Appendix J: Working with DV Offenders Involved In the Military Adopted (August 12, 2016)

The following Guidelines have been developed to address the unique aspects of treatment with domestic violence offenders who also have military experience. These Guidelines supplement the DVOMB approved Standards for Treatment for Court Ordered Domestic Violence Offenders and are found in the Appendix of the Standards.

The treatment issues unique to military require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment. It is imperative that treatment providers are prepared to assess and respond to the myriad of experiences and needs within military offender populations. Providers must seek appropriate training to work effectively with this population. Providers are encouraged to use these guidelines and seek to increase their competence in working with diverse groups of offenders who have had military experience.

A. Recommended Competencies for Providers

1. PTSD – Post Traumatic Stress Disorder (PTSD) current research indicates that PTSD is not a causal factor in domestic violence. Research further demonstrates that combat exposed veterans are more likely to exhibit symptoms of combat operational stress (combat operational stress reactions COS-R) than an actual full blown PTSD diagnosis. Clinicians should understand the diagnostic criteria for PTSD as well as be versed in combat operational stress.

2. TBI – Traumatic Brain Injury is a significant neurological injury and should be evaluated and treated by a neurologist. Providers should obtain a release of information and consult with the treating neurologist. The key issues to explore would be the offender's ability to participate meaningfully in the treatment process, the offender's ability to retain new information and the offender's ability to emotionally self-regulate.

3. Deployment cycle, also known as the Army Force Generation (ARFORGEN) cycle, is the military's training and deployment cycles. It affects both the Service Member and the family as Service Members are typically either deploying or preparing to deploy. What stage a Service Member is in may affect their ability to participate in weekly treatment as well as potentially create significant stress factors for the military family.

4. Military culture and customs – The military has a unique culture which is steeped in history, values and traditions. The DVOMB considers understanding the military and its unique culture a cultural competency issue for practitioners.

5. Uniform Code of Military Justice (UCMJ) is the legal code which governs Service Members and their behaviors. Even if a Service Member is sentenced in a civilian court of law, their actions can still be adjudicated under UCMJ. Understanding judicial and administrative actions can assist a provider in understanding a Service Member and also potentially assist in managing risk. Providers treating military personnel should know the offender's First Sergeant (1SG) and Company Commander, have a release of information for both and coordinate care with one or both throughout treatment.

The offender should provide the treatment provider with the Command and 1SG's contact information. NOTE: You will need a release of information to speak with either the Commander or a 1SG as confidentiality limits apply.

6. Protective orders can be civil (temporary protection order –TPO, or permanent protection order – PPO, or military protection order - MPO). A MPO is issued by the Commander and is typically time limited. Unless the Commander specifically processes the MPO through the Military Police, the MPO is ONLY valid ON POST. This is important to note as a MPO will not protect a victim off post UNLESS the Commander has had the MPs put the MPO into NCIC. It is extremely rare for a Commander to do this as the MPOs are time limited, typically 1 week to 1 month.

7. Service Members with a MPO can and do still have access to weapons. In order to restrict access to weapons, the Service Member must voluntarily surrender them OR an on post Behavioral Health Provider must write a weapons profile. Conversely, if a Service Member has a PPO, they are prohibited from owning and possessing personally weapons. However, they may still use a weapon are part of their military duty (i.e. they can still deploy and be issued a government weapon).

B. Assessment Considerations

1. Deployments – the number and frequency of deployments is a significant assessment consideration. Ideally, a Service Member is granted one year stabilization between deployments. However, if a Service Member returns from deployment and moves to a new unit, that unit may be preparing to deploy and thus the Service Member and the military family would have repeated back to back deployments. Assessment considerations would include, stress, separation and reunification issues, parenting issues and finances.

2. Combat exposure – not all deployments involve combat exposure. Many deployments result in what Service Members refer to as being a "Fobette" meaning they stayed on the FOB (Forward Operating Base) the entire deployment. Assessment considerations in this scenario would include boredom, morale and separation issues as well as meaningfulness of service issues.

3. Disability issues – a Service Member may have a service related disability. Again, research has failed to establish a causal factor between combat and domestic violence. However, serving on active duty with a disability creates significant stress for the Service Member and the unit. Additionally, the process for obtaining a medical discharge is lengthy and frustrating for the Service Member and the military family. Assessment considerations would include financial concerns, loss of purpose, fear of the unknown, unit support or lack thereof, guilt, etc.

4. Collateral loss (loss of battle buddies/fellow Service Members) is a significant issue for Service Members. Assessment considerations would include survivor's guilt, COS-R and/or PTSD symptoms.

5. Insomnia – a significant number of Service Members report significant and long term sleep disruptions. On post behavioral health offers many sleep specific programs to help Service Members with their sleep issues. Conversely, as clinicians, we know that

long term sleep deprivation is a significant clinical issue which requires intervention for any therapeutic program to be effective.

6. Substance abuse – Service Members who struggle with substance abuse can seek confidential substance abuse treatment via Army Substance Abuse Program (ASAP). If the Service Members waits until their substance abuse issues become known to Command, their career could be negatively affected. Clinicians may want to encourage Service Members to seek voluntary, confidential help if they suspect any substance abuse issues are present. Once Command becomes aware of any use/misuse issues, they will Command direct the Service Member to complete an evaluation. Confidentiality for the Solider is EXTREMELY limited in these cases, so it may be best that a Service Member self refers for a substance use/abuse treatment or education. Currently, Service Members who are identified as having substance abuse issues could face separation from the military.

C. Treatment Parameters and Dynamics

1. Understanding the functional power structure of defense – Providers treating military personnel should consider the efficacy of the power and control structure that is embedded within the military culture.

2. Providers should consider the unique way in which military personnel define "threat" and seek to assist Service Members in exploring the ways in which the military requires/trains them to respond to threats versus how a family would need them to define and respond to a perceived threat.

3. The military, by virtue of the ARFROGEN cycle, significantly disrupts family attachment, roles and routines. Continued deployment and redeployment can create significant disruption to familial roles, expectations and family processes. This can and often does create significant conflict. Assessment considerations would include family roles and rules, attachment patterns, expectations regarding parenting and child development. Additionally, due to how rapidly children develop and grow, Service Members often have to grieve the loss of the child(ren) they knew when the left versus the child(ren) that greets them upon redeployment. Spouses, similarly, may change and grow over the course of repeated deployments, which can create significant disruptions to the military family.

D. Supervision/consultation issues

1. The provider working with military families should assure that they have adequate training and support for themselves and for their victim advocate.

2. The Provider should have a working relationship with the closest military base's Department of Behavioral Health (DBH), Family Advocacy Program at DBH and Family Advocacy Program via Army Community Services (ACS). If the Service Member has been discharged, the provider should have resources and connections with the local VA Hospital and outpatient clinic.

E. Victim advocacy

1. Similar to the treatment provider, a treatment victim advocate working with military victims should know and understand PTSD, TBI and COS-R. Moreover, they should seek to help victims understand that PTSD is not an excuse for domesticviolence.

2. Treatment victim advocates should be connected to the unique benefits available to military victims to include medical care, MPOs and transitional compensation.

3. A treatment victim advocate must be able to help victims discuss the pros and cons of a civilian versus a military protection order and the implications for both.

4. A treatment victim advocate working with military victims should understand the unique implications (i.e. UCMJ actions) which can and often do affect pay, restrictions to post and ultimately discharge from active duty. These are serious concerns for military victims which ideally should be explored and discussed so that the victim can make an informed decision for themselves and their families. The treatment victim advocate will need a release of information to speak with a military victim advocate. The treatment victim advocate should discuss what the military victim advocate would have to report to the MEDCOM Family Advocacy Program prior to sharing any information. A military victim advocate does not serve in the role as a treatment victim advocate.

5. Military victims have a right to "restricted" versus "unrestricted reporting" and military victim advocate should be well versed in these two reporting options. It may behoove a military victim to file a restricted report with a military victim advocate as later, should they need it, they can unrestrict the report and document that they did share concerns with ACS.

Resources

http://www.dtic.mil/doctrine/dod_dictionary/

http://www.defense.gov/About-DoD/insignias