subcommittees: (1) child abuse and neglect, (2) spouse abuse and neglect, and (3) sexual assault and rape. The standing committee plays an advisory role to the hospital commanding officer and makes recommendations for FAP management and expansion. Required to meet at least quarterly, the FAC reviews individual and community factors relating to family advocacy incidents and forwards recommendations and reports of actions to the CO. The FAC consists primarily of medical personnel and others designated by the CO of the hospital.

The three working subcommittees have case management responsibilities. They review all abuse and neglect cases reported to the FAR. They have responsibility for case disposition and diagnose each case presented as unfounded, suspected, or established abuse or neglect. Unfounded cases are those in which the investigation reveals no probable cause to suspect that abuse or neglect has been perpetrated. Suspected cases are those that remain under investigation or where maltreatment may have occurred, but there is insufficient evidence to confirm the incident. Cases are established when an outside agency such as CPS or a military or civilian law enforcement agency provides sufficient corroborative evidence. In

addition, self-admission of abuse or neglect can establish a case for reporting purposes.

Subcommittees evaluate the service response for each case and thus provide a mechanism for quality assurance. Similar to the standing FAC committee, each subcommittee also has responsiblity for dealing with community-wide advocacy issues in its area of concern.

SRA staff observed FAC meetings of both central and working subcommittees at five site locations. These observations and the interview data revealed a high degree of variation among bases in the structure, composition, and functions of committees.

**Committee Structure.** The FAC structure was not uniform across sites. In some cases, structural variation reflects the size of the facility. Camp Pendleton, with a large NRMC, added a high risk and education subcommittee to the three required subcommittees. Atsugi, limited to a dispensary, is not required to develop a committee structure. Its program consists of one physician and the OIC who discuss reported family advocacy cases informally. In some cases, the NRMCs have not created all three subcommittees. Program staff often cited too few cases and lack of program staff as reasons for having fewer than the required number of subcommittees.

The frequency of committee meetings often depends on the number of reported cases and the interest of members in the program. In general, medical facilities are more likely to have an organized child abuse subcommittee. The presence of spouse abuse/neglect and sexual assault/rape subcommittees is less predictable, even at the larger medical complexes.

**Committee Composition.** Membership varies across sites, particularly that of nonmedical personnel. At some medical facilities all committee members are medical personnel or are assigned to the hospital. The latter group typically includes security or legal officers responsible for hospital affairs, or chaplains assigned to the hospital command.

Other FACs, especially subcommittees, are more open to nonmedical personnel, including directors and staff members of Navy and Marine Corps FSCs and command representatives, such as human affairs officers and base security police. Some but not all child abuse subcommittees invite a representative from the local CPS unit to attend FAC meetings. County-based public health nurses are regular committee members at one installation. The presence of an NIS agent on the FAC is not routine. In more than one instance, NIS personnel declined committee membership because of possible conflicts of interest from investigating cases for prosecution rather than for treatment.

In most cases, the chair of the child abuse subcommittee is a pediatrician who also chairs the standing FAC committee. Aside from the FAR, this individual frequently is the most actively involved person in family advocacy within the hospital setting. Chairs of the spouse abuse and neglect and the sexual assault and rape subcommittees are more varied in profession. Often a specialist in family practice chairs the spouse abuse and neglect subcommittee while a specialist from the OB/GYN clinic chairs the sexual assault and rape subcommittee. Still, nurse-practitioners, ER change nurses, or psychologists also might assume these roles. The FAR chairs subcommittees in only a few cases.

One frequently mentioned concern about subcommittee composition is the presence of command representatives. At various installations, these either are human affairs officers with responsibilities for alcohol and related problems, members of the dependents' assistance teams for specific ships and squadrons, or unit representatives. Concerns focus on three interrelated issues: client privacy, the need for human service credentials, and the "need-to-know."

Client privacy is the particular concern of base legal officers because of the significant potential for litigation in family advocacy cases. It also is a concern to committee members because of the career implications for individuals suspected of abuse and neglect. The larger

the committee, the greater is the chance that the personal problems of active duty personnel will become general community knowledge.

The concern with command representatives as committee members stems from the conviction of some medical and base service providers that only certain professionals should communicate directly with commanding officers about treatment issues involving members of their command. However, the larger dilemma is whether the sponsor's command should be notified in advocacy cases. There is little consensus over this issue.

There is little agreement about what constitutes "professionalism" in family advocacy cases. Medical facilities undergo a structured credentialing procedure. Some medical practitioners are uneasy because similar procedures are not in place outside the hospital setting. Clearly, there is no consensus about the type of practitioners most valuable or knowledgeable in family advocacy matters.

The "need-to-know" issue is raised not only by committee members but among those outside the formal FAP structure. For example, some child care specialists, base counselors, and school nurses believe that, once they report a suspected child abuse situation, they have a definite need to know about committee decisions on the case. They often express frustration when there is no subsequent feedback. Committee members express the same frustration in locations where CPS investigators do not report back to them routinely about military families investigated for child abuse.

The "need-to-know" issue often has implications for committee membership. On the one hand, there is an expressed need for interorganizational cooperation and involvement of individuals outside the medical facility to develop more effective programs. On the other hand, there is also a need to avoid legal and ethical problems arising from violations of case privacy.

Attempts to resolve these dilemmas across sites are occurring. At some bases, smaller groups of two to four individuals have begun meeting to

discuss specific cases on a weekly or biweekly basis. This leaves the larger subcommittee to perform tasks other than case management. At other bases, command personnel are invited to attend committee meetings on an ad hoc basis when members of their command are being discussed.

Concerns about the size and composition of committees surfaced at the majority of the sites. Problems over FAC composition, however, are more prominent at smaller bases where the "fishbowl" nature of the community makes case privacy more difficult.

**Committee Function.** There is general agreement among the medical personnel interviewed that family advocacy subcommittees have three principle tasks. First, they provide case disposition of abuse and neglect cases occurring in their community. Second, they ensure that cases are referred to appropriate service resources. Third, they evaluate the treatment received in the medical setting. Committee members often see the FAR as the primary response person in cases of abuse and neglect; the subcommittee oversees the FAR's response and monitors case management.

FAC members disagree more often on other tasks suggested by the BUMED Instruction. Some recognize committee responsibility for family advocacy prevention, community education, provision of nonmedical treatment, tracking, reporting, and policy decisions. Others believe these responsibilities are significantly less important than case disposition, referral, and quality assurance.

Working subcommittees deal almost exclusively with the disposition and management of cases brought to their attention by the FAR. They pay less attention to case identification even though committee members often refer cases to the FAR. At bases with both central and working subcommittees, the policy role of the central committee is seen as important.

Cases reported directly to civilian CPS and law enforcement agencies involving Navy and Marine Corps families living off base typically fail to come under committee scrutiny. Within the military community, cases that

do not require medical attention often are handled entirely by other military agencies, such as FSCs and security police, and are not even monitored by the FAC.

The likelihood of nonmedical abuse and neglect incidents being brought to the FAC's attention is directly related to the efficacy of reporting procedures between the FAR and personnel from other organizations. The majority of cases discussed by the committees surface in the medical setting either from self-referrals or medical examinations. Security police serve as a secondary source of reported advocacy cases.

In many instances, committee personnel express concern over the potential magnitude of abuse and neglect on base and the failure of the FAC to identify a significant number of these cases. Some members believe that they would be overwhelmed if the number of cases reported to them increased a great deal. Therefore, even though CPS and FSC staff often are criticized for not notifying the FAR of their cases, most respondents acknowledge that committees often lack the necessary staff or time to handle additional cases.

Because the Instruction lacks clarification of case presentation procedures for committees, it is not surprising that FAC systems for identifying and monitoring cases often differ. Some committees use names in the recorded minutes and discussions. They believe this allows committee members to become familiar with recurring cases and serves to eliminate duplication of services. Other committees use numbers to identify cases to protect client privacy. In actuality, numbered cases often are referred to by name in the course of the committee's discussion.

The relationship between the FAC and the FAR differs by base and by type of committee. Although the FAR usually plays an instrumental role in all program aspects, some FACs are less dependent on FARs. At one extreme, committees simply rubber stamp a FAR's diagnosis and recommendations. Other committees use the FAR's information about a case only as a catalyst for discussion and decisionmaking. Because committee members believe that

they have less experience or contact with victims, they often give the FAR the lead role in spouse abuse cases where physical injuries are minimal, or in sexual assualt and rape cases when victims reports the incident days after the attack. In the latter case, medical evidence usually has been obliterated. This approach contrasts with child abuse cases, where the medical response serve as the primary focus of FAC discussions. In these cases, FARs provide background information about the family.

Committee members often mention difficulty with case disposition, particularly in establishing an abuse or neglect case. According to the BUMED Instruction, this determination must be based on investigations conducted by the NIS; military, State, county, or local child protective agencies; or State, county, or local law enforcement agencies. The committee's determination, therefore, depends upon corroboration by outside investigative agencies, or a confession from the abuser. This can mean a very lengthy process. Sometimes the medical evidence is considered conclusive, but the necessary legal evidence is lacking. In other cases, either the victim or the investigative personnel may be unwilling to follow up the incident. This can result in an established case as far as the committee is concerned, but only a suspected case for reporting purposes to Washington.

Other concerns raised about case disposition included definitions of abuse and neglect and intent of the perpetrator. What family members define as abuse and neglect often contrasts with committee member definitions. In one case, committee members had clearly established a case of spouse abuse because the husband had admitted to assaulting his wife physically. The husband, however, did not believe that his actions could be considered spouse abuse. There are sometimes different definitions of abuse and neglect between families and committee members overseas where there is a high concentration of bicultural marriages. The wife may not realize that the husband does not have a right to push and shove her about. This makes it difficult for committee members to secure the cooperation of the victim.

Committee members, themselves, often differ in their perceptions of abuse and neglect. Some use a broad definition while others are more restrictive. Intent of the abuser enters into committee discussions. Neglect based on ignorance rather than deliberate maltreatment is common, particularly among young families. Committee members often struggle to determine the proper way to handle these cases. In summary, committee members indicate that many of the cases coming before them are highly ambiguous. Clearcut medical, legal, or historical evidence is the exception rather than the rule. This forces many cases into a mixed medical and legal diagnostic category which is time consuming and frustrating.

Another problem for some committees is the lack of reported cases. This usually results in less regular committee meetings, or no meetings at all. On some bases, however, this situation turns committees from a tertiary prevention focus to a primary prevention focus. Rather than emphasizing case management, they begin to concentrate on community education. For example, a sexual assault and rape subcommittee at a base with a large number of single sailors was planning to initiate a series of bench talks around sex education.

In general, the focus of the committees is geared more toward case disposition than treatment response. At times, case discussions are extremely time consuming and focus more on personal debates over definitions of abuse and neglect than on responding to an identified need. Some committees put off devising a treatment plan until after a diagnosis of suspected or established is reached. As a consequence, some cases are continued month after month without service response to the family.

**Base Committees.** In the fall of 1982, a new set of Family Advocacy Coordinating Teams (FACTs) initiated by Navy Family Support Centers began in several commands. These committees differ structurally and functionally from the medical committees developed through the BUMED Instruction. Chaired by the director or a staff member of the Navy FSC, these committees include a wide range of command representatives and service providers:

housing directors, child care professionals, base security personnel, NIS officers, chaplains, and legal officers. In some instances, medical personnel as well as the FAR are members. At the time of the site visits, these base committees were developing policies on reporting procedures between them and the FAR. They also were planning to develop a community response to abuse and neglect through better interagency cooperation and to sponsor educational activities aimed at command personnel and family members. Although some medical personnel are concerned about the potential for duplication of their hospital committee, others believe that command involvement is vital to strengthening family advocacy efforts at the base.

## PROGRAM OPERATION

### Case Identification

The BUMED Instruction assumes that a viable FAP will develop clear, routine channels for reporting incidents along with community awareness and understanding of the prevalence and nature of domestic violence and sexual assault. Although progress is being made, neither of these objectives is being met fully in either Navy or Marine Corps communities. A majority of the 13 bases visited during the study had just begun to establish community education programs and to develop defined reporting procedures.

The vast majority of family advocacy cases handled by the FAP surface through medical channels, primarily from the emergency room, or from pediatric or general medical officers. Although most hospital personnel are aware of reporting requirements, a significant number expressed a need for more in-service training in family advocacy case identification and management. This is considered particularly important for medical staff not directly involved with the FACs. In addition, a number of medical personnel expressed confusion about the role of the FARs and purposes of the FACs.

Educational activities around family advocacy issues have been conducted by medical personnel, such as pediatricians attending wives' clubs, physicians attending command briefings, and committees working with special groups (such as the sexual abuse subcommittee working with single sailors in Memphis). Although most medical personnel interviewed believe that community education is essential, they also believe that lack of staff time and resources prevent them from fully implementing this aspect of the program.

Outside the hospital, the greatest awareness of family advocacy issues and reporting requirements is found among Navy and Marine Corps FSC staffs. However, FSC staffs at some bases express reluctance to report cases to the hospital, especially spouse abuse cases, because of:

- Reduction in client privacy caused by committee size and composition;
- Lack of trained counselors at the hospital to work with families experiencing abuse and neglect;
- Better position of the FSC compared to the hospital to work with the sponsor's command;
- Reluctance of hospital staff to deal with spouse abuse cases of a non-medical nature;
- Unclear impact of case reporting;
- Reluctance of victims to work through hospital procedures; and
- Secondary nature of abuse to other family problems in many family advocacy cases.

Although FSC staffs routinely make reports to the FAR in child abuse cases, these reports often are duplicates of those made to civilian authorities.

Interviews with other agency representatives demonstrated wide variations in knowledge about advocacy issues and reporting procedures. For instance, staff from drug and alcohol rehabilitation services often are members of working subcommittees. However, knowledge of required family advocacy procedures does not always extend to staff members not on the committees. Despite a substantial number of referrals from FACs, abuse issues often are not addressed directly in the course of drug and alcohol rehabilitiation. Further, there is no indication that abuse incidents are reported routinely to the committees if they are uncovered in the course of rehabilitation. In most cases, client confidentiality supersedes family advocacy reporting requirements.

Of all base human service providers, child care directors and staff are perhaps the least knowledgeable about family advocacy issues and the program. Although some child care directors have worked at centers for more than 20 years, they report never seeing a single case of abuse or neglect. Some report that they are unfamiliar with abuse and neglect signs and symptoms. Others know the signs, but did not know what procedures to follow if a case is identified. Although some child care center directors are more familiar with the issues and procedures, many believe that reporting serves little purpose and merely results in the child being taken out of their facility. Many are not clear about the FAR's role or general reporting procedures and requirements. For most child care personnel, their first involvement with FAP came through NMPC-66 training. In general, child care directors and staff see a need for more training in abuse and neglect issues and express willingness to attend FAC meetings.

Compared to child care directors, school counselors and administrators at overseas DoDDS generally are more aware of abuse and neglect concerns and reporting procedures. When reluctance to report cases is voiced, it usually stems from a conviction that the situation can be handled best by school personnel, or a failure to see beyond the administrative impact of reporting.

Chaplain involvement in family advocacy cases is extensive, especially in cases of spouse abuse on bases without FSCs. Chaplains are more reluctant to handle child maltreatment cases. As a consequence, they refer most of these cases directly to the base hospital, the FSC, or local CPS. Issues around case confidentiality cause some chaplains to feel uneasy about reporting cases through hospital channels as does the expressed unwillingness of some victims to be brought into official reporting procedures through hospital committees. A few chaplains express concern that some committee members doubt their credentials for working with victims. Compared to base and fleet chaplains, those assigned to the hospital or to FSCs have better working knowledge of both family advocacy issues and procedures.

Ombudsmen express the need for more personal and community education around abuse and neglect issues. In some cases, Ombudsmen have little familiarity with the roles of the FAR or hospital committees. Although most are aware of hospital-based programs around child abuse, they are more likely to make referrals to chaplains attached to FSCs. The majority believe that the incidence of abuse and neglect is much higher than is reported. They often attribute the discrepancy between incidence and case reports to the lack of family awareness about available resources and procedures for seeking help. In a few instances, Ombudsmen have been asked by base personnel to provide informal safe homes for victims. Given the responsiblity involved in sheltering victims, most believe that these requests are inapprop.iate.

The level of knowledge and involvement of law enforcement personnel in family advocacy cases varies noticeably across bases. On some bases, they routinely re-ort domestic disturbance incidents to the FAR and bring or refer victims to the hospital. At other bases, procedures for case handling are less clearcut. In these situations, security police often refer cases to chaplains, FSCs, and command representatives. Security police sometimes feel they are caught in a bind between the hospital and the FSC, both of which want to be contacted first in family advocacy cases.

In both CONUS and overseas locations, few linkages exist between base security and local law enforcement agencies that would provide a conduit for FAC involvement in off-base incidents. Security police generally acknowledge a need for more training about responding to family advocacy calls and additional information about procedures for case management.

At most bases, case reports to the Navy Medical Command have escalated yearly. At the same time, the majority of individuals interviewed for this project believe that hospital committees are dealing with only the tip of the iceberg. If this is true, increased case identification will depend on more community awareness of abuse and neglect, stricter reporting requirements, and clearer guidelines and protocol for case reporting.

**Intake and Assessment**

According to the BUMED Instruction, the FAR is responsible for gathering background information on a family advocacy case, and presenting it to the working committees for disposition. In the FAR's absence, the Duty FAR, a rotating position drawn from a roster of "on call" personnel such the Medical Officer of the Day or Administrative Watch Officer, conducts initial intake for the FAR. Further, the Instruction suggests that each command develop a means by which abuse, neglect, and sexual assault incidents can be reported to the FAR or DFAR. These reports provide the FAR with necessary background information about those incidents.

Once an incident has been recorded in the Family Advocacy Log with the case number, date, name of the victim, and reporting person and agency, it is the FAR's responsibility to conduct the initial clinical interview. The FAR uses these reports in establishing working files and determining the course of action for each reported incident.

In a case of an emergency because of severe injury or the potential for injury, guidelines provide for emergency admittance to the hospital or

to other protective custody or shelter resources. The FAR arranges these procedures with legal or other personnel.

The importance of the intake and assessment process lies in its impact on case disposition, diagnosis, and the subsequent design of effective intervention strategies. The ability to perform a proper case assessment because of lack of time and staff resources often delays the FAC from executing its function or forces it to make case decisions without a sound basis.

Case flow as outlined in the Instruction seems relatively straightforward--the medical officer or command personnel transfers information to the FAR, the FAR logs the information and conducts an interview and initial assessment; and the FAR brings the case to the committee's attention.

In actuality, there are variations in this flow at the 13 sites, which are based on three primary factors: the source of case identification, the nature of the problem, and the location of the incident--CONUS or overseas.

**Source of Case Identification.** At each site, FARs indicate they routinely receive phone calls from emergency room staffs and others in the hospital when a suspected abuse case surfaces. When possible, they do immediate follow up in terms of talking with the victim, ascertaining the situation, and working out short-term arrangements. In non-emergency situations when the FAR is not present, a Duty FAR logs the incident, and the FAR follow ups the contact when he or she returns to duty. According to interviews with non-hospital personnel who had attempted to report and refer abuse situations to the hospital, DFARs vary in their knowledge of procedures involving family advocacy issues.

When cases first come to the attention of non-hospital personnel, procedures vary. In some instances, FSC counseling personnel perform all the clinical intervention tasks, including family therapy sessions, before or without notifying the FAR. Chaplains also counsel families before notifying medical personnel. Military police, in responding to domestic

disturbance calls, carry out initial investigation activities. Copies of their subsequent reports may or may not be forwarded to the FAR. On some bases, FARs receive reports or phone notification by security police; at other bases, they do not.

In those cases where the FAR is notified by other agencies, the information received might form the initial part of the assessment procedure.

**Nature of the Problem.** Of the three major categories of abuse, child abuse has the most clearly defined intake and assessment procedures. In some locations, base personnel notify simultaneously the FAR and a child protection agency. In most situations, however, the FAR is the initial referral point for all suspected child abuse cases from medical and nonmedical personnel. The intake process includes a discussion of the situation with the original observer of the suspected abuse and notification of civilian child protection personnel. Frequently, the FAR interviews family members to obtain background information and to let them know that a report has been made to State agencies. Some FARs counsel the family during and after the investigation and disposition by State agencies, while others pick up the case again only after an investigation is conducted. Most often, both the FAR and the civilian investigator assess the situation and begin treatment strategies before a case is brought to the working FAC, especially in places where committees meet monthly.

Spouse abuse cases do not lend themselves to similar procedures, primarily because the law does not require reporting to civilian agencies, and because no agencies are mandated to respond to spouse abuse. Whether to seek legal or physical protection against an abuser is the adult spouse's decision, not the FAR's. The FAR's intake and assessment role primarily involves interviewing victims, and alerting them to the available avenues and community resources for changing the situation. The FAR also may attempt to interview the abuser and, sometimes with the support of the command, refer the family to treatment. FARs frequently express

frustration with these cases because of the victim's reluctance to seek redress, the abuser's reluctance to enter treatment, and the command's lack of support.

Intake and assessment in cases of sexual assault or rape involve the FAR in interaction with other medical personnel, most often the emergency room staff, legal personnel such as base police or NIS, as well as the victim. Some hospitals, such as NRMC Charleston, have developed an on-call volunteer-based program for victim support during and after hospital contact. In many cases, these volunteers play an active role in the intake procedure. The assessment phase does not include any determination of the validity of the rape incident because that is purely a legal determination. It does include referrals to civilian resources such as rape crisis centers, if they are available, or hospital psychologists if the victim is on active duty.

**Variations By Location.** Intake and assessment procedures vary widely between overseas locations and those within the United States. The major differences result from the absence of civilian treatment and law enforcement overseas, which provide referral and investigative support to CONUS-based FARs. As a result, the FARs overseas often assume the roles of investigator and counselor during the intake and assessment phases of a case. Such dual roles often place additional, and sometimes conflicting, demands on the FAR. In some situations, the dispersion of the base population overseas makes case investigation, especially home visits, time consuming. Because of limited staff support, cases often have to be continued in FAC meetings because the FAR lacks sufficient time to conduct a case assessment. In some overseas sites, Navy or Marine Corps FSC staff provide short-term treatment before and following the committees' disposition of the case and thus become involved in the assessment phase.

An important part of the assessment procedure overseas is comparing the client's needs against base resources. If insufficient resources exist to respond to a particular situation, action may be initiated to shorten the tour of duty overseas for the active-duty member, the family, or both.

Such a decision involves close interaction and discussion with the sponsor's CO and may become complicated if the spouse is a host-country national.

Although effective intake and assessment procedures by the FARs and DFARs are essential to expediting service response and ensuring that working subcommittees have adequate information for making sound case dispositions and intervention strategies, obstacles sometimes exist in the intact and assessment process. The primary obstacles to effective procedures observed across sites arise from three sources: time constraints on the FAR, inadequate sharing of information between service agencies and the FAR, and confusion over role responsibilities in responding to family advocacy clients.

As noted elsewhere in this report, the majority of FARs interviewed are able to devote only a portion of their time to family advocacy responsibilities. In most instances, the FAR role is a collateral duty. Even when it is not, the FAR is often the only social worker in the hospital setting and, as such, is required to take on additional responsibilities. Because intake and assessment (particularly when it involves home visits or extensive interviewing) can be extremely time consuming and the background of cases extremely complex, FARs often fail to complete in-depth evaluations before bringing cases to working subcommittees. As a consequence, committee decisions may be delayed or based on insufficient information.

Because of concerns over confidentiality, FARs also cannot assume that extensive case information will be provided by other service agencies. In CONUS, civilian child protection agencies have stringent requirements concerning release of information. Military parents under investigation for child abuse are within their rights to refuse permission for a civilian caseworker to share case information with the FAR. In general, CPS does not alert FARs to cases that have not originated through base medical channels. Further, some base personnel, especially FCS staff and chaplains, feel that communication between clients and themselves are

confidential, particularly in self-referred cases or if they believe the FAP is an administrative and data-gathering, rather than a treatment-oriented, program. As a result, they may be reluctant either to refer abuse and neglect cases to the FAR or to share communication between the client and themselves with the FAR. In general, however, the smaller the base, the more information sharing is routine among medical and base personnel.

On most of the bases visited, the FAR is not always seen by base personnel as the primary contact person in family advocacy cases, particularly in those cases not requiring medical attention. Cases often are referred directly to persons other than the FAR, especially chaplains, CPS and FSC personnel.

In summary, intake and assessment processes are most effective when cases originate within the hospital setting, when there is exchange of information between the FAR and other agency personnel, and when the FAR has adequate time or staff resources to devote to the process.

**Intervention and Prevention**

The Enclosure to BUMED Instruction 6320.57 provides operational guidelines for family advocacy intervention and prevention. Patterned after the medical model, the Instruction specifies three levels of program intervention: primary, secondary, and tertiary. Primary intervention efforts help individuals and families to function adequately. Individuals and families under intense stress are targets for primary intervention. Abuse and neglect is kept from happening by either strengthening family immunity and resistance to the problem or by directing attention to social conditions that breed the problem.

Primary prevention activities include community education and publicity that explain how family problems can lead to abuse and neglect. They also explain where FAP assistance can be found when these problems

arise. The Enclosure suggests that certain facilities and programs at military installations should be evaluated and modified to improve their effectiveness in meeting family needs. Examples cited are child care, religion, recreation, health, and dental care.

Secondary intervention is directed toward individuals and families who have been identified as high risk but have not yet been involved in abusive or neglectful behavior. Services and programs should be geared toward assisting these families to overcome areas of dysfunction that place them in a high-risk category. Families subjected to intense stress include those in which the father is on duty away from home, a new birth has occurred, limited bonding is observed between parent and child, or when family members are recovering from illness, trauma, or emotional dysfunctions.

Tertiary intervention provides services to individuals and families in which abuse and neglect have already occurred. At this level, the FAR is advised to learn the full range of treatment resources available in the local civilian and military community and to make maximum use of them.

Throughout the Enclosure, instructions for implementing the various components of the program are interspersed with advice about appropriate and effective intervention. One treatment strategy suggested for dealing with stress and conflict is behavior modification. Also recommended are working with the social network of the involved member and family and encouraging the involvement of both victim and perpetrator in formulating intervention strategies.

For established cases of sexual offenses within the Navy, the Naval Military Personnel Manual specifies one intervention responsibility. Issued under NAVPERS 15560, where reasons for discharge are specified, the manual states:

> Commission of a serious offense that reflects sexual perversion, not involving an incestuous relationship, including but not limited to (1) lewd and lascivious

> acts; (2) sodomy, (3) indecent exposure, (4) indecent acts with or assault upon a child, or (5) other indecent acts or offenses. If circumstances involve an incestuous relationship, preliminary notification to NMPC 66F before the initiation of administrative processing is required. Notification should include, if feasible, a psychiatric evaluation obtained via the nearest medical facility and the commanding officer's recommendation regarding further treatment or a potential for the member's continued service. The ultimate decision to direct processing the member for administrative discharge will be made by COMNAV MILPERSCOM after a thorough review which will consider, as an alternative to processing, treatment in a Family Advocacy Program. (Naval Military Personnel Manual, 1983, Article 3610200.4.C.)

Thus, certain cases involving sexual offenses would be removed from the purview of the FAP, whereas established cases of incest would be subject to FAP intervention.

In the field, successful intervention and prevention strategies hinge upon four factors: service focus, service strategy, service resources, and service jurisdiction.

**Service Focus.** At present, tertiary intervention in abuse and neglect cases is the primary focus of family advocacy personnel. FARs recognize their responsibilities for prevention activities, but their efforts are aimed primarily at families where abuse or neglect already has occurred. Family advocacy personnel usually attribute the lack of secondary and primary intervention activities to shortages of base and community service resources and staff.

Despite the emphasis on tertiary intervention, base respondents recognize the need for early intervention. For example, Ombudsmen report that they receive telephone calls from parents who are afraid they will abuse their children. They also report calls from wives who are concerned about escalating tensions with their husbands. Although Ombudsmen attempt to offer support to these families and frequently refer callers to an FSC for assistance, they often are frustrated by the lack of support services.

Ombudsmen stress the need for more community resources for handling abuse and neglect cases and the need for greater awareness and prevention of abuse and neglect.

Some bases have established formal mechanisms to identify and assist high-risk families who have not yet demonstrated abusive or neglectful behavior--secondary intervention. Camp Pendleton, for example, monitors families with infants whose medical or social history suggests potential problems. Through home visits, public health nurses play a key role in this program. Although not designated as "high risk" committees, working committees at bases other than Camp Pendleton also discuss specific family situations that could precipitate abuse or neglect. Labels such as "marital discord" and "parent-child stress" are used to describe these situations.

Once a family comes to the attention of the FAR and the FAC, it may be tracked, even if no abuse or neglect has occurred. This type of case monitoring, however, is far less common in terms of subcommittee or FAR activity than cases involving actual abuse or neglect.

Primary intervention activities do occur at some locations. Largely initiated by FSC staff, these activities consist primarily of community education seminars around the dynamics of abuse and neglect and service resources. Of course, there are other program activities to prevent abuse and neglect that are not directly tied to the FAP. For example, the FAC at Charleston has established a well-baby program to support young mothers through hospital and home visits by volunteers. Other prevention activities include deployment support and courses in parent education or marital enrichment.

Regardless of the balance between primary, secondary, and tertiary intervention activities at the base level, respondents recommend increasing the prevention focus of the local FAP. They are less specific, however, about how to turn the concept of prevention into program activities.

**Service Strategies.** The BUMED Instruction provides very general guidelines for service intervention in family advocacy cases. It states that the most effective method of treatment intervention is behavioral and it focuses on the need to train individuals to use constructive methods to deal with stress and conflict. Although this statement reflects an orientation toward treatment and a goal of intervention, it does not provide family advocacy personnel with clear-cut service response methods. This lack of specification, in part, reflects the indeterminate state of current literature on abuse and neglect intervention strategies.

Although most respondents believe that "stopping the abuse or neglect" is a major goal of intervention, they are less clear about related service strategies. For example, family advocacy personnel often disagree over whether to remove the abused or the abuser from the home, whether the abused or the abuser should be the focus of intervention, or how the FAC should proceed in a case where the victim is reluctant or unwilling to seek outside assistance. According to respondents, abused women frequently resist any treatment beyond medical assistance. This resistance stems in part from concern over possible retaliation from their husbands and in part from their fear that attention focused on the problem will hurt their husband's career. It also is common for abusers to resist acknowledging their behavior or enter into counseling. If the abuser is on active duty, the FAC may attempt to enlist the assistance of the sponsor's command to ensure that treatment recommendations are followed.

Although respondents may disagree about the best response to abuse and neglect, they prefer a treatment to an administrative response to these cases. With the exception of sexual assault and rape, FAC members generally choose not to involve the sponsor's CO in abuse and neglect cases unless the family member fails to follow committee recommendations. A number of respondents, however, especially some Marine Corps FSC Directors, believe that the sponsor CO should be notified routinely in all cases of abuse and neglect involving command personnel.

Involvement of the sponsor's command does not always elicit the support the FAC expects. In some cases, commands resist committee attempts to ensure implementation of the intervention plan. The sources of their resistance often depends on the type and nature of the problem. Child abuse, for instance, is often seen by command representatives as requiring legal and administrative intervention rather than support services to the family. In other cases, COs do not believe they should become involved in family matters, particularly in husband and wife disputes. Still others resist the idea of therapeutic assistance, particularly if the member is a good performer. When the abuser is the spouse of the member, the command can only exert influence through the member. Despite the variation in command support for FAC recommendations, members believe that increasing command awareness of domestic violence issues is instrumental to the development of program efforts.

**Service Resources.** In most base situations, family advocacy personnel have limited resources for intervention; they note the lack of such resources as a recurring frustration. Although hospital-based personnel could provide a potential source of help, these professionals often lack the time and skills to work with families. Even when available, for example, hospital psychiatrists and psychologists are primarily responsible for psychiatric testing and evaluation of active duty members. In most situations, time limitations preclude their involvement in family advocacy cases.

Although the FSCs and ARSs often provide a major FAP resource, neither are present on all bases. In addition, some FSCs are limited to information and referral services and lack counselling staff. As a consequence, they have limited involvement in the FAP.

Most military-sponsored services that are fully staffed and capable of assisting in family advocacy are located on larger bases. Overseas locations rarely have the needed treatment resources. Even in communities where civilian support services augment base resources, obstacles sometimes prevent coordination and adequate response to abuse and neglect cases in-

volving military personnel and families. The obstacles include the distance between base and community resources, the intricacies and limited coverage of CHAMPUS regulations (non-existent in the case of dual active duty couples), and the problems inherent in case tracking after referral is made to civilian agencies. In addition, civilian resources may be overloaded. For example, some FARs report that community shelters for battered women usually are filled to capacity, and community mental health centers have long waiting lists for potential clients.

**Jurisdictional Impacts.** Personnel responsible for family advocacy intervention are partially identified in Section 1 of the BUMED Enclosure entitled, "Legal and Clinical Intervention Guidelines." Although the FAR assumes responsibilities for clinical intervention during the initial stages of an abuse or neglect case, the Instruction specifies necessity for collaboration, effective liaison, and consultation between military and civilian judicial and legal authorities. In reality, jurisdictional issues often create confusion over whether military or civilian service personnel have primary case management responsibilities.

The question of who has legal authority in a given situation is an extremely complex issue at many bases. Authority for intervention depends upon the location of the incident, military or civilian status of the victim and perpetrator, the severity of the incident, and the types of agreements existing between potential intervenors. Although jurisdictional issues vary considerably across bases, several issues are perceived as being major roadblocks to effective service response.

Under certain Status of Forces Agreements, the host foreign country may assume jurisdiction over military personnel and dependents as well as DoD civilian personnel. The host country's legal system may not recognize U.S.-defined civil or criminal violations involving abuse and neglect. If it does not, the military cannot assume authority over active duty members in off-base locations, dependents, or DoD personnel. Regardless of the jurisdictional situation, however, the military can place administrative sanctions on members and families involved in abuse and neglect, including

initiating an early return of the member, family, or both and through denial of base services and privileges.

In CONUS, the FAR is required by the BUMED Instruction, as well as by Federal and State legislation, to notify State authorities directly concerning child maltreatment incidents. At some locations involving exclusive jurisdiction, however, military legal personnel insist that the FAR notify them before notifying CPS. This situation usually is accompanied by intense debate over jurisdictional responsibilities, military turf, and strained relationships between military and civilian personnel. In some cases, it prevents CPS from conducting an investigation of a child abuse incident within the statutory time limits.

Despite the obvious need, not all bases have worked out formal agreements allowing child protection agents to investigate child maltreatment incidents that occur in base housing under exclusive jurisdiction. According to one respondent, base housing under exclusive jurisdiction presents a special problem because cases cannot be tried in State courts. As a consequence, there is little purpose served by CPS conducting an investigation. Because the Federal courts have been reluctant to hear these cases, they often must be handled administratively through the command or managed totally through FAP intervention.

Because of jurisdictional issues, effective communication and liaison between military and civilian personnel is often hampered in abuse and neglect cases. As a consequence, some cases fail to receive adequate investigation and response. This is especially true when abuse and neglect occurs overseas.

**Interorganizational Cooperation**

The BUMED Instruction recognizes the importance of interorganizational cooperation between medical, line, and civilian agencies to program success. In fact, the Instruction declares that the diagnostic

determination of established maltreatment must be based on both medical information and information from NIS; military, State, county, or local child welfare agencies; State, county, or local law enforcement agencies; military law enforcement groups; or investigations conducted in accordance with the JAG manual.

In general, FAC members usually indicate that there is cooperation between base and community organizations in responding to abuse and neglect incidents, but that the degree of cooperation varies across organizations and across sites. At those bases where linkages between agencies are more developed, there are several factors at work:

- The FAP has clear and established objectives.

- The FAR has established liaison with people in other service agencies, both military and civilian.

- The network of agencies involved with FAP is larger and includes not only the medical facility, but also available base and community agencies such as the FSC, schools, child care centers, and security police.

- The FAR maintains open communication channels with base and community agencies.

These observations indicate that interorganizational linkages are built largely upon good communication and a clear understanding of FAP tasks and objectives. The success of the FAP depends on various agencies providing information through medical reporting channels about abuse and neglect incidents so that the FAR can coordinate an effective service response. Interorganizational cooperation also depends on a two-way flow of information in which base and community personnel receive feedback about case disposition and service response.

There are a number of concerns about organizational cooperation. First, duplicate committees are causing confusion in some installations. For example, the FACTs formed at bases in San Diego and Charleston have effectively coordinated some base community efforts, but the FACTs are only

informally linked to the FAP working subcommittees. They also present some possible problems in coordination and reporting because of confusion over case referral and management responsibilities.

Second, many agencies that refer abuse and neglect cases to the FAR often fail to receive feedback about case disposition because they are not represented on the FAC. This may have a negative impact on the coordination of service efforts and future reporting of abuse and neglect cases to the FAR.

Third, there often is competition between military agencies in different lines of command. This competition is particularly intense for issues related to case reporting and decisionmaking. Although competition most often occurs between medical and FSC personnel, it also occurs between the medical community and the PMO. Competition between medical and line agencies tends to be exacerbated when the medical facility is Navy and the line agency is Marine Corps.

Fourth, concerns about credentials of treatment providers outside the hospital are common. The study and treatment of family violence crosses many disciplinary lines and includes many different professionals. The concern over credentials most often is between organizations and not within organizations. Although credentialing can be a legitimate issue, in most instances the expressed concern tends to mask underlying competition between some medical and line personnel.

Lastly, there is widespread confusion about the objectives of the FAP, the purpose and tasks of the subcommittees, and the roles played by various organizations in the program. Common to both medical and nonmedical personnel, this confusion indicates that the program's goals still are unclear and that detailed local instructions are needed. This confusion tends to strain interorganizational cooperation in abuse and neglect cases.

To understand the competition between organizations, it is important to note that various agencies frequently are involved in cases, but have no

representation on the FAC. Although medical, security, legal, and human service agencies may handle different aspects of family violence, their responsibilities sometimes overlap. When two agencies like the medical facility and the FSC, both perform social work functions, for example, rivalry can be anticipated when their personnel have minimal contacts.

Although competition and rivalry can lead to ineffective coordination of service delivery, the existence of both the hospital and FSC strengthens program efforts, even though the situation increases confusion in the service delivery system and tends to prompt concerns over credentialing. At installations where the FSC is not on line or only embryonic, the FAC often lacks the initiative to promote cooperation with the base community. This results in reduced attention to family abuse and neglect cases.

Various organizations or commands often have different responsibilities for the people involved in abuse and neglect and want to control how information about cases is disseminated. The sponsor's command, for example, often wants to know when their people are involved.

Although rivalries between organizations and commands are inevitable, the FAP sometimes heightens the friction. This is particularly true when the FAP's goals and objectives are unclear. When this occurs, there are noticeable negative effects on service coordination within the FAP and adherence to program expectations. Program clarity also affects the likelihood of case reporting and community education about the program.

The FAP's flexibility is especially important in controlling family advocacy information. When the FAP is narrowly defined, only medical staff or personnel attached to the hospital are members of FAP committees; all information and reporting is supposed to come through the FAR. More often, a flexible view results in broader representation on the FAP committees. Although the FAR has chief responsibility for reporting and collecting information on most bases, FAPs with broader community representation often develop more effective coordination and service delivery.

When a FAP has a strong medical focus, the FAR tends to become overloaded with responsibilities for case coordination and management. As a consequence, it takes longer to manage cases and, in the process, interorganizational communication and cooperation break down and cases are neglected. Even when some committees involve nonmedical members, they maintain a strong medical focus. For example, at one base, a weekly child abuse subcommittee that included a CPS worker resembled a classic medical case conference. Emphasis was placed on medical procedure and correct diagnosis of physical problems. The CPS worker had three cases on which to report, but was not given time for presentation. Her contributions to other cases were not considered seriously.

Although broader FAC membership typically results in greater input on cases and better understanding of other agency operations and responsibilities, it also results in a serious threat to client confidentiality. Some FAPs have attempted to control membership on the committees and still receive broad-based information by inviting base personnel selectively to committee meetings.

Clear FAP objectives are especially important when committee membership draws from many different agencies. Many committee members are unsure of their responsibilities and question the objectives of the FAP and the role of the committees. In some cases, their participation is viewed more as a courtesy than as a desire for their direct involvement in case disposition and management. With clearer objectives, more appropriate committee participation can be expected and encouraged.

**Case Reporting**

The BUMED Instruction provides for several levels of case reporting:

- Local reporting of abuse and neglect incidents to the FAR from military and civilian agencies and to local commands and civilian agencies from the FAP;

- Reporting to gaining commands of suspected or established FAP cases; and

- Reporting to the Central Registry of all suspected and established cases of abuse and neglect through the Chief of BUMED.

At all 13 sites, abuse and neglect cases are being reported to the FAR by a variety of civilian and military agencies and individuals. However, reporting procedures are more institutionalized at bases with a more established FAP.

Child maltreatment and sexual assault and rape cases are more likely to be self-referred or reported through FAP channels than those dealing with spouse abuse. This reflects the continuing ambiguity about handling spouse abuse and the precedence for reporting child and sexual abuse. Spouse abuse cases tend to surface at a wider range of agencies and referral sources. In many locations, base and civilian organizations feel less obligated to report spouse abuse cases and often leave the reporting decision to the abused spouse.

Several issues affect the reporting of incidents to the FAR and, in turn, to the FAC. First, the purpose for reporting is unclear to many line personnel. This tends to occur at installations where treatment resources are minimal. Unfortunately, this situation often reflects lack of clear understanding of the goals of FAP; it also reflects vague local program expectations. While the BUMED Instruction explicitly requires FAP case reporting, it does not detail the purposes of reporting or what happens to cases when they reach the Central Registry. The need for case reporting is further diminished since the Instruction encourages but does not mandate reporting by nonmedical agencies and individuals.

The reporting of self-referred cases, particularly those involving spouse abuse, has been especially troublesome. Many line personnel (e.g., FSC staff and chaplains) are concerned about breaches in confidentiality if they report self-referred cases to the FAR. They express concerns over potential consequences to a sponsor's career if his or her CO learns about the incident. FARs often share this concern. As a consequence, however, many cases go unreported.

Persons interviewed assign responsibility to the FAR for case reporting to civilian agencies. Attempts have been made at some bases, however, to control the process of reporting to the civilian authorities. One base has proposed that the FSC should grant reporting approval to the FAR before any incident is reported to non-military agencies. At another base the PMO takes the lead in reporting child abuse incidents, after PMO investigation, to the CPS. Until organizational roles are defined by official Navy instructions, the delays and omissions of military-civilian reporting and subsequent legal and ethical questions will continue.

Reporting between military installations when sponsors are transfered is another problem area. According to the BUMED Instruction, a copy of a sponsor's FAP file should be forwarded to the CO or the OIC at the gaining medical facility who then notifies the FAR. Although most FARs indicate that they are forwarding established case records, they report receiving only a small number. Many FARs take the initiative of telephoning FARs at gaining commands to inform them of forthcoming transfers. In some cases, FARs have requested that a transfer not be made because of the sponsor's involvement in FAP treatment.

One problem in transferring cases to other FAPs involves the medical charts. Although FAP-related medical records are required to be labeled with an octagonal shaped stamp, they often are not. Moreover, sponsors and family members sometimes remove identifying labels and documents from their medical records, which they handcarry to the gaining command. FARs often are unaware of FAP transferred cases because of the slippages that can occur in the present system.

Another problem area in FAP case reporting results from the lack of coordination between medical centers and subordinate facilities. According to the BUMED Instruction, medical centers are to ensure that subordinate facilities establish local directives supporting the FAP, with clear procedures for reporting FAP cases back to the medical center. At one of the sites visited, a previous FAP at a subordinate facility failed to submit reports because of disagreements with the FAR. Treatment at another

site was delayed because the FAC at the subordinate facility could not reach appropriate diagnosis of either suspected or established abuse. In general, no consistent relationship between central and subordinate facilities is observed across the 13 sites.

A common issue affecting case reporting to the Central Registry is the difficulty in reaching case diagnoses. According to the BUMED Instruction, the appropriate FAC subcommittee makes a diagnosis of suspected, established, or unfounded maltreatment in each reported case of abuse and neglect. Committees largely draw from the medical evidence of a patient's condition and information obtained from family members and collateral contacts. However, the Instruction calls for the diagnosis of all established cases to be based on results of investigations conducted in accordance with the JAG manual and by NIS; State, county, or local child protection agencies; State, county, or local law enforcement agencies; and military law enforcement agencies.

Although legal personnel frequently are members, NIS participation in FAC subcommittees seldom occurs. One reason is the possible conflict of interest in performing the required NIS investigations. The only non-military agency that consistently participates at most CONUS sites is CPS. Except for local courts, no non-military agency can make a ruling to establish child or spouse abuse at overseas bases. The establishment of maltreatment at most sites primarily comes from medical information gathered by the FAR. Although mandated, little input comes from non-medical sources. This finding holds serious implications for FAP case reporting.

**Follow-Up Procedures**

Procedures for the follow up of family advocacy cases are an essential component to effective management of abuse and neglect cases and are discussed in several sections of the BUMED Instruction:

- The FAC working subcommittees are to make plans for definitive management of individuals and community problem situations relating to abuse, neglect, and sexual assault;

- The FAR and the FAC members are to establish internal reporting and follow-up procedures;

- A complete diagnosis and treatment recommendation is to be placed in the FAP files;

- All incidents diagnosed as suspected or established abuse or neglect are to remain in active status until intervention by military and civilian agencies has been terminated; and

- If after one year, there are no further indications of abuse or neglect, inactive files are to be closed.

Although the Instruction does not require the FAC or FAR to treat the patient or family, they are required to provide case management. This consists of providing treatment recommendations and maintaining periodic contact with the family to insure that no further indications of abuse or neglect occur. As interpreted in the field, follow-up procedures usually refer to tracking the case after referral to treatment facilities.

The respondents at nearly every base report few resources to handle the problem of family maltreatment. This is true both for established and newly developed FAPs. Complaints about treatment inadequacies occur regardless of the quality or quantity of resources available. For those programs that are best developed, caseloads tend to be greater. Not unexpectedly, as knowledge of the program becomes widespread, more cases are reported. When the FAR is primarily responsible for case management, an increasing caseload often overloads both the FAR's and the FAC's capacity for case disposition and management.

In newly developed FAPs, fewer cases are reported. However, since there are few resources available, the few cases tend to overload the service delivery system. Smaller bases usually do not have an FSC, or the

FSC is embryonic. In some cases, treatment providers tend to believe that an FSC will automatically relieve them of their overload problems. The anticipation of a FSC may keep FACs from actively developing existing or new resources.

Case follow up often is difficult when cases are referred to civilian resources. Because of concerns over case confidentiality and lack of interaction with the FAP, civilian treatment providers seldom provide feedback about abuse and neglect cases. Case feedback is more likely to occur if the treatment is provided in the military community.

In general, there is an increasing emphasis on providing treatment and follow up within the Navy and Marine Corps systems. Many bases are considering the use of safe houses or shelters for responding to abuse situations. Although their use has had varying degrees of success, most bases consider them important resources. An approach taken by one base is to hire contract workers from women's shelters and children's centers to work at the FSC. This encourages the interface of civilian and military personnel and facilitates the placement of victims and families in community agencies.

Follow-up procedures at most bases are hindered by inadequate criteria for changing the status of a case from active to inactive. According to the Instruction, a case becomes inactive when military and civilian agencies are no longer actively involved with intervention. If the FAR or FAC does not learn of any continued abuse or neglect as the case is reviewed quarterly, it becomes closed after one year. In the field, however, treatment progress often is monitored too inadequately to determine the success of intervention, especially when cases are referred to the civilian community. A FAR or FAC could make treatment recommendations and provide no tracking, and all responsibilities required by the Instruction would have been discharged. Generally, cases remain active until the sponsor is transferred from the base or is discharged.

### Program Evaluation

The BUMED Instruction recommends systematic program evaluation to ensure that it is successfully discharging its tasks and meeting its objectives. The Instruction for the Family Advocacy Program makes few specific references to evaluation, except to suggest that:

- Existing or potential conflicts, program deficiencies, or recommendations for program improvement should to brought to the attention of the commanding officer; and

- The success of the program rests on the ability to evaluate and redirect current resources in a manner that continues to allow for maximizing medical care to Navy and Marine Corps members and families.

Across the installations visited, there are no efforts to evaluate the effectiveness of the local FAP. The FARs and FACs largely are assuming that the program is working because of an increase in reported cases. This informal assessment is often skewed, however, because records involving family violence or sexual abuse have been kept systematically only in the past few years. As a consequence, comparison figures for the rate of abuse and neglect across a specified time period may reflect more improvements in case identification and record keeping than an actual increase in the number of cases. Only a few bases have the necessary case records to estimate realistically the effects of the program. While there are individual suggestions for training and changes in program components, there is no systematic attempt at program evaluation. Until the Instruction specifies the need for evaluation and outlines a methodology, local attempts to evaluate the FAP will be limited.

## PROGRAM RECOMMENDATIONS

During the site visits, respondents were asked to offer specific recommendations for strengthening the FAP on their base. They were asked to make these recommendations while assuming two different situations: the

possibility and the impossibility that base resources and staff would be increased to respond to abuse and neglect cases. Their recommendations focused on five areas:

- Staffing;
- Prevention services;
- Program guidance;
- Training; and
- Command support.

Not surprisingly, respondents most often mentioned the need for additional FAP staff. Many FARs reported that they lack the necessary time and resources to respond adequately to all abuse and neglect cases. Respondents most often reported the need for additional clinical resources, especially at bases without FSCs.

Closely tied to the need for additional staff is their recommendation for greater FAP prevention efforts. Although respondents value the need to provide community education in family advocacy issues and greater outreach to families under stress, their insufficient staff resources limit any major prevention efforts.

The need for greater program guidance was recommended at all sites. Many respondents believe that the BUMED Instruction provides policy for responding to abuse and neglect cases, but lacks specific operational procedures. Issues around interorganizational liaison and the division of FAP responsibility between base agencies, especially between the hospitals and FSCs, present the greatest concern to respondents. Respondents requested clear program guidance around issues of case disposition and reporting procedures. There were also requests for additional training in

abuse and neglect case processing. Security policy, child care center staff, and emergency room and OB/GYN staff hospital personnel most often requested additional in-service education, especially in areas of case identification and assessment. Security police expressed a special need for training in methods to handle spouse abuse calls. Training in case identification and assessment was of particular interest to hospital personnel.

The recommendation for more active involvement of the sponsor's CO in abuse and neglect cases most often was voiced by line personnel, especially in the Marine Corps. Hospital personnel least often made this recommendation. To date, most FARs do not routinely contact the sponsor's CO in family advocacy cases. The exception occurs in cases when members and their families fail to cooperate with the investigation or follow FAP recommendations. Some respondents at each base believe that notification of the sponsor's CO is essential to ensure effective prescreening before reassignment and cooperation with FAC recommendations.

A sixth recommendation which came from overseas installations is the need for better prescreening before making overseas assignments. Many new cases of abuse and neglect involve families under stress before they were transferred. Some transferred families had active FAP case files from their previous assignments. Although respondents are aware of Navy and Marine Corp mission requirements, many believe that better prescreening of families before overseas assignment would decrease the number of abuse and neglect cases and lead to fewer early returns.

# SECTION III

# CONCLUSIONS

## Section III
## CONCLUSIONS

Under Phase II of this study, the SRA study team assessed the structure and operation of the FAP at 13 Navy and Marine Corps Installations. The findings from the investigation document wide variations in program structure and operation across installations. Regardless of their program status, however, most base personnel recognize the seriousness of abuse and neglect and the importance of responding to these problems through effective interagency cooperation and coordination. Differences in base and community resources and the perceived scope of abuse and neglect often are intervening variables in program development.

In reviewing the assessment data across installations, SRA project staff identified current program strengths as well as the concerns and dilemmas facing FAP and related base personnel. These strengths, concerns, and dilemmas are discussed in the following sections. Factors associated with FAP effectiveness also are discussed.

Although the bases selected varied across demographic and mission variables, caution should be used in generalizing study results to other Navy and Marine Corps installations. Still, study results make a contribution to understanding the current status of the FAP and provide a foundation for developing program hypotheses at other Navy and Marine Corps installations.

### PROGRAM STRENGTHS

Despite variation in FAP development and sophistication across installations, bases share some strengths in their response to abuse and neglect. For example, medical personnel at most locations visited have responded to the BUMED Instruction and established policies and procedures for handling abuse and neglect cases. Although some program efforts are

more developed than others, medical and base personnel generally share a pro-family advocacy stance and demonstrate program initiative and flexibility. Other program strengths include:

- **Competent and Professional Staffs.** Although the number and expertise of support personnel vary by base, most base and medical personnel demonstrate an awareness of abuse and neglect dynamics and are attempting to coordinate service response to these cases. In general, FARs demonstrate initiative and competence and are well respected by base leadership and support personnel. In addition, FAC meetings are conducted professionally and with respect for family privacy.

- **Program Responsiveness.** Despite professional resource limitations at some bases, FAP staff at each base have initiated policies and protocol for identifying, assessing, and coordinating service response to abuse and neglect cases. In most situations, FARs respond to family advocacy cases promptly and follow established protocol.

- **Case Successes.** Program personnel report a number of successes in resolving abuse and neglect situations. These successes involve more than responding to cases where abuse and neglect have already occurred. Some successes include the development of prevention programs that lessen family stress and provide support to families that are at "high risk" of abuse and neglect incidents.

- **Interagency Cooperation.** In general, a solid foundation has been laid between FAP representatives and other base service providers. Most base organizations and personnel are referring abuse and neglect cases through FAP channels and FARs are coordinating service response.

- **Availability of Civilian Resources.** At most CONUS installations visited, base resources are augmented by civilian services and

program. Civilian resources (e.g., community hospitals, mental health centers, private practitioners) are especially important to FAP success at installations that lack base support systems. In CONUS, local CPS units play an instrumental role in coordinating assessment and service response in child maltreatment cases. In general, bases share a positive working relationship with civilian agencies and personnel.

- **Established Emergency Room Protocol.** To facilitate program response, clear guidelines for handling abuse and neglect cases are posted in most base medical centers. These guidelines usually instruct hospital personnel to contact the FAR or DFAR if abuse or neglect is suspected.

- **Command Support.** With few exceptions, both hospital and base leadership recognize the threat that abuse and neglect pose to personal, family, and community well-being and they support FAP efforts. Unit and division commanding officers also are providing support.

- **Positive Impact of Family Advocacy Training.** The 1982 family advocacy training workshops have increased the sensitivity of medical and base personnel to abuse and neglect issues. They also have facilitated communication and cooperation between medical and base service providers.

- **Foundation for Program Development.** Although the developmental status and sophistication of FAPs varied across bases, at a minimum each base has developed a foundation for improving prevention and intervention services in areas of abuse and neglect. At most bases, medical and base personnel perceive the FAP concept outlined in the BUMED Instruction as providing a basis for building an effective program response to abuse and neglect.

## AREAS OF CONCERN

The Family Advocacy Program currently is confronted by problems that are best described as developmental. For example, the increasing number of family advocacy cases have not necessarily been paralleled by increases in program staff and resources. As a consequence, case assessment and disposition is hindered at some bases by an increasing backlog of cases. Although the establishment of FSCs at selected bases provides a vehicle for more effective service delivery and response, their roles in the FAP continues to be negotiated at the base level. There also are program delays associated with inexperienced staff and the need for greater program clarity. Such concerns are not intrinsic program flaws, but they are obstacles to further program development and refinement. These and other concerns identified during the site visits are outlined below:

- **Lack of Program Clarity.** Despite the program detail provided in the BUMED Instruction, base and medical personnel often are unsure of the goals of the FAP, the role of the FACs, and the responsibilities of the FAR. Program objectives and procedures are especially unclear to nonmedical personnel, especially Ombudsmen, chaplains, and child care staff. This confusion restricts the amount of case referral and coordination.

- **FAR as a Collateral Duty.** The amount of time that FARs devote to FAP-related duties often is insufficient given program responsibilities. In many cases, FARs also serve a number of other hospital-related duties. Time constraints limit the FAR's ability to perform case investigation, coordination, and follow up. As a consequence, some base personnel view the FAP as an administrative detour to service and express reluctance to report cases through hospital channels.

- **Role Ambiguity Between the FAR and FSC Staff.** Lack of effective liaison and coordination between the FAR and FSC staff promotes

duplication of service efforts and confuses base service providers about appropriate referral protocol.

- **Insufficient Assessment and Treatment Resources.** Although procedures for case identification have often improved at bases, staff resources for case assessment and treatment have remained relatively constant. This is especially the case in rural and overseas communities. As a consequence, case disposition and treatment response are sometimes delayed. In addition, lack of support services necessitates early returns for some overseas families involved in abuse and neglect.

- **Diagnostic Emphasis.** Because of time devoted to discussing case diagnosis, the FACs focus and energy often is diverted from developing treatment strategies and follow-up procedures.

- **Lack of Training in Program Development.** In general, medical and base personnel demonstrate limited knowledge about how to develop a coordinated service response to abuse and neglect issues that minimizes program duplication and maximizes program effectiveness. This deficiency often leads to the FAP remaining an insular hospital-oriented program.

- **Child Maltreatment Focus.** At the bases visited, program attention and response more often were directed to child maltreatment than to spouse abuse or sexual assault and rape. Because of this focus, spouse abuse situations are more prone than child abuse cases to be handled outside the FAP protocol. Although sexual assault and rape cases frequently surface through the hospital emergency room, few bases have FACs that focus exclusively on these cases.

- **Program Procrastination.** In some cases, FAP participants attribute program inertia to anticipating a new line Instruction or to the scheduled opening of a base FSC. Not only do these program delays fail to provide the necessary groundwork for incorporating new

guidance and resources, but they also hinder program response to abuse and neglect cases.

- **Confusion about Procedures for Case Reporting to Gaining Medical Commands.** Although most FARs report forwarding case materials to the gaining medical facility when a family advocacy case relocates, few reported receiving such notification. They report confusion about correct procedures for handling the transfer of case files in some situations. In many situations, base legal officers advise FARs against forwarding working files because of the Privacy Act.

- **Failure to Understand the Full Scope of the FAP.** Medical and base personnel, even FARs and FAC members, often are unsure of the impact of establishing an abuse or neglect case on the sponsor's career. They also are uninformed of how case reports are processed at the Washington level.

- **Reactive Orientation.** Although the BUMED Instruction suggests that family advocacy intervention should incorporate both prevention and treatment services, base programs focus more on responding to existing abuse and neglect cases than on preventing new cases. A reactive orientation is especially prevalent at bases without FSCs.

- **Working Relationships with Civilian CPS Units.** Relationships between base family advocacy personnel and CPS personnel vary in CONUS locations. Some CPS workers share incident reports and the results of child maltreatment investigations with the FAR, while those at other bases will not provide feedback in child maltreatment cases involving Navy or Marine Corps personnel or dependents without a signed release of information. The latter situation limits the ability of FAP staff to initiate or complete case reports or effectively track cases.

## PROGRAM DILEMMAS

Other issues facing the FAP are not necessarily program concerns, but require choices between potentially equally justifiable alternatives. Program dilemmas, in some instances, arise from policies and procedures beyond the control of FAP staff, such as jurisdictional issues stemming from the Status of Forces Agreement. In other instances, they involve making program and case decisions within policy, resource, and legal parameters. They include:

- **Notification of Commanding Officers.** Medical and base personnel often differ concerning when or if to notify a sponsor's commanding officer in abuse and neglect cases. Some personnel feel that the sponsor's commanding officer will help ensure family cooperation with FAP staff; others, especially medical and FSC staffs, fear that the command will attempt to handle the abuse or neglect administratively rather than support FAP procedures and recommendations.

- **Guidelines for Establishing a Case.** There is an observable lack of consensus about what constitutes established abuse and neglect. In some situations, FACs spend hours discussing the parameters of abuse and neglect and potential mitigating circumstances to the act. Committee members often attempt to distinguish maltreatment caused by accidents from cases caused from lack of knowledge. As a consequence of definitional ambiguity, establishing a case often is extremely difficult and time consuming.

- **Case Confidentiality/Privacy.** Concerns for case confidentiality and privacy arise not only around notification of the sponsor's commanding officer, but also among service providers. In some situations, FSC staff and chaplains are reluctant to refer cases through the FAP because they consider information between the client and themselves confidential. This issue has implications for FAC membership. Some FAC members feel uncomfortable including

command representatives and personnel from security police and base housing on committees. Other members believe that wide representation is essential to facilitate case disposition, service response, and case coordination.

- **Staff Credentials for Treatment.** Medical and service professionals often differ about the necessary qualifications for treating victims and perpetrators of abuse and neglect. Because there are no credentialing procedures outside of the hospital setting, medical practitioners express concern about quality assurance when cases are handled outside hospital channels.

- **Response to Dependents/DoD Personnel Overseas.** Because military personnel have limited authority over military dependents and DoD personnel overseas, they often depend upon the host government to exercise jurisdiction in problem situations. Authorities in both Japan and Italy have been reluctant to become involved in family disputes involving American citizens. As a consequence, FAP staff often depend on cooperation from the abused family. This situation poses a special challenge in child maltreatment cases when there is no authority to remove a child from a dangerous situation against parental wishes.

- **Relationships Between Clinics/Dispensaries and NRMCs.** The interface between clinics/dispensaries and NRMCs vary widely across the bases visited. In most situations, however, there is little interface between levels of medical service. Although some clinics and dispensaries forward case reports to BUMED through the NRMC, case consultation is minimal or nonexistent. In one situation, the NRMC was providing support to subordinate medical facilities to establish local FAPs. In general, however, the interface between NRMCs and clinics and dispensaries is poorly defined and requires clarification.

- **Role of FSCs in Family Advocacy.** There is wide variation in the role of FSCs in the FAP. Although some FSCs limit their involvement in abuse and neglect cases to providing information and referral services, others want to become the focal point for family advocacy case coordination and community development. Both medical and FSC personnel expressed a need for clearer delineations of their respective roles in the FAP.

- **Base Need for Shelters/Safe Houses.** Base and medical personnel often are divided over the merits of base shelters and safe houses. Safe houses are provided by community families who agree to let abused spouses and their children temporarily reside in their homes. Although some personnel believe they are instrumental to an effective FAP, others doubt whether removing victims from their homes is the best solution. Legal and security officers especially are concerned about the use of safe houses. In general, they believe that these homes cannot offer the victim protection and can turn into a volatile situation if the abuser demands to see his or her family.

- **Punishment Versus Rehabilitation.** Although the BUMED instruction emphasizes a rehabilitative approach, base and medical personnel vary widely in their attitudes toward abuse and neglect. At present, there is a lack of established criteria about if and at what point abuse and neglect cases should be handled through punitive rather than treatment and rehabilitation channels. Many program participants expressed a need for guidelines similar to those developed in incest cases that specify both treatment and administrative alternatives and the basis for making such a decision.

## KEYS TO SUCCESS

There are a number of prerequisites for developing and maintaining an effective and responsive family advocacy program within the Navy and Marine

Corps context. Based upon the analysis of participant comments and program components at several sites, the elements that make up a successful program appear to include:

- **Command Support and Concern.** Both hospital and line commands need to recognize the impact of dysfunctional families on mission readiness and support FAP personnel, the FAR in particular.

- **Program Clarity.** Programs must establish well defined procedures for case referrals, intake, assessment, and disposition, and continually educate non-FAP personnel about these procedures.

- **Collaborative Team Approach.** Because of the multiple factors involved in abuse situations, intervention strategies call for combined expertise from a number of disciplines or specialities.

- **FAP Leadership.** Energetic and committed FARs who view themselves as program managers as well as clinicians provide a focal point needed by other program participants.

- **Effective Liaison with CPS/Local Authorities.** Better developed communication channels between the FAP and civilian agencies leads to better informed working committees and more effective.

- **Quality Staff.** The more all program staff are familiar with abuse and neglect dynamics and treatment alternatives, the better the chances are for successful program outcomes.

- **FAC Membership.** Those committees which draw their membership from the widest array of individuals and organizations, including line and civilian participants, function most effectively.

- **Proactive Focus.** Command and community awareness of family advocacy issues and the Family Advocacy Program are essential for maintaining effective response.

- **Presence of FSC.** Although FSCs are not the only service resource for family advocacy clients, they are often essential for providing information, referral, and counseling services. They also constitute a primary link with the line community.

- **Availability of Support Facilities.** Because medical facilities do not have the staff resources necessary to meet family advocacy cases, a wide array of alternatives, both civilian and military, must be available and utilized.

- **Training Experiences/Opportunities.** FAP participants and FARs in particular need ongoing training in both case management and the dynamics of family violence and networking opportunities with other military and civilian professionals.

- **Program Flexibility.** Each individual program must be able to ascertain the full extent of its potential resources and design appropriate procedures for its own locale.

In summary, this report has attempted to describe the current status of the Navy Family Advocacy Program evidenced at the command level at 13 sites and highlight program strengths, concerns, dilemmas, and keys to success. The data suggest that the program is in a state of transition. Although bases are attempting to refine their policies and procedures and improve service delivery and coordination, program efforts are hampered by lack of program clarity, program staff, and community resources for assessment and intervention.

Phase III of this research project will extend the analysis of Phase II data. The third phase focuses on three major objectives:

- Integrate and compare the knowledge bases from Phase I and II;

- Identify gaps between service needs and program; and

- Identify program implications and recommendations from the research data.

The project is scheduled for completion in the Fall of 1983.

# Appendix A

# Methodology

## APPENDIX A
## METHODOLOGY

### RESEARCH DEVELOPMENT

Sponsored by the Office of Naval Research, Department of the Navy and conducted by SRA Technologies, Incorporated of Arlington, Virginia, the project was contracted in 1982. The research began with an extensive review of the literature on family violence in military and civilian settings. A report on the literature findings was issued in February 1983, entitled Department of the Navy Family Advocacy Program: Service Need and Service Response, Phase I: Reconnaissance. The report included an analysis of military responses to child, spouse, and sexual abuse, especially the BUMED Instruction 6320.57 initiated 1980 by the Department of the Navy. Phase II of the research is based on site interviews in various Navy and Marine Corps installations to examine the program in operation. The Phase II assessment process has two major foci: (1) to determine if the guidelines are being implemented effectively, are adequate to meet local command needs, and are being supplemented appropriately by local instructions; (2) to discover obstacles to effective program delivery, and the underlying nature of those obstacles.

### PHASE TWO APPROACH

The Phase II investigation of the Navy Family Advocacy Program used a modified case study methodology for program assessment. The method was selected because of the exploratory nature of the study and the lack of previous research on the effectiveness of military family advocacy efforts. The approach allowed maximum flexibility for examining the strengths and weaknesses of command level programs and provided an opportunity to identify differences among commands in program implementation. It also permitted the examination of internal program operations and potential program impact. The key elements of the case study methodology included:

- Project guidance by Navy and Marine Corps leaders and a Project Advisory Committee;

- Site visits to a broad sample of Navy and Marine Corps installations;

- Trained professional site visit teams knowledgeable in Navy human service delivery systems;

- Semi-structured, open-ended interviews with medical and non-medical base personnel;

- Observations of family advocacy committee meetings; and

- Comparisons between commands on key variables.

The Phase I project report resulted in a set of hypotheses regarding the delivery of family advocacy services to Navy and Marine Corps personnel and families. To test these hypotheses, SRA proposed a field study of eight command family advocacy programs. The study later was expanded to include 13 Navy and Marine Corps installations. A Project Advisory Committee monitored the selection of sites and the development of the questionnaires used to guide the interviews with medical and non-medical personnel. The Committee included professionals from the Office of Naval Research, the Navy Family Support Program, the Marine Corps Family Service Program, and the Navy Medical Command.

## SITE AND SAMPLE DESCRIPTION

The study was conducted at the following installations;

- Naval Station, Charleston, South Carolina;
- Marine Corps Air Station, Cherry Point, North Carolina;
- Naval Air Station, Brunswick, Maine;

- Naval Air Station, Memphis, Tennessee;
- San Diego, California;
- Marine Corps Base, Camp Pendleton, California;
- Marine Corps Air Ground Combat Center, Twentynine Palms, California;
- Marine Corps Logistics Base, Barstow, California;
- Fleet Activities, Yokosuka, Japan;
- Naval Air Facility, Atsugi, Japan;
- Marine Corps Air Station, Iwakuni, Japan;
- Naval Support Activities, Naples, Italy; and
- Naval Support Office, LaMaddalena, Sardinia.

The sites provided a broad range of potential conditions that might impact on family advocacy programs. Some of the bases are large; others are quite small. Some are located in metropolitan areas with extensive support systems; others are largely isolated from support. Some are in CONUS; others are in Europe and Asia. Some have well staffed regional medical centers; others have only small clinics. The variations that were expected in program operations at these sites were realized in the data.

**Site Selection Grid**
**DON Family Advocacy Project**
**SRA Technologies Arlington, Virginia 22204**

| | Charleston | Cherry Point | Brunswick | Memphis | San Diego | Camp Pendleton | 29 Palms | Barstons | Yokosuka | Iwakoni | Atsugi | Naples | LaMaddalena |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community Type** | | | | | | | | | | | | | |
| Air | | * | * | * | * | * | * | | | * | * | | |
| Surface | * | | | | | | | | * | | | *(NATO) | * |
| Submarine | * | | | | * | * | * | * | * | | | | |
| **Base Population** | | | | | | | | | | | | | |
| Members | 23,600 | 15,000 | 3,800 | 13-16,000 | 95,000 | 33,000 | 6,500 | 900 | 3,000 | 3,300 | 900 | 8,000 | 2,000 |
| Dependents | 36,000 | 10,000 | 5,00 | 10,000 | 110,000 | 9.700 | 6,000 | 1,700 | | 700 | 2,500 | | 750 |
| **Military Branch** | | | | | | | | | | | | | |
| Navy | * | | * | * | * | | | | * | | * | * | * |
| Marine | | * | | | | * | * | * | | * | | | |
| **Location** | | | | | | | | | | | | | |
| CONUS | * | * | * | * | * | * | * | * | | | | | |
| Europe | | | | | | | | | | | | * | * |
| Asia | | | | | | | | | * | * | * | | |
| **Family Service Centers** | * | * | | | * | * | * | * | * | * | * | * | |
| **Medical Facility** | | | | | | | | | | | | | |
| Regional | * | | | * | * | * | | | * | | | * | |
| Hospital | | * | | | | | | | | * | | | |
| Clinic | | | * | | | | * | * | | | * | | * |
| **Civilian Community** | | | | | | | | | | | | | |
| Urban | * | | | | * | * | | | * | | | * | |
| Rural | | * | * | * | | | * | * | | * | * | | * |

The primary objectives for the site visits were as follows:

- Describe the structure and operation of the Family Advocacy Program;

- Assess the current relationship between service need and service response;

- Identify major program strengths, concerns, and dilemmas;

- Document effective program practices;

- Examine the extent of liaison between medical and nonmedical personnel in the treatment and prevention of abuse and neglect; and

- Identify program needs and recommendations for program improvement.

To accomplish these objectives, SRA devoted an average of five person days to interviews and observations at the selected sites. Small installations with limited medical and human service personnel required less time than large multi-mission installations. When possible, SRA scheduled site visits at the time of family advocacy committee meetings. Most interviews were scheduled before the visit by the study team; others were scheduled after arrival at the base. Cooperation with the study team was uniformly positive.

Over the 10-week data collection period, SRA staff conducted personal interviews at each base with the following categories of military and civilian personnel:

- Command leadership;

- Navy medical service personnel;

- Navy and Marine Corps human service providers;

- Representatives from civilian agencies; and
- Navy volunteer groups.

## DATA COLLECTION AND ANALYSIS

SRA used questionnaires to gather data about the base Family Advocacy Program from persons representing each of the above groups. Questionnaires were semi-structured with open-ended questions to elicit detailed responses. The questionnaires were developed after two preliminary site visits and were reviewed and approved by the Project Advisory Committee.

Questions varied according to the organization and responsibility of the respondent. However, all interviews were based on several major themes: the history and development of the Family Advocacy Program at each installation; the current structure of the local program; the current program operations for case identification, client intake and assessment, intervention and prevention, interagency cooperation, case follow-up, and case reporting procedures. Persons interviewed also were asked about their overall assessment of the Family Advocacy Program and their recommendations for program improvements, if any.

SRA analyzed questionnaire data for informational content and for qualitative interpretation of the Family Advocacy Program. The study team conducted multiple interviews to reduce bias and provide broad representation of perspectives. A comparative qualitative analysis of the questionnaires focused on:

- Extent of agreement of program goals and objectives;
- Extent of knowledge of abuse and neglect case procedures;
- Level of communication on family advocacy issues; and

- Presence of obstacles to program operation and interorganizational cooperation.

SRA considered the degree of consensus among those interviewed at a base as a primary indication of positive movement toward common goals and objectives.

During the site visits, interview data were complemented by observations and archival analyses. The study team paid careful attention to base and local community factors that might impact on individual and family stress and violence. SRA recorded data on base and civilian populations, available housing, recreation facilities, public transportation, human service organizations, and mission demands.

SRA attended meetings of Family Advocacy Committees where they were operational and could be scheduled. These meetings provided opportunities for nonparticipant observations of interorganizational cooperation, family advocacy leadership, case management, treatment strategies, and program direction. The meetings typically lasted from one to three hours. Whenever possible, SRA attended subcommittee and other special purpose meetings.

After collecting and aggregating the data from the interviews, observations, and records, SRA staff prepared summary case study reports for each site reviewed. These case studies highlighted living conditions on the military installation, development of the local Family Advocacy Program, program structure and operations, current directions, and program impact.

SRA compared data across commands on the key variables of the study. This analysis focused largely on differences in the structure and operation of the individual programs and the reasons for these differences. The results of this comparative analysis make up the heart of this report and will be used to discuss the implications and recommendations presented in a subsequent and final project report.

# APPENDIX B

## Interview and Observation Guides

Dept. of Navy Family Advocacy Program
Winter, 1983

Site________________________
Date________________________
Observer______________________

**FAC Meeting: Observation Guide**
**Type of Meeting:_______________**

1) Who's there? (May be indicated on seating chart)

2) Seating chart: (indicate seating position and title/agency)

3) Proceedings: (Check and indicate more information where appropriate)

____ Minutes:

____ Reports of working committee:

____ Actions since last meeting:

____ New business:

____ Follow-up of old business:

4) Length of meeting: ____________ hours
Did it start on time?

5) Working relationships (Any subgroupings?)

6) Did members know what was to be discussed?

7) Check the following: (Give examples where appropriate)

The committee demonstrated: (if not applicable or observed put N/A)

| Yes | No | |
|---|---|---|
| ____ | ____ | a) Respect for client privacy |
| ____ | ____ | b) Awareness of civilian resources |
| ____ | ____ | c) Awareness of Navy/Marine community resources |
| ____ | ____ | d) Awareness of BUMED/DoD directives |
| ____ | ____ | e) Evidence of communication between meetings |
| ____ | ____ | f) Absence of turf issues |
| ____ | ____ | g) Educational orientation |
| ____ | ____ | h) Problem resolution-focus |

8) Group Interaction (complete after meeting)

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **Goals of Group:** | Confused; diverse; conflicting; indifferent; little interest. | | | | Clear to all; all care about the goals, feel involved. |
| **Participation:** | Few dominate; some passive; some not listened to; several talk at once or interrupt. | | | | All get in; all are really listened to. |
| **Knowledge:** | Little knowledge of area, resources | | | | Strong knowledge of area, resources. |
| **Leadership:** | Group needs for leadership not met; group depends too much on single person or on a few persons. | | | | As needs for leadership arise various members meet them; anyone feels free to contribute as he sees a group need. |
| **Use of Member Resources:** | Poor use of resources, people ignored, lacked contributions. | | | | Good use of resources; people freely contribute. |
| **Minority Opinions:** | No acceptance of minority opinion, lack of tolerance. | | | | Toleration of opinions; attempt to incorporate opinions into discussion. |

| | | 1 | 2 | 3 | 4 | 5 | |
|---|---|---|---|---|---|---|---|
| Communication: | Poor communication, little discussion. | | | | | | Good communication, active discussion. |
| Decision-Making: | Unilateral, Needed decisions don't get made, decison made by part of group, others uncommitted. | | | | | | Joint; Consensus sought and tested; deviation appreciated and used to improve decision; decisions, when made, are fully supported. |
| Cohesion: | Low | | | | | | High |

9) Other comments by observer:

Dept. of Navy Family Advocacy Program
Winter, 1983
Site___________________
Date___________________
Interviewer______________

**Interview Guide No. 1: Family Advocacy Representative**

**I. BACKGROUND**

1a. Name/Rank/Title:_________________________________

1b. Length of time in position:

1c. Full time/collateral duty. If collateral, what are your other responsibilities?

1d. Previous training/professional experience in domestic violence/rape:

**II. ROLE of FAR:**

2a. What do you perceive as your responsibilities as FAR?

2b. Of these responsibilities, which take most of your time?

2c. What do you see as the most important tasks for a FAR?

2d. Have your responsibilities/priorities changed since beginning this position?

III. STRUCTURE/ORGANIZATION OF FAC:

3a. May we have the number of cases of each type submitted to the working committees each month for the past 12 months?

Provided          Fill in on back page

3b. May we have an organizational chart of the FAC?

Provided          Fill in 3c.

3c. Who is on the Central Family Advocacy Committee (rank/title)?

Chair ________________________________

How chosen?

Chair: Child Abuse ________________________

How chosen?

Child Abuse Members

Chair: Spouse Abuse ________________________

How chosen?

Spouse Abuse Members

Chair: Sexual Assault/Rape ____________________

How chosen?

Sexual Assault/Rape Members

| 3d. How often do each of the committees meet? | What was the date of their last meeting? |
|---|---|
| Central ____________ | ____________ |
| Child ____________ | ____________ |
| Spouse ____________ | ____________ |
| Sex. Assault/Rape ____________ | ____________ |

3e. Briefly, what is the role of each committee member?

3f. What do you see as the major goals of the FAP?

3g. What do you see as the most important tasks of the FACs?

## V. INTAKE AND ASSESSMENT

4a. How do you first learn of cases of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

4b. In your experience, what types of individuals or families are most commonly involved with: (probe)

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

4c. Is there a 24-hour hotline on base or in the community for such problems? If so, where is it housed and how does it work?

V. INTERVENTION/PREVENTION

5a. Please go through a "typical" case from the beginning of your contact to the end of your and the FAC's responsibility:

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape

5b. In child maltreatment, how do intervention and follow-up strategies vary:

By the sex and age of the child?

By the sex of the abusive parent?

By the rank of the abusive parent?

What other variables are involved?

5c. In spouse abuse cases, do case management procedures vary by the rank of the abuser? What happens if the victim refuses FAP intervention?

5d. In sexual assault/rape cases, how do procedures vary if the victim is a dependent civilian as opposed to a military member? A male as opposed to a female victim? When the sexual assault/rape occurs on base as opposed to off base?

5e. What kinds of assistance/support are available for:

Physically abused children?

Neglected children?

Sexually abused children?

Battered wives?

Battered husbands?

Married sexual assault/rape victims?

Single sexual assault/rape victims?

Male sexual assault/rape victims?

Child abusers?

Spouse abusers?

Sexual abusers?

5f. Of these victims and offenders, whom can you respond to most effectively? Why?

Least effectively? Why?

5g. What are the most serious obstacles encountered in responding to victims of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

What do you see as possible solutions?

5h. In what ways are victims involved in determining the intervention plan?

In what ways are offenders involved?

## VI. JURISDICTIONAL ISSUES

6a. What types of jurisdictional issues, if any, arise in child maltreatment cases here?

How are these issues usually handled?

6b. OVERSEAS SITES ONLY: What types of jurisdictional issues, if any, arise with the host national legal system around cases of child maltreatment, spouse abuse, and sexual assault/rape?

## VII. LINKAGES/INTERAGENCY COOPERATION

7a. On a scale from 1 to 5, low to high, how would you rate the level of interaction between you and local civilian agencies regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation?

| Agency | | Level of Interaction | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| Child Protective Srvs | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Spouse Abuse Programs | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Rape Crisis Centers | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Law Enforcement | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Mental Health Clinics | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Private Therapists | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Local Schools | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents Anonymous | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents United | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7b. What obstacles do you see, if any, to better coordination?

7c. On a scale from 1 to 5, low to high, how much interaction exists between you and other military organizations regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation?

| | | Level of Interaction | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| FSC | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Child Care | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Alcohol Rehab (Hosp) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Legal Personnel (JAG) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Chaplains | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Base C.O. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| NIS | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Security Police | NA | 1 | 2 | 3 | 4 | [illegible] | 1 | 2 | 3 | 4 | 5 |
| CAAC's | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| DOD Schools (overseas) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7d. What obstacles do you see, if any, to better coordination?

## VIII. FOLLOW-UP PROCEDURES

8a. What information is contained in the FAC case files? How long are records maintained?

8b. What are the strengths of the case record keeping system? What changes, if any, would you suggest?

8c. What information, if any, is included in reports to the individual's CO?

8d. What happens when FAP cases receive PCS orders? Are there any concerns or issues around this? What changes, if any, would you suggest?

8e. What are the strengths of current follow-up procedures?

8f. Do you follow up on clients referred to the civilian community? If so, how?

## IX. CASE REPORTING:

9a. What criteria do you actually use to decide that a case is "suspected"? What happens then?

9b. What criteria do you actually use to decide that a case is "established"? What happens then?

9c. What percentage of the cases brought to the FAC are reported to BUMED?

9d. Is case confidentiality ever an problem? If so, in what ways?

9e. Are there any particular requirements of the BUMED Instruction that present difficulties? Which ones?

Possible solutions?

X. CASE IDENTIFICATION:

10a. What types of briefings about family violence are conducted by you or FAC members? For whom? Frequency?

10b. Other than briefings, what other public awareness activities are conducted by you or FAC members? For whom? Frequency?

10c. How aware is command leadership of family violence and rape issues?

10d. How supportive is command leadership of the FAP? In what ways is this support demonstrated?

## XI. TRAINING

11a. What types of family advocacy training have FAC members had in the past year? Who had this training? Was there NMPC-66 training?

What was the impact of the training?

11b. What are the training needs here for members of the FAC? How should this be done?

11c. What are some of your own training needs in the area of family advocacy? How should this be done?

## XII. PROGRAM EVALUATION/RECOMMENDATIONS

12a. What do you see as the most important ingredients for a successful FAP? (Prioritize)

12b. On a scale from one to five, low to high, how much success has the program had in each area to date?

| | Low Success | | | | High Success |
|---|---|---|---|---|---|
| Publicity | 1 | 2 | 3 | | 5 |
| Outreach | 1 | 2 | 3 | 4 | 5 |
| Interagency Cooperation | 1 | 2 | 3 | 4 | 5 |
| Command Support | 1 | 2 | 3 | 4 | 5 |
| Case Indentification | 1 | 2 | 3 | 4 | 5 |
| Training | 1 | 2 | 3 | 4 | 5 |
| Follow-Up | 1 | 2 | 3 | 4 | 5 |
| Prevention Efforts | 1 | 2 | 3 | 4 | 5 |
| Other ____________ | 1 | 2 | 3 | 4 | 5 |
| ____________ | 1 | 2 | 3 | 4 | 5 |

12c. Overall, what do you see as the program's strengths? (Prioritize)

Barriers to success? (Prioritize)

Primary needs? (Prioritize)

Future directions? (Prioritize)

12d. What recommendations do you have for strengthening the FAP on this base, assuming that resources and manpower are not increased? If they are increased?

12e. What haven't we discussed that would better help us understand the situation here?

12f. Is there anything else you'd like to discuss?

Dept. of Navy Family Advocacy Program
Winter, 1983

Site______________________
Date______________________
Interviewer________________

## Interview Guide No. 2: Family Service Center

### I. BACKGROUND

1a. Name/Rank/Title in FSC

a. Director

b. Deputy Director

c. Head, Social Work Staff:
(Get exact title)

1b. Length of time in position

a

b

c

1c. Previous professional experience/training in family violence/rape

a

b

c

## II. ROLE OF FSC IN FAMILY ADVOCACY

2a. What is the FSC's involvement in the Family Advocacy Program?

2b. What tasks are involved in carrying out these responsibilities?

2c. How are you involved with the Family Advocacy Committee(s)?

a

b

c

2d. How much time does this take?

a

b

c

2e. How have the responsibilities/priorities of the FSC toward Family Advocacy changed since your assignment to this FSC?

## III. STRUCTURE OF FAP

3a. What do you see as the major goals of the FAP?

3b. What do you see as the most important tasks of the FACs?

3c. What do you perceive to be the responsibilities of the FAR?

## IV. INTAKE AND ASSESSMENT

4a. In working with FSC clients, how do you first learn of incidents of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

4b. Of clients coming through the FSC during the past 12 months, how many (%) involved:

Child Maltreatment?

Spouse Abuse?

Sexual Abuse/Rape?

4c. In your experience what types of individuals or families are most often involved in Child Abuse?

Spouse Abuse?

Sexual Assault/Rape?

## V. INTERVENTION AND PREVENTION

5a. With regard to your involvement with Family Advocacy issues, please go through a typical intervention from the time you first learn of it to the end of your responsibility.

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape

5b. In child abuse cases, how do intervention and follow-up strategies vary by the sex and age of the child?

By the sex of the abusive parent?

By the rank of the abusive parent?

What other variables affect intervention and follow-up strategies?

5c. In spouse abuse cases, do case management procedures vary by the rank of the abuser? What happens if the victim refuses intervention?

5e. What kinds of assistance/support are available for:

Physically abused children?

Neglected children?

Sexually abused children?

Battered wives?

Battered husbands?

Married sexual assault/rape victims?

Single sexual assault/rape victims?

Male sexual assault/rape victims?

Child abusers?

Spouse abusers?

Sexual abusers?

5f. Of these whom can you respond to most effectively? Why?

Least effectively? Why?

5g. What are the most serious obstacles encountered in responding to victims of:

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape?

What do you see as possible solutions?

5h. In what ways are victims involved in determining intervention plans?

In what ways are offenders involved?

## VI. JURISDICTION ISSUES

6a. What types of jurisdictional issues, if any, arise in child maltreatment cases here?

How are these issues usually handled?

6b. **OVERSEAS SITES ONLY:** What types of jurisdictional issues, if any, arise with the host national legal system around cases of child maltreatment, spouse abuse, and sexual assault/rape?

## VII. LINKAGES/INTERAGENCY COOPERATION

7a. On a scale from 1 to 5, low to high, how would you rate the level of interaction between you and local civilian agencies regarding cases of domestic violence and sexual assault/rape? For each, how would you rate the quality of cooperation:

| | Level of Interaction | | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| Child Protective Srvs. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Spouse Abuse Pgms | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Rape Crisis Centers | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Law Enforcement | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Mental Health Clinics | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Private Therapists | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Local Schools | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents Anonymous | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents United | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7b. What obstacles do you see, if any, to better coordination?

7c. On a scale from 1 to 5, low to high, how much interaction exists between you and other military organizations regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation?

| | Level of Interaction | | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| FAP (Medical treatment facility) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Child Care | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Alcohol Rehab (Hosp) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Legal Personnel | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Chaplains | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Base C.O. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| NIS | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Security Police | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| CAAC | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| DOD Schools (overseas) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7d. What obstacles do you see, if any, to better coordinaton?

## VIII. CASE REPORTING

8a. How are cases referred to the FAR?

8b. Are there instances when a referral would not be made to the FAR? Under what circumstances?

8c. Is case confidentiality ever an issue? How?

8d. What information, if any, is included in reports to the individual's C.O.?

## IX. FOLLOW-UP PROCEDURES

9a. Once you have referred abuse cases to the FAR, what follow-up occurs?

## X. CASE IDENTIFICATION:

10a. What types of briefings about family violence are conducted by the FSC? For whom? Frequency?

10b. Other than briefings, what other types of public awareness activities are conducted by the FSC? For whom? Frequency?

10c. How aware is command leadership of family violence and rape issues?

10d. How supportive is command leadership of the FAP? In what ways is this support demonstrated?

XI. TRAINING

11a. What types of family advocacy training have FSC staff had in the past year? Who had this training? Was there NMPC-66 training?

11b. What was the impact of the training?

11c. What are the training needs here for the staff of the FSC? How should this be done?

## XII. PROGRAM EVALUATION/RECOMMENDATIONS

12a. What do you see as the most important ingredients for a successful FAP? (Prioritize)

12b. On a scale from one to five, low to high, how much success has this program had in each area to date?

| | Low Success | | | High Success | |
|---|---|---|---|---|---|
| Publicity | 1 | 2 | 3 | 4 | 5 |
| Outreach | 1 | 2 | 3 | 4 | 5 |
| Interagency Cooperation | 1 | 2 | 3 | 4 | 5 |
| Command Support | 1 | 2 | 3 | 4 | 5 |
| Case Indentification | 1 | 2 | 3 | 4 | 5 |
| Training | 1 | 2 | 3 | 4 | 5 |
| Follow-up | 1 | 2 | 3 | 4 | 5 |
| Prevention Efforts | 1 | 2 | 3 | 4 | 5 |
| Other________ ____ | 1 | 2 | 3 | 4 | 5 |
| ______________ | 1 | 2 | 3 | 4 | 5 |

12c. Overall, what do you see as the program's strengths? (Prioritize)

Barriers to success? (Prioritize)

Primary needs? (Prioritize)

Future directions? (Prioritize)

12d. What recommendations do you have for strengthening the FAP on this base, assuming that resources and manpower are not increased? If they are increased?

12e. What haven't we discussed that would better help us understand the situation here?

12f. Is there anything else you'd like to discuss?

Dept. of Navy Family Advocacy Program
Winter, 1983
Site____________________
Date____________________
Interviewer____________________

**Interview Guide No. 3: Ombudsmen**

1. What commands do you represent as Ombudsmen?

   a.
   b.
   c.
   d.
   e.

2. Approximately how many families do you each represent as Ombudsman?

   2a.
   2b.
   2c.
   2d.
   2e.

3. How long have you lived in this area?

   3a.
   3b.
   3c.
   3d.
   3e.

4. Given your knowledge of this community, what is the extent of child maltreatment?

5. What is the extent of spouse abuse in this community?

6. Are there incidents of sexual assault/rape? If yes, what is the extent?

7. How do incidents of Child Maltreatment come to your attention?

   Spouse Abuse?

   Sexual Assault/Rape?

8. How many actual incidents of Child Maltreatment have you dealt with as Ombudsman in the past year?

   Spouse Abuse?

   Sexual Assault/Rape?

9. With regard to your involvement in Family Advocay cases, please describe a typical intervention from the point of contact to the end of your responsibility:

   Child Maltreatment

   Spouse Abuse

   Sexual Assault/Rape

10. In your experience what types of individuals or families are most commonly involved with child maltreatment?

    Child Maltreatment

    Spouse Abuse

    Sexual Assault/Rape

11. Where do you refer individuals or families with these problems?

    Child Maltreatment

    Spouse Abuse

    Sexual Assault/Rape

12. What problems exist in responding to individuals and families involved in:

    Child Maltreatment?

    Spouse Abuse?

    Sexual Assault/Rape

13. Do you refer people to the FAR? What do you perceive as the responsibilities of the FAR?

14. In what ways could the Navy/Marine Corps deal more effectively with these problems?

15. Have you received any type of training in identifying or responding to child maltreatment? What type?

16. Have you ever received any training in spouse abuse? What type?

17. Have you ever received any training in working with victims of sexual assault/rape? What type?

18. What types of briefings or educational seminars have been conducted about family violence on base? Who conducted these briefings or seminars?

19. What do you see as the most important ingredients for a successful Family Advocacy Program?

20. Of these ingredients, which ones has the Family Advocacy Program had the most success in achieving?

The least success? Why?

21. Overall, what do you see as the strengths of the Family Advocacy Program? (Prioritize)

    Barriers to success? (Prioritize)

    Program needs? (Prioritize)

    Future directions? (Prioritize)

22. What recommendations do you have for strengthening the FAP on this base?

23. What haven't we discussed that would better help us understand the situation here?

24. Is there anything else you would like to discuss?

Dept. of Navy Family Advocacy Program
Winter, 1983
Site________________________
Date________________________
Interviewer________________________

Interview Guide No. 4: Hospital Personnel

## I. BACKGROUND

1a. Name/Rank/Title________________________________________

1b. Length of time in position

1c. General job description

1d. Previous experience/training in domestic violence/rape

## II. ROLE

2a. In what ways do you work with cases of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

## III. STRUCTURE/ORGANIZATION OF FAC

3a. Are you a member of the FAC?

3b. If 3a is "yes", what committee(s) are you on?

3c. If 3a is "yes", how do you participate on the FAC?

3d. What do you see as the major goals of the FAP at this base?

3e. What do you perceive as the role of the FAR?

## IV. INTAKE AND ASSESSMENT

4a. How is an abused child first identified?

4b. How is a battered spouse first identified?

4c. How is a rape victim first identified?

4d. Once identified, what procedures follow for:

Abused Children

Abused Spouse

Sexual Assault/Rape Victim

4e. During an emergency, how do the procedures differ? Do these emergency procedure differ depending on whether it is a case of child maltreatment, spouse abuse, or sexual assault/rape?

4f. At what point is the FAR notified?

4g. At what point does your responsibility end?

4h. Is the victim given written resource information if they refuse further assistance? If yes, what type?

4i. What are the most serious problems encountered in treating victims of

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

4j. In your experience, what types of individuals or families are most commonly involved with: (probe)

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

## V. INTERVENTION AND PREVENTION

5a. With regard to your involvement, please go through a typical case from the time you first learn of it to the end of your responsibility.

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape

## XI. TRAINING

11a. What types of family advocacy training have you received in the past year?

11b. What training needs exist for members of the hospital staff regarding family advocacy? How should this be done?

11c. Is staff burnout an issue? How is this handled?

11d. Are there any support services for staff that enable them to respond more effectively to these cases?

## XII. PROGRAM EVALUATION/RECOMMENDATIONS

12a. What do you see as the most important ingredients for a successful FAP? (Prioritize)

12b. On a scale from one to five, low to high, how much success has the program had in each area to date?

| | Low Success | | | High Success | |
|---|---|---|---|---|---|
| Publicity | 1 | 2 | 3 | 4 | 5 |
| Outreach | 1 | 2 | 3 | 4 | 5 |
| Interagency Cooperation | 1 | 2 | 3 | 4 | 5 |
| Command Support | 1 | 2 | 3 | 4 | 5 |
| Case Identification | 1 | 2 | 3 | 4 | 5 |
| Training | 1 | 2 | 3 | 4 | 5 |
| Follow-up | 1 | 2 | 3 | 4 | 5 |
| Prevention Efforts | 1 | 2 | 3 | 4 | 5 |
| Other: | | | | | |
| ____________________ | 1 | 2 | 3 | 4 | 5 |
| ____________________ | 1 | 2 | 3 | 4 | 5 |

12c. Overall, what do you see as the program's strengths? (Prioritize)

Barriers to success? (Prioritize)

Primary needs? (Prioritize)

Future directions? (Prioritize)

12d. What recommendations do you have for strengthening the FAP on this base, assuming that resources and manpower are not increased? If they are increased?

12e. What haven't we discussed that would better help us understand the situation here?

12f. Is there anything else you'd like to discuss?

Dept. of Navy Family Advocacy Program
Winter, 1983
Site ______________________
Date ______________________
Interviewer ______________________

## Interview Guide No. 5: Legal and Law Enforcement Personnel

### I. BACKGROUND

1a. Name/Rank/Title ______________________

1b. Length of time in position

1c. Previous professional experience/training in domestic violence/rape

### II. ROLE

2a. In what ways do you work with the Family Advocacy Program?

2b. Do you work directly with victims of:

| | | |
|---|---|---|
| Child maltreatment? | Yes | No |
| Spouse abuse? | Yes | No |
| Sexual assault/rape? | Yes | No |

2c. If so, in what ways?

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape

2d. Do you work directly with offenders in cases of:

| | | |
|---|---|---|
| Child maltreatment? | Yes | No |
| Spouse abuse? | Yes | No |
| Sexual assault/rape? | Yes | No |

2e. If so, in what ways?

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape

2f. How have your responsibilities toward these victims/offenders changed since beginning your job?

## III. STRUCTURE/ORGANIZATION OF FAC:

3a. Are you a member of the FAC? Yes No

3b. If 3a "yes," what committee(s) are you on?

3c. If 3a "yes," how do you participate on the FAC?

3d. What do you see as the major goals of the FAP?

3e. What do you see as the most important tasks of the FACs?

3f. What do you perceive as the role of the FAR?

IV. INTAKE AND ASSESSMENT

4. How do you first learn of cases of Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

4b. In your experience, what types of individuals or families are most commonly involved with:

Child Maltreatment

Spouse Abuse?

Sexual Assault/Rape?

## V. INTERVENTION/PREVENTION

5a. Please go through your involvement in a "typical" case from beginning to end:

Child Maltreatment

Spouse Abuse

Sexual Assault/Rape

5b. In spouse abuse cases, what happens if the victim refuses intervention?

5c. In sexual assault/rape cases, how do procedures vary if the accused is civilian or military? For a male or female rape victim? When the sexual assault/rape occurs on base as opposed to off base?

**OVERSEAS:** How do rape procedures vary if the accused is a host national?

## VI. JURISDICTIONAL ISSUES

6a. What types of jurisdictional issues, if any, arise here in child maltreatment cases?

How are these issues usually handled?

6b. **OVERSEAS SITES ONLY:** What types of jurisdictional issues arise with the host national legal system around child maltreatment and, spouse abuse? Around sexual assault/rape?

## VII. LINKAGES/INTERAGENCY COOPERATION

7a. On a scale from 1 to 5, low to high, how would you rate the level of interaction between you and local civilian agencies regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation? (Probe)

| Agency | | Level of Interaction | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| Child Protective Srvs. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Spouse Abuse Pgms | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Rape Crisis Centers | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Law Enforcement | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Mental Health Clinics | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Private Therapists | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Local Schools | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents Anonymous | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents United | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7b. What obstacles do you see, if any, to better coordination?

7c. On a scale from 1 to 5 low to high, how much interaction exists between you and other military organizations regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation?

| | Level of Interaction | | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| FAP (Medical treatment facility) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Child Care | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Alcohol Rehab (Hosp) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Legal Personnel | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Chaplains | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Base C.O. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| NIS | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Security Police | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| CAAC | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| DOD Schools (overseas) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| FSC ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7d. What obstacles do you see, if any, to better coordination?

## VIII. FOLLOW-UP PROCEDURES:

8a. Do you ever communicate directly with an individual's commanding officer in cases of domestic violence or rape? Under what circumstances?

8b. What information about domestic violence/rape cases is included in reports to the individual's C.O.?

8c. What types of punishment can happen to offenders in established cases of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape

8d. What happens most often in cases of:

Child Maltreatment?

Spouse Abuse/Rape?

Sexual Assault?

8e. How do legal procedures differ for enlisted personnel as opposed to officers?

8f. As an individual from the legal/law enforcement community, what is your opinion about the best way to handle offenders in cases of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

## X. CASE IDENTIFICATION

10a. How aware is command leadership of domestic violence and rape issues?

10b. How supportive is command leadership of the FAP? In what way is this support demonstrated?

## XI. TRAINING

11a. What types of family advocacy training, if any, have you been involved with in the past year? Please describe.

Impact of this training?

11c. What are the training needs here for legal/law enforcement personnel?

## XII. PROGRAM EVALUATION/RECOMMENDATIONS

12a. What do you see as the most important ingredients for a successful FAP? (Priortize)

12b. On a scale from one to five, low to high, how much success has the program had in each area to date?

| | Low Success | | | High Success | |
|---|---|---|---|---|---|
| Publicity | 1 | 2 | 3 | 4 | 5 |
| Outreach | 1 | 2 | 3 | 4 | 5 |
| Interagency Cooperation | 1 | 2 | 3 | 4 | 5 |
| Command Support | 1 | 2 | 3 | 4 | 5 |
| Case Identification | 1 | 2 | 3 | 4 | 5 |
| Training | 1 | 2 | 3 | 4 | 5 |
| Follow-up | 1 | 2 | 3 | 4 | 5 |
| Prevention Efforts | 1 | 2 | 3 | 4 | 5 |
| Other ________________ | 1 | 2 | 3 | 4 | 5 |
| ________________ | 1 | 2 | 3 | 4 | 5 |

12c. Overall, what do you see as the FAP's strengths (Prioritize):

Barriers to success? (Prioritize)

Primary needs? (Prioritize)

Future directions? (Prioritize)

12d. What recommendations do you have for strengthening the FAP on this base, assuming that resources and manpower are not increased? If they are increased?

12e. What haven't we discussed that would help us to better understand the situation here?

12f. Is there anything else you'd like to discuss?

Department of Navy
Family Advocacy Program
Winter 1983

Site ______________________
Date ______________________
Interviewer _______________

Interview Guide No. 6: Alcohol Rehabilitation Workers and Chaplains

I. BACKGROUND

1a. Name/Rank/Title: ______________________________________

1b. Length of time in present position

1c. General job description

1d. Previous professional experience/training in domestic violence/rape

II. ROLE

2a. In what ways do you work with cases of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

## III STRUCTURE/ORGANIZATION OF FAC

3a. Are you a member of the FAC?

3b. If 3a is "yes", what committee(s) are you on?

3c. If 3a is "yes", how do you participate on the FAC?

3d. What do you see as the major goals of the FAP at this base?

3e. What do you perceive as the role of the FAR?

## IV. INTAKE AND ASSESSMENT

4a. How do you first learn of cases of domestic violence and sexual assault/rape?

4b. In your experience, what types of individuals or families are most commonly involved with: (Probe)

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

## V. INTERVENTION AND PREVENTION

5a. What programs and services are offered by you and your staff for victims and offenders of:

Child Maltreatment?

Spouse Abuse?

Sexual Assault/Rape?

5b. What are the most serious obstacles encountered by you in responding to cases of domestic violence and rape?

5c. What do you see as possible solutions to these problems?

## VII. LINKAGES/INTERAGENCY COOPERATION

7a. On a scale from 1 to 5, low to high, how would you rate the level of interaction between you and local civilian agencies regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation? (Probe)

| Agency | | Level of Interaction | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| Child Protective Srvs. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Spouse Abuse Pgms | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Rape Crisis Centers | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Law Enforcement | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Mental Health Clinics | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Private Therapists | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Local Schools | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents Anonymous | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Parents United | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7b. What obstacles do you see, if any, to better coordination?

7c. On a scale from 1 to 5, how much interaction exists between you and other military organizations regarding cases of domestic violence and sexual assault/rape?

[For each] How would you rate the quality of cooperation?

| | Level of Interaction | | | | | | Quality of Cooperation | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Low | | | | High | Low | | | | High |
| FAP (Medical treatment facility) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Child Care | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Alcohol Rehab (Hosp) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Legal Personnel | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Chaplains | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Base C.O. | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| NIS | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Security Police | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| CAAC | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| DOD Schools (overseas) | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| FSC | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| Others ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| ____________ | NA | 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |

7d. What obstacles do you see, if any, to better coordinaton?

7e. How aware is command leadership of domestice violence and rape issues?

7f. Do you ever communicate directly with an individual's commanding officer in cases of domestic violence or rape? (Probe)

## XI. TRAINING

11a. What types of family advocacy training, if any, have you been involved with in the past year? Did you have NMPC-66 training?

11b. What was the impact of this training in working with victims and offenders of domestic violence and rape?

11c. What do you see as the training needs at this base for persons working with cases of domestic violence and rape?

11d. What are some of your own training needs in the area of family advocacy? How should this be done?

## XII. PROGRAM EVALUATION/RECOMMENDATIONS

12a. What do you see as the most important ingredients for a successful Family Advocacy Program?

12b. On a scale from one to five, low to high, how much success has the program had in each area to date?

| | Low Success | | | | High Success |
|---|---|---|---|---|---|
| Publicity | 1 | 2 | 3 | 4 | 5 |
| Outreach | 1 | 2 | 3 | 4 | 5 |
| Interagency Cooperation | 1 | 2 | 3 | 4 | 5 |
| Command Support | 1 | 2 | 3 | 4 | 5 |
| Case Identification | 1 | 2 | 3 | 4 | 5 |
| Training | 1 | 2 | 3 | 4 | 5 |
| Follow-up | 1 | 2 | 3 | 4 | 5 |
| Prevention Efforts | 1 | 2 | 3 | 4 | 5 |
| Other ______________ | 1 | 2 | 3 | 4 | 5 |
| ______________ | 1 | 2 | 3 | 4 | 5 |

12c. Overall, what do you see as the strengths of the Family Advocacy Program? (Prioritize)

Barriers to success? (Prioritize)

Primary needs? (Prioritize)

Future Directions? (Prioritize)

12d. What recommendations do you have for strengthening the FAP on this base, assuming that resources and manpower are not increased?

If they are increased?

12e. What haven't we discussed that would better help us understand the situation here?

12f. Is there anything else that you would like to discuss?

Dept. of Navy Family Advocacy Program
Winter, 1983

Site________________________
Date________________________
Interviewer_________________

Interview Guide No. 7: Child Care Director

1. Name/Rank/Title: ______________________________________________

2. Length of time in position:

3. General job description:

4. In what ways do you work with the FAP on this base?

   Are you a member of the FAC?

5. Previous professional experience/training in family violence.

6. On the average, how many children are under your care?

7. Given your knowledge of this community, what is the extent of:

   Child neglect?

   Child abuse?

   Child sexual abuse?

Other t )es of family violence/sexual assault and rape?

8. How do instances of child maltreatment come to your attention?

9. Once you learn of child maltreatment, what do you do?

10. How many actual incidents of child maltreatment have you dealt with as Child Care Director in the last year?

11. In your experience, what types of individuals or families are most commonly involved with child maltreatment?

What differences exist between families that neglect their children versus those who physically or sexually abuse their children?

12. Where do you refer individuals or families who are suspected of child maltreatment?

Do you make referrals to the FAR? Under what circumstances?

13. What do you perceive as the responsibilities of the FAR?

14. What problems exist in responding to individuals and families who maltreat their children?

15. In what ways could the Navy/Marine Corps deal more effectively with child maltreatment problems?

16. Have you received any type of training in identifying or responding to child maltreatment? If so, what type of training?

17. What are the training needs for you and your staff in the area of child maltreatment? How should this training be done?

18. What types of briefings or educational seminars have been conducted about family violence on base? Who conducted these briefings or seminars?

19. What do you see as the most important ingredients for a successful Family Advocacy Program?

    Of these ingredients, which ones has the FAP had the most success in achieving?

The least success? Why?

20. Overall what do you see as the strengths of the Family Advocacy Program? (Prioritize)

    Barriers to success? (Prioritize)

    Program needs? (Prioritize)

    Future directions? (Prioritize)

21. What recommendations do you have for strengthening the FAP on this base?

22. What haven't we discussed that would better help us understand the situation here?

23. Is there anything else that you would like to discuss?