CHILD & FAMILY
RESEARCH PARTNERSHIP

Military Families and Veterans Pilot Prevention Program

Final Evaluation Report

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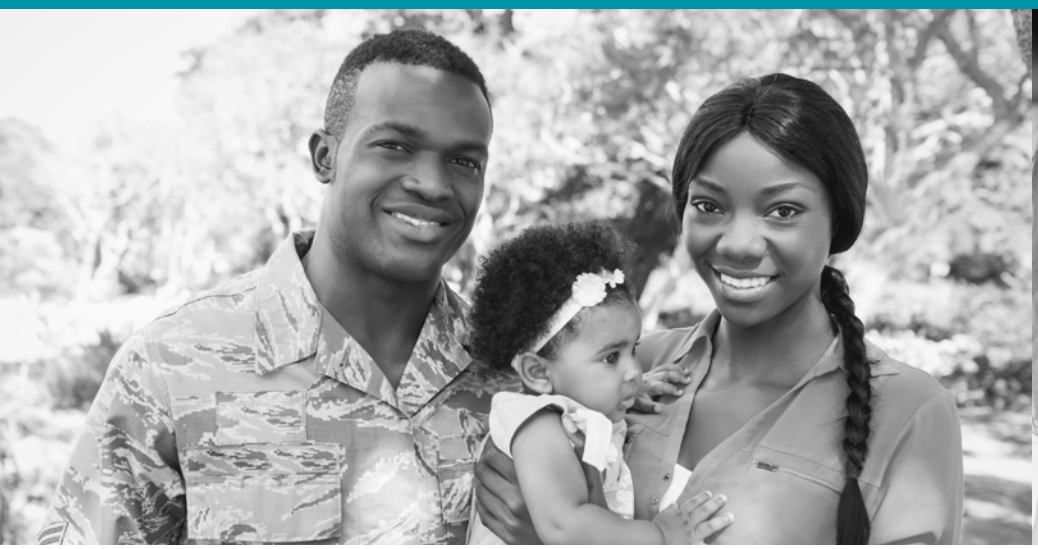


The University of Texas at Austin
Lyndon B. Johnson School of Public Affairs

Authors

Cynthia Osborne, Ph.D.
Director, Child and Family Research Partnership
Associate Professor
Lyndon B. Johnson School of Public Affairs
The University of Texas at Austin

Kaeley Benson, Ph.D.
Senior Policy Associate
Child and Family Research Partnership

Abby Lane, MPP
Graduate Research Assistant
Child and Family Research Partnership

Data Support

Erin Wu, MPH
Data Research Associate
Child and Family Research Partnership

John William Meyer
Graduate Research Assistant
Child and Family Research Partnership

EXECUTIVE SUMMARY

Background and Overview

The Prevention and Early Intervention (PEI) Division of the Texas Department of Family Protective Services (DFPS) contracted with the Child and Family Research Partnership (CFRP) at the University of Texas at Austin's LBJ School of Public Affairs to evaluate the Military Families and Veterans Prevention Program (MVP). DFPS designed the MVP program to serve military and veteran families who are at a high risk of family violence and/or abuse and neglect. The MVP program was designed to serve the three largest military communities in Texas: Fort Hood in Bell County; Joint Base San Antonio in Bexar County; and Fort Bliss in El Paso County.

The overarching goal of the MVP program is to prevent child abuse and neglect by building and supporting military families' protective factors, resulting in stronger families and improved military communities. Communities were given flexibility to concentrate their resources to best fit the challenges in their region. However, each community was required to develop a comprehensive plan that included: evidence-based or promising practice programs to support military families; performance measures that gauge program effectiveness; programs with a focus on children ages 0-17; and an approach focused on the needs of military and veteran families, and the military culture and environment they live in. Communities were also required to develop an official working relationship with the local Family Advocacy Program (a Department of Defense sponsored program for child and domestic abuse prevention and intervention) and provide ancillary services targeted toward needs identified in their Community Needs Assessment.

This report serves as the final evaluation report by CFRP on the MVP program. Three overarching research aims guided the mixed-methods evaluation:

1. What are the unique needs among military and veteran families, and how do these needs vary among members of military and veteran families?
2. How do programs serving military and veteran families modify their recruitment strategies, service delivery, or other program elements to most effectively serve these families?
3. Do the programs increase protective factors among military and veteran families and prevent incidents of child abuse and neglect?

This report reviews the unique context of each military community participating in the program and outlines the structure each community created for their MVP program. At the time of this report, two of the three communities were in their second year of serving families (the third community had a delayed start). This report focuses primarily on implementation findings—identifying the unique needs of military and veteran families and highlighting the ways in which programs adapt to meet the needs of military and veteran families. In addition, this report includes preliminary evidence on communities' progress toward meeting PEI goals for the MVP programs. We conclude

the report with a summary of the lessons learned and policy recommendations to guide future community-based initiatives to support military and veteran families.

Findings

In each of the MVP communities, the programs aimed to match services to the diverse needs of the military population in their area. Programs offered a range of services to these groups, simultaneously meeting the needs of these populations and making efforts to achieve overarching PEI program goals of increasing protective factors and keeping children safe.

The unique needs of military and veteran families stem from the challenging life circumstances faced by these families, characterized by frequent relocations and separations, physical and/or emotional trauma, and high levels of social isolation and stress. These circumstances, combined with a pervasive culture in the military in which military members perceive negative consequences for seeking help, make military and veteran families particularly challenging to serve.

In addition to the needs stemming from the challenging circumstances of military life, somewhat surprising to providers was the breadth and depth of the need for intervention services among military and veteran families in crisis. The most surprising was the number of military families with active-duty members who needed assistance meeting their most basic needs including housing and food.

Importantly, this evaluation highlighted how differently military and veteran life is experienced by each member of the family. Military spouses demonstrated needs different from military-connected youth, which were different from the active-duty member or veteran. Many of the MVP programs seemed better equipped to serve military-connected family members, including spouses or children, rather than the enlisted member, because family members were often the most available for services and they faced less stigma for receiving services.

Most MVP providers did not appear to modify program content to address the specific needs of military populations, primarily using MVP funds to better target outreach and recruitment efforts. MVP providers did report modifying program structure including the number of classes, the length of the classes, and the location of the classes to meet the needs of military families, who often struggled with transportation, child care, and for enlisted members, not having the flexibility to take off a few hours every week for several weeks. Providers also noted that it could be difficult to balance maintaining program fidelity with modifications to program structure.

Recruiting military families into the programs proved challenging. Contractors and subcontractors reported issues of privacy, confidentiality, and stigma preventing military families from seeking help. Military connections were essential to recruitment; buy-in from military and base staff eased challenges to recruitment (especially on base) and military connections of MVP program staff helped build trust and connections with potential clients. Other providers reported not yet having issues with retention, due in part to the hard work of dedicated staff. However, providers reported

retention challenges related to work and training schedules of active-duty service members, deployments, frequent moves, and the unmet basic needs of families, especially transportation and child care.

Community collaboration, an important part of the MVP program, was frequently reported as successful between contractors, subcontractors, and a diverse array of organizations within their communities. In contrast, communities found mixed levels of success in collaborating with local military partners, and faced challenges formalizing collaboration efforts. In communities where partnerships with military partners were successfully formed, these relationships were fruitful for recruitment and service delivery.

Problems identified as challenges for recruitment and collaboration reappeared as service delivery challenges reported by providers (e.g., stigma around seeking help, frequent moves of military families, etc.). Providers frequently reported that unmet basic needs of military and veteran families often made it difficult for families to participate in programs and often required providers to focus on intervention, rather than prevention. Providers also reported structural and contractual barriers to service delivery.

To date, the MVP program is on track to meet the PEI goals of improving protective factors and keeping children safe. Nearly 90 percent of the MVP providers for whom complete pre-and post-Protective Factors Survey (PFS) data were available (approximately one-third of the full sample) demonstrated improvement in at least one protective factor. Similarly, less than one percent of MVP clients were identified as a designated perpetrator, despite nearly one-quarter of the sample having a history of child abuse or neglect.

Lessons Learned and Recommendations

This evaluation highlighted three overarching lessons learned. A summary of each lesson learned is below along with associated policy recommendations for future implementation efforts.

Lesson Learned #1: Many military families, particularly active-duty members in the lower ranks of the military, and veterans have challenges meeting their most basic needs. These needs often interfered with programs' efforts to support parenting and increase protective factors. CFRP recommends that programs to support military and veteran families include strategies for crisis management and identifying resources to meet basic needs as central required components of the program (not ancillary or optional components). Furthermore, families need to be linked to services as soon as possible given their transitory nature and linked to additional, ongoing resources and services once participation in MVP programs is over.

Lesson Learned #2: Most programs modified recruitment efforts and program structure to reach and accommodate military families but did not modify program content to meet the unique needs of military families because of issues related to model fidelity. We recommend that to best meet the needs of military families, communities need to identify programs that have an

evidence-base for serving military families, or have content specific to military life and culture (examples of which are provided in the report). Additionally, communities and programs need to recognize how needs vary across members of the military and military families (e.g., active-duty, veteran, spouse, youth).

Lesson Learned #3: Privacy, confidentiality, and stigma are major barriers to recruitment, but military connections help. We recommend that the state do more to facilitate and maintain relationships between military leaders and base staff and community-based organizations providing services, especially when military leadership changes. Helping to facilitate these relationships might also help ease the challenges with establishing Memorandums of Understanding between Family Advocacy Program (FAP) and community-based providers.

CHAPTER 1: INTRODUCTION

Purpose and Objectives

After 2001, the U.S. experienced a large increase in the number of military combat deployments.[1] Research indicates that rates of child maltreatment increase dramatically during a deployment.[2] For example, rates of neglect by civilian female spouses during deployment are nearly four times greater and rates of physical abuse are nearly twice as high as during non-deployment time periods.[3] Deployments are associated with increased stress levels for both the deployed military member and the sole parent remaining at home.[4] Although deployments have decreased over the last several years,[5] there remains a great need for prevention services in military communities to alleviate the challenges and stressors associated with deployments and separations (including military members' transitions back into family life post-deployment),[6] as well as frequent moves and other risk factors associated with routine military life.[7]

This need is particularly great in Texas, which has the third highest active-duty military population in the U.S.[8] Approximately 10 percent of all active-duty forces in the U.S. reside in Texas.[9] Additionally, nearly 1.7 million veterans, and 53,000 Selected Reserve members live in Texas.[10,11] A recent report using data from Texas's new Military Student Identifier, found that Texas is among the top three states serving military connected students. During the 2014-2015 school year, the state served approximately 64,700 active duty-connected, 3,800 National Guard-connected, and 7,500 reserve-connected children. An additional 6,400 military-connected children were served the same year in state pre-kindergarten programs.[12,a]

The Prevention and Early Intervention (PEI) Division of the Texas Department of Family Protective Services (DFPS) contracted with the Child and Family Research Partnership (CFRP) at the University of Texas at Austin's LBJ School of Public Affairs to evaluate the Military Families and Veterans Prevention Program (MVP). DFPS designed the MVP program to target the three largest military communities in Texas, and specifically those military and veteran families with children 0-17 years of age who are at risk of family violence or child abuse and neglect.

Background and Significance

CHILD MALTREATMENT IN THE MILITARY

In general, the rate of child abuse and neglect among military families is lower than their civilian counterparts. According to the U.S. Department of Defense (DoD), the rate of child victims is about "half of their counterpart rates in the U.S. civilian population as compiled by the U.S. Department of Health and Human Services" (HHS).[13] Recent reviews of the literature also indicate

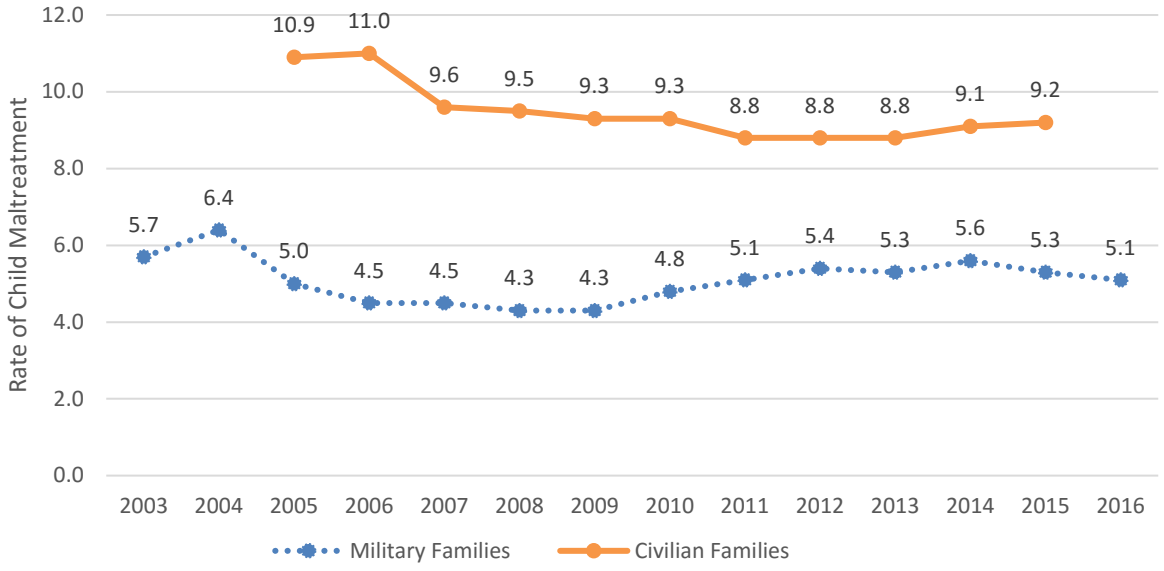
[a] The Military Student Identifier does not identify children of veterans who are no longer active-duty, reserve, or National Guard members.

that rates of child maltreatment are consistently lower among military families compared to civilian families.[14]

Increasing Rates of Maltreatment in the Military

Though the overall rate remains lower, researchers have noted that substantiated reports of child maltreatment have risen faster among military families than civilian families, particularly in the last decade.[15] In 2003, the rate of reported and confirmed cases of child maltreatment among military families began to climb faster than in the general population (Figure 1). For example, the number of cases of child abuse or neglect in the Army spiked 28 percent between 2008 and 2011, whereas the number of civilian cases increased by only one percent.[16] The upward trend in child maltreatment among military families between FY 2009 and 2014 (Figure 1) is credited by the DoD to an increase in the number of incidents involving child neglect.[17] In response, the DoD launched a new campaign to bring attention to child neglect. Substantiated reports of child neglect have decreased in the last two years.

Figure 1. Rate of Child Maltreatment Victimization among Military and Civilian Families



Notes: Rates per 1,000 children. Rates are based on the most recent estimate of unduplicated victim counts for federal fiscal years (FFY). Unduplicated civilian victimization rates unavailable prior to FFY 2005.
Sources: Department of Defense (DoD)18 and U.S. Department of Health and Human Services (HHS)[19]

Among substantiated reports among military families in FY16, 59 percent of incidents were cases of child neglect, 20 percent were physical abuse, 17 percent were emotional abuse, and four percent were sexual abuse.[20] The largest share of victims of substantiated child abuse and neglect were children ages one to five – 33 percent of victims fell in this age range. However, 22 percent of victims were under age one, much higher than their share of the child population (less than eight percent).[21] Parents made up the vast majority of perpetrators in substantiated

reports—50 percent of perpetrators were the military parent, 41 percent were the civilian parent, and the remaining nine percent were either an extra-familial caregiver (3%), another family member (4%), or unknown (2%).[22] There is little research on how child maltreatment in military families differs by race and ethnicity – one study found higher rates of maltreatment among minority children in military families (as compared to non-Hispanic white children), although these rates were still found to be lower than the civilian population.[23]

Risk Factors for Maltreatment

Military families face unique life circumstances associated with military service that place greater burdens on them than the burdens placed on families in the general population.[24] Active-duty service members and their families are expected to move every three to five years, and when not in combat, active-duty service members train for combat, during which it is not uncommon for the service member to spend only one or two weeks at home out of every six to eight weeks.[25] With every move, family members are expected to start over—a new school, new friends, a new job, a new home, a new community, and new experiences, and for many, these changes are exacerbated by an inevitable deployment.

Common perceptions around military life assume that the military affords families a relatively healthy and stable economic outlook. Although the military often offers relatively higher pay and benefits than comparable civilian occupations, the economic picture for families of lower ranking enlisted soldiers is more complicated. Financial distress is reported among some service members and their families, particularly among junior enlisted ranks, with some service members' families even qualifying for food stamps (SNAP). In a review of the evidence on the economic conditions of military families, researchers found an increased likelihood of financial strain when: 1) the service member was from a lower pay grade; 2) the service member's spouse was unemployed; 3) the service member was wounded; 4) a family member had special medical or educational needs; or 5) the family experienced challenges readjusting the various phases of the deployment cycle. This review also highlighted how pervasive financial strain is in the military with approximately one in seven junior military families reporting financial stress, including having trouble making ends meet in a given month.[26]

This review also cited an analysis of data on Army applicants that found when members of the military transition out of active duty service, many experienced a significant drop in earnings, "and the decrease was steeper the longer they served."[27] This review also identified evidence that young veterans of recent wars may face slightly higher unemployment rates. Economic challenges may become so severe for some veterans that they experience homelessness: "about 1 in 150 veterans were homeless, and veterans were more likely than nonveterans to become homeless," according to one federal report reviewed.[28] In addition, "the military lifestyle takes a toll on the earnings of [military] spouses." Due to frequent moves, "spouse's careers are regularly interrupted, and employers are hesitant to offer them jobs that require a large investment in training or a long learning curve." Deployment can also affect spouses' employment. Military wives are also more likely to work less than they would prefer and be overeducated for the job

they hold – two factors affecting their earnings.[29] These economic challenges place additional stressors on families, increasing the risk for child maltreatment.[30]

The increasing rate of maltreatment in military families coincides with the increase in deployments that began in 2002. More than two million service members have been deployed, and 800,000 have experienced multiple deployments.[31] Many military members who deploy leave families at home—more than two million American children have had a parent deployed to Iraq or Afghanistan.[32] Furthermore, soldiers who have served in the Iraq and Afghanistan wars have also experienced longer deployments, and more back-to-back deployments than soldiers have in any other war in history.[33] Although the wars in Iraq and Afghanistan are officially over, members of the military remain deployed in these regions and continue to face the effects of recent deployments.

Deployment imposes stresses on military families because of separation and combat stressors, and the challenges of reintegration for families.[34,35] Deployment and its associated stresses on the family and service member are the most commonly cited military experiences associated with increased risk for child maltreatment. Today, active-duty members of the military begin reintegrating back into their families quickly post-deployment, often within a few days of being on the frontlines, which can make reintegrating into civilian life challenging. Parental stress plays a critical role in child maltreatment, particularly child neglect.[36] One study found that, compared to military families in which the service member had never been deployed, families with a service member concurrently deployed (deployed at the time of the incident) and previously deployed were at higher risk of a range of forms of neglect.[37] More frequent and lengthier deployments appear to be associated with greater levels of parental stress and depressive symptoms, poorer family or couple functioning, poorer general wellbeing, and greater use of mental health services for the military spouse.[38] Young children with parents who have been deployed experience more emotional and behavioral problems as compared to their counterparts who have not experienced parental deployment.[39] Older children (e.g., teenagers, school-aged children) exposed to cumulative deployments have increased risk-taking behaviors and increased levels of anxiety.[40]

Guard and Reserve members experience a unique set of challenges. They are required to leave civilian jobs when activated, which often means taking pay cuts, and they have less access to military installations for family supports.[41] They may also experience combat-related duty and their families face the associated stressors related to deployment. Reservists and their families have less experience dealing with deployment and reintegration, less support than active-duty soldiers and families, and are less likely to be integrated into a military social support network.[42,43] Returning from active-duty can be particularly difficult for Guard and Reserve members because they are expected to return to civilian sectors, not the military and its associated support network.

There is some evidence that the association between deployment and increased risk of child maltreatment may differ based on which parent is deployed. In a study using Army data from the

early 2000s, the rate of child abuse and neglect overall was more than 40 percent higher during deployment compared to when both parents were at home.[44] Civilian mothers who remained at home while their husbands were deployed showed the greatest increase in the rate of child abuse and neglect during deployment compared to civilian fathers, suggesting that civilian mothers and civilian fathers may experience different stressors during their spouses' deployment or differ in how they cope with such stress.[45]

In addition to deployment and reintegration, there are several other characteristics of the military experience associated with increased family stress, and greater risk for child maltreatment:[46]

- Young parents with young children;[47] approximately two-thirds of the Army population is under 30 years of age, and almost half of children are under 6 years of age. A recent Institute of Medicine (IOM) report indicates that children less than 3 years of age are at the greatest risk for child maltreatment.[48]
- Frequent required moves/geographic mobility; [49,50,51]
- Isolation from the military community among Reserve families or isolation from extended family and support networks;[52,53] and
- General stresses of deployment, including risk of service member injury and death and Post-Traumatic Stress Disorder (PTSD).[54,55,56,57]

Though some of these experiences alone are not necessarily negative, they may cause families to experience extra stress, isolate families from social support systems, and make it difficult for families to access resources.

Children of veterans returning from combat, particularly those with severe mental distress, may be at risk for diminished parenting capacity, including experiencing family violence.[58] One in five Iraq and Afghanistan veterans suffer from PTSD or major depression. Veterans with PTSD commit acts of domestic violence at rates greater than veterans without PTSD, and at rates greater than the general population.[59] Spouse abuse is a risk factor for child abuse, though the relation is complex.[60,61] Children may be harmed in a domestic violence incident, whether directly or indirectly/inadvertently or may be mistreated by a victim of domestic violence who is experiencing diminished parenting capacity. Children's exposure to domestic violence can be problematic as well. In one study, child maltreatment was twice as likely to occur among families with a prior incident of spouse abuse.[62]

CHALLENGES EXPERIENCED BY MILITARY-CONNECTED YOUTH

Serving military or veteran families means it is necessary to also understand challenges facing children and youth in military families. The experiences of military-connected youth are distinct in many ways from children in civilian families. Specific challenges may come in the form of frequent moves and dealing with separation from a parent during training or deployment. Military-connected youth, however, are resilient and military life often brings unique opportunities.

Deployments and Separations Place Strain on Youth and Their Families

Deployment can be a time of stress and uncertainty for military-connected youth who worry about the safety of their parent.[63] Deployment is also associated with mental health problems; increased internalizing and externalizing behavior problems (e.g., anxiety, depression, and aggression); increased risk for child maltreatment; and difficulties in school for children and youth.[64] Researchers have also found that the number of deployments and length of deployments matter[65] – two problems that military families have increasingly faced in recent years.[66] Older children (e.g., teenagers, school-aged children) exposed to cumulative deployments have increased risk-taking behaviors and increased levels of anxiety.[67]

During deployment, children may also have to take on more family responsibilities, such as caring for younger children and providing emotional and financial support for their families. These additional responsibilities may be challenging for youth, especially at the time, but may also help build resilience and "serve as a source of strength elsewhere in their lives."[68] Children of parents who deploy to war zones may also face difficulties when parents return home and reintegrate into the family, particularly if the parent has a serious injury or experiences posttraumatic stress disorder.[69] Families must readjust after reintegration and pre-existing stressors may be exacerbated during these times. One set of researchers noted, "Imagine, for example, how hard it could be for a child already burdened with ADHD to complete difficult yet routine school homework after a parent returns from war with a traumatic brain injury or posttraumatic stress disorder."[70]

Children of Guard and Reserve members face many of the same challenges as children of active duty parents. These youth have parents who may be separated from them for training, or even deployed, but these families are often less well-connected to military communities and resources.[71] Reservists and their families have less experience dealing with deployment and reintegration, less support than active duty soldiers and families, and are less likely to be integrated into a military social support network.[72,73]

Frequent Moves Present Challenges and Opportunities for Youth

A child growing up in a military family is likely to experience multiple moves as he or she grows up – as often as every two or three years – much more frequently than their civilian counterparts.[74] Moving is difficult on children because it can upset family routines, disrupt schoolwork, cause discontinuities in health care, and "isolate children from family and close friends," which may be even more difficult for adolescents at a stage where peers are especially important.[75] Moves in the middle of the school year are especially difficult because they cause challenges for making friends, which makes military-connected youth particularly vulnerable to bullying. Although frequent moves can present challenges to military-connected youth, these moves also may act as positive opportunities. For example, children who move have the chance to meet new people, build self-confidence, explore new activities, build new skills, and even experience different cultures both within and beyond the U.S.[76]

PROTECTIVE FACTORS FOR MILITARY FAMILIES

Despite the multitude of stressors surrounding military families, there are also many aspects of the military experience that support healthy families. The bonds between military family members may be stronger because they have gone through the challenges of military life together.[77] Amidst the instability of military life, there can also be stability for many: ensured employment, access to social support, and consistently having most basic needs met.[78] Several characteristics of military families serve as protective factors:

- Service members are screened for mental health and criminal histories prior to service start;[79,80,81]
- Low rates of illicit drug use;[82,83]
- High rates of married and two-parent families; [84,85]
- Stable employment of at least one adult that includes earnings and benefits;[86,87,88]
- Access to health and social services;[89,90] and
- Social support and structured community.[91]

Additionally, although some aspects of military life may bring adversity to the lives of military-connected youth, context matters. Children who grow up in families with stable relationships, positive parenting practices, and parents who display positive responses to adversity are often more resilient and better able to cope with challenges they encounter.[92] Military families also report a strong sense of community,[93] which may help families hold positive identities and cope with challenges through a network of support. One study found that, compared to civilian youth, children in military families have demonstrated "greater respect for authority and are more tolerant, resourceful, adaptable, responsible, and welcoming of challenges."[94] Although military-connected youth may face additional challenges as compared to their civilian peers, these children are often well equipped to handle them and succeed in the face of adversity.

Some, but not all, of the protective factors for military families overlap with the protective factors[95] linked to a decreased likelihood of child abuse and neglect, which include:

- Family functioning/resiliency ("the well-being or performance of the family unit in such domains as relationships within the family health/competence, conflict resolution, cohesion, leadership, and expressiveness");
- Social-emotional support ("the individual's perception that empathy, caring, reassurance, or understanding will be provided by social networks if needed");
- Concrete support ("the tangible resources such as food, cash, child care assistance, and clothing that social networks may provide as buffers against parenting stresses");
- Child development/knowledge of parenting; and
- Nurturing and attachment (the quality of the relationship between the child and their caregivers).

Child maltreatment prevention focused for many years on reducing the risk factors associated with child maltreatment, but more recently prevention began to aim at increasing protective

factors that reduce the likelihood of child maltreatment.[96] A protective factors framework affords programs the ability to focus on factors that can be shaped by prevention strategies, whereas some risk factors including age, or prior history of child maltreatment are less malleable.

Social-emotional support and concrete support are protective factors against child maltreatment that overlap with the protective factors in military families. This support however, may only apply to active-duty military families. Reserve and Guard members likely have less access to the social-emotional and concrete support common among active-duty military families, and veteran families may have even less access.

MILITARY CULTURE AND SUPPORTING MILITARY FAMILIES

It can be challenging for military families to seek services to prevent child maltreatment or to intervene in the case of existing child maltreatment. Child maltreatment may be perceived as a problem to keep secret and one that families may be reluctant to openly discuss or receive services for, both within and outside the military.[97] Within the military, families have access to the Family Advocacy Program, but may face a stigma associated with participating in family programs or fear the consequences of asking for help.[98] Similar barriers exist with seeking help outside the military, but with the added challenge of having to locate services off base.

The Family Advocacy Program

The Family Advocacy Program (FAP) is a congressionally mandated DoD program designed to be a key element of the DoD's Coordinated Community Response system to prevent and respond to reports of child abuse/neglect and domestic abuse in military families, in cooperation with civilian social service agencies and civilian law enforcement. FAP support, treatment, and case management services are provided to individuals who are eligible for treatment in military medical treatment facilities. The goals of the FAP include promoting prevention, early identification, reporting, and treatment of child and spouse abuse.

The process of substantiating and responding to suspected child maltreatment cases begins with a report of suspected abuse to an installation's FAP or civilian Child Protective Services (CPS). Generally, if CPS has received a call and identifies the family as a military family, CPS will contact FAP to work in coordination to investigate the issue. CPS interviews the child and parent and the case is referred to the civilian court system if there is evidence of abuse. In the event that the FAP is the notified party, "they ensure that everyone who is capable of protecting the safety and well-being of the child — the active-duty member's commander, law enforcement, the medical treatment facility and CPS — is aware of the risk and protective factors that are impacting the family. These community members often work as a team to ensure that children are protected, the parents receive appropriate intervention, and the family receives the services they need to be able to form more healthy relationships."[99]

Neither the DoD nor any of the military branches tolerate abuse of military family members. The DoD and the military branches believe that child abuse causes pain to the family, as well as

diminishes military performance, and is contrary to military values.[100] However, abuse reported to the FAP does not necessarily mean the end of a service member's career: after first ensuring the safety and protection of abuse victims, the chain of command typically supports service members who stop abusive behavior, commit to treatment recommendations, and work to achieve more positive family relationships. Extreme violence, continuing abusive behavior, refusing to comply with treatment plans, or causing serious injury to a family member may result in administrative discharge or court martial,[101] in addition to civilian penalties. The military also has the unique ability to remove the offending parent from the home in cases of child maltreatment allowing maltreated children to remain safely in their homes, which is common when child maltreatment co-occurs with substance abuse or spouse abuse.[102]

Community-Based Efforts

Community-based efforts to serve military families have to overcome military families' issues of stigma and fear associated with asking for help, earn trust, and make themselves visible to military families. Families often experience difficulties accessing services due to geographic mobility (e.g., it may be difficult to access resources or families may reside on small installations lacking comprehensive services),[103] or because families live off-base.[104,105] The latter is particularly relevant for Guard or Reserve families, who the military has relied heavily upon in recent wars. In addition, in the Army, approximately 60 percent of soldiers and families do not live on Army installations, therefore this problem is not isolated to Guard and Reserve families.[106]

Some research indicates that to be successful, programs targeting military families should teach positive parenting techniques that are evidence-based, adapt programs to reflect military culture and values, provide services in a variety of settings, and focus on treating parents' mental health needs.[107] For example, to overcome the reluctance of military families to participate in family programs, service providers could be called "trainers" or "coaches" to reflect their role as strength builders and reduce the stigma associated with care.[108]

Programs who serve families more broadly, often develop affiliated programs to target military families, or adapt curricula to address issues unique to military families including relocation, deployment, reunification, and combating stress.[109,110] Programs also target the family support professionals delivering services to military families, ensuring they are properly trained to meet the needs of the military families they serve.[111] Other programs provide supplemental resources and materials directly to participating military families including child behavior tips, parent-child activities, self-care strategies, and strategies to support children through difficult periods of transition and separation.[112,113,114]

Overview of the Military Families and Veterans Prevention Program

In response to direction from the 84th Texas Legislature, the Prevention and Early Intervention (PEI) Division of the Department of Family and Protective Services (DFPS) launched the Military Families and Veterans Prevention Program (MVP) in 2016. The program was developed in order to serve military and veteran families who have committed, have experienced, or who are at a high risk of family violence and/or abuse and neglect. The MVP program was designed to serve the three largest military communities in Texas: Fort Hood in Bell County; Joint Base San Antonio in Bexar County; and Fort Bliss in El Paso County.

The overarching goal of the MVP program is to prevent child abuse and neglect through an increase in protective factors, resulting in stronger families and improved military communities. The specific aims of the program are:

- To improve the wellbeing of Texas military and veteran families by promoting positive parental involvement in their children's lives.
- To educate, facilitate, and otherwise support parents' abilities to provide continued emotional, physical, and financial support.
- To build a community coalition of local stakeholders who are focused on the prevention of child abuse and neglect.
- To prevent child abuse and neglect occurrences in military communities.

Communities were given flexibility to concentrate their resources to best fit the challenges in their region. For example, the communities vary widely in their veteran and active-duty populations. Each community, however, developed a comprehensive plan that includes:

- Evidence-based or promising practice programs;
- Performance measures that gauge program effectiveness;
- Programs with a focus on children ages 0-17; and
- An approach focused on the needs of military and veteran families, and the military culture and environment they live in.

Communities were further required to develop an official working relationship and partnership through a signed Memorandum of Understanding (MOU) with the local FAP office. The MOU was intended to establish open lines of communication; create processes and procedures to prevent duplication of services, and for making/accepting referrals between the two agencies; to facilitate the community MVP contractor's access to the military installation; and streamline a coordinated service delivery plan for the military community. Establishing MOUs with the FAP proved challenging, due to a number of factors detailed later in this report.

In addition to the promising-practice or evidence-based program, communities were required to provide at least one ancillary service based on the needs identified in their Community Needs Assessment. These ancillary services could include, but were not limited to: transportation,

education assistance, case management, parent support groups, respite care, and crisis intervention. A status update on each of the communities' progress can be found in Chapter 2.

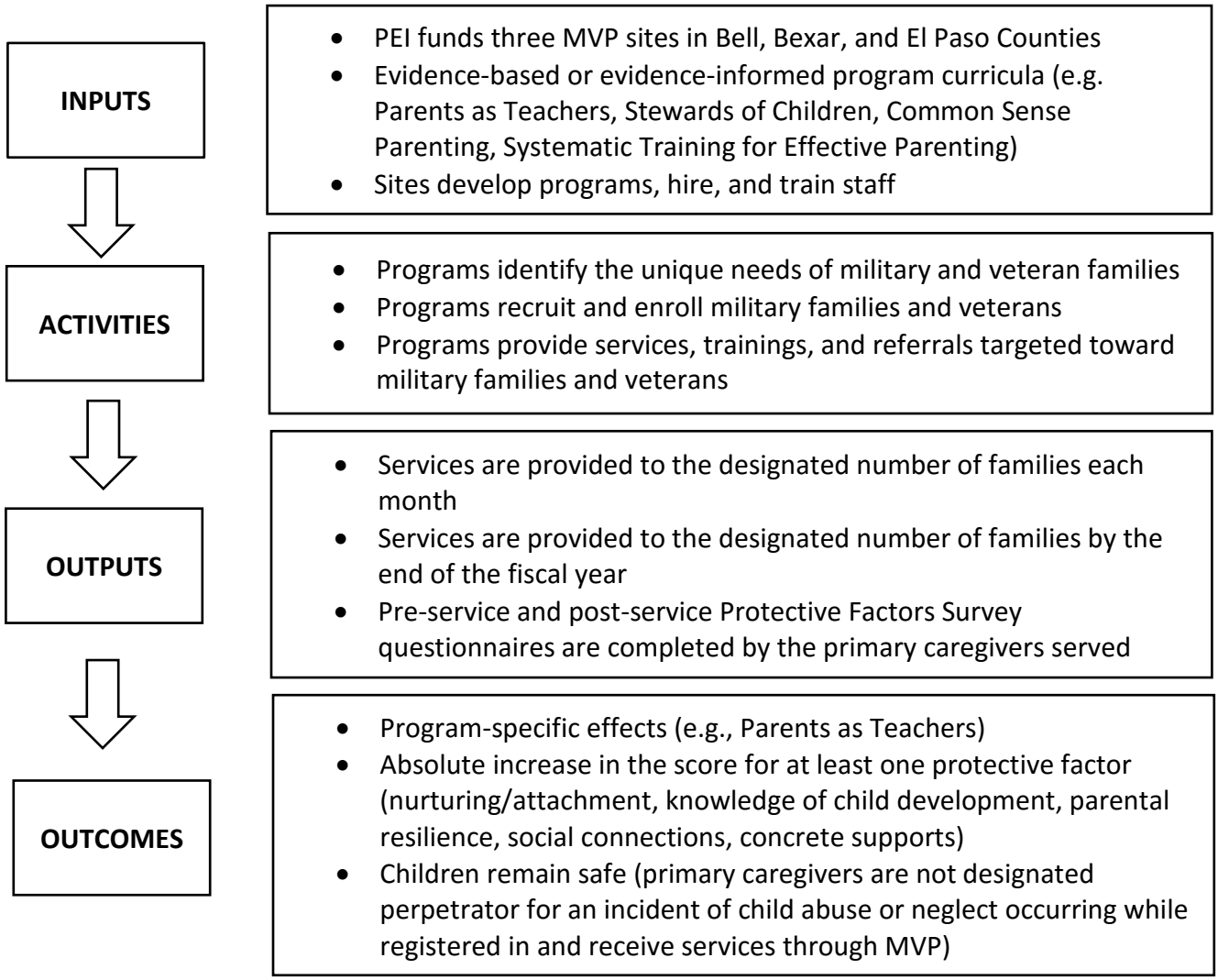
Overview of the Evaluation and Final Report

PEI contracted with the Child and Family Research Partnership (CFRP) to evaluate the effectiveness of the MVP program and determine how communities can best serve the unique needs of military and veteran families. Three overarching research aims guided the mixed-methods evaluation:

1. What are the unique needs among military and veteran families? How do needs vary among members of military and veteran families?
2. How do programs serving military and veteran families modify their recruitment strategies, service delivery, or other program elements to most effectively serve military and veteran families?
3. Do the programs increase protective factors among military and veteran families and prevent incidents of child abuse and neglect?

The logic model guiding the evaluation is shown in Figure 2.

Figure 2. Logic Model



REPORT OVERVIEW

This report serves as the final evaluation report by CFRP on the MVP program. Chapter 2 details community contexts and outlines the structure of the MVP program in each community. Chapter 3 of the report reviews the methodology. Findings from the evaluation are discussed in Chapters 4 through 6. Chapter 4 reviews the unique needs of military and veteran families. Chapter 5 discusses how the MVP program is meeting the needs of military and veteran families, including how communities modify program elements to most effectively serve families. Chapter 6 reviews evidence on how MVP programs are meeting PEI goals of increasing protective factors and preventing incidents of child abuse and neglect. In Chapter 7, we draw on these findings to provide policy recommendations and conclusions.

CHAPTER 2: THE MVP PROGRAM

Community Context

MVP was designed to target the three largest military communities in Texas located in Bell, Bexar, and El Paso Counties. A description of each community, including important community context relevant to MVP providers, follows.

BEXAR COUNTY

Bexar County is home to Joint Base San Antonio (JBSA), the largest joint base in the DoD. Joint Base consists of Fort Sam Houston, Randolph Air Force Base, and Lackland Air Force Base and is under Air Force jurisdiction.[115] These bases are home to more than 31,900 active-duty military and 40,500 dependents.[116] Bexar County is also home to a large veteran population – more than 155,600 veterans live in Bexar County.[117] Nearly 50,600 of these veterans are ages 17 to 44.[118]

Bexar County includes San Antonio, officially nicknamed Military City USA in 2017, due to the city's large and consistent military population.[119] In interviews, providers in Bexar County report serving a large veteran population and note that many families or military personnel may be temporarily relocated to JBSA for training, thus many families' stays in the area are temporary.

The community needs assessment for Bexar County identified several major areas of concern. Child Protective Services' (CPS) military unit in central Texas identified an increase in reported incidents of child abuse and neglect. The contractor reviewed local 2-1-1 data, which shows military families often call requesting assistance with basic needs, including food assistance, utility assistance, health services (e.g., Medicaid), and rent assistance.[120] Providers in the community also report problematic service fragmentation among providers, which creates barriers for families in accessing local resources.[121]

United Way of San Antonio and Bexar County (UWSA), the lead contractor for MVP in Bexar County, recently began implementing MISSION UNITED (MU), a military information and referral program the organization joined in November 2015. MU connects with local agencies and companies to identify for-profit companies that offer a discount to veterans and members of the military and non-profit organizations that have military- and/or veteran-specific programs. The MU program provides window decals for these organizations to place on their front door, with the objective of making resources for military and veteran families more easily identifiable.[122] Additionally, through the MU program, UWSA will be able to connect with other United Way programs working with the military to identify best practices, partner with other local military initiatives, and access a database allowing UWSA to track calls to military navigators, referrals, and follow up efforts.[123]

The county is also home to ReadyKidSA, a coalition of organizations investing in children early in life, by working to "create a comprehensive early childhood system that promotes the social,

emotional, physical, and cognitive development of children 0-8" and "providing parents and caregivers with the tools and resources to better support their families."[124] This coalition, partially funded through PEI's Texas Home Visiting program, provides a base level of existing support for families and young children, which MVP programs can build on and use as a network of support. UWSA leads the ReadyKidSA Coalition.[125]

EL PASO COUNTY

Fort Bliss, a U.S. Army installation in El Paso, is home to almost 26,400 active-duty military and more than 39,100 dependents.[126] El Paso County is also home to nearly 12,700 veterans.[127] Combined, these groups make up a large portion of the population of the city of El Paso. The location of Fort Bliss is also unique: it is a large military base situated in a major metropolitan area, on the U.S./Mexico border, next to Ciudad Juarez, a populous Mexican city. The local community needs assessment identified the county as predominately Hispanic, under-educated, and economically disadvantaged.[128]

The community needs assessment indicated that key stakeholders feel there is a lack of prevention services, support and education services, and behavioral health resources in the community.[129] Community stakeholders also expressed concern over the impact of multiple deployments on families in the area, including concern about single-headed household families created by the deployment of a parent, "isolated and stressed primary caregivers, and the introduction of an array of combat-related physical and emotional stressors" into family life.[130] In addition, other risk factors and barriers faced by families were identified, including: housing and food insecurity, poverty, unemployment and underemployment, low educational attainment, substance abuse, and mental health issues, among others. The mix of these community characteristics was described as resulting in "a community rich in culture, but limited in resources."[131] Community members surveyed by the contractor in El Paso identified parenting education classes, mentoring, and linking families to community supports (case management) as the three services most needed by military families.[132]

BELL COUNTY

Bell County is home to Fort Hood, a U.S. Army base home to more than 32,500 active-duty military and more than 49,300 dependents.[133] Providers in Bell County report that many families relocate to Fort Hood in preparation for the deployment of a family member. Fort Hood supports hundreds of thousands of individuals within the community (e.g., active-duty members, deployed members, retirees, survivors, family members; on-post population, such as on-post family members and civilian employees; and off-post family members).[134] Bell County is also home to nearly 49,400 veterans and nearly half of these veterans are ages 17 to 44.[135]

As a part of the community needs assessment for Bell County, an interview with Fort Hood Family Advocacy Program (FAP) staff identified a number of areas of need for the community, including: programming for teens and preteens (such as mentoring), employment and education services for civilian spouses, parenting programs, services for victims of domestic violence, housing

assistance, and tutoring. Local 2-1-1 data identified the top needs of military-connected callers as: utility, rent, and food assistance, as well as child care.[136]

Due to continued contracting issues between PEI and organizations in Bell County, which delayed MVP implementation at this site, this report will focus largely on the MVP programs in Bexar and El Paso Counties.

Program Structure

The following section provides details on the program structure within each community, including information on lead contractors, subcontractors, services provided, and the start of service. Details from this section are drawn from each community's response to PEI's request for proposals (RFP) for the MVP program. Details on service delivery were taken from the communities' quarterly reports.[137]

BEXAR COUNTY

In Bexar County, United Way of San Antonio and Bexar County (UWSA) was selected as the primary contractor, acting as the fiscal agent for eight subcontractors who provide all services to families. See Table 1 for details on subcontractors and the programs and services provided in Bexar County. The evidence-based programs included in Bexar County's menu of services are: Parents as Teachers, Common Sense Parenting, and Darkness to Light Stewards of Children Training. Bexar County's ancillary services provided include: mentoring (Big Brothers Big Sisters); a family hotline, websites of information (parenting.org, YourLifeYourVoice.org), BoysTown Press, PSAs (Boys Town Texas, Inc.); intervention services (ChildSafe); and services for basic needs and counseling (Family Services Association of San Antonio). An overarching goal of UWSA in taking on the MVP contract was linking providers along the continuum of care for military and veteran families in the areas, to reduce fragmentation of service delivery. Toward these objectives, UWSA set out to create a Services for Children of Military & Veteran Families subcommittee to the ReadyKidSA coalition. Subcontractors began to serve families in spring 2016.

Table 1. Subcontractors and Services Provided in Bexar County

Subcontractor	Program/Services Provided
Any Baby Can	Case management
Big Brothers Big Sisters	Mentoring
Boys Town Texas, Inc.*	Common Sense Parenting
The Children's Shelter	Parents As Teachers, iParent SA
ChildSafe	Darkness to Light Stewards of Children Training, counseling
Family Services Association of San Antonio	Parents As Teachers, counseling
Military and Veteran Community Collaborative	Training on cultural competency
Voices for Children	Outreach through training

**Note: The FY17 third quarter report from UWSA indicated that Boys Town was closing operations.*

EL PASO COUNTY

In El Paso County, the Child Crisis Center of El Paso (CCCEP) is the main contractor for the MVP program and provides the Systematic Training for Effective Parenting (STEP) program. CCCEP also subcontracts with Big Brothers Big Sisters to provide mentors to military-connected youth. Ancillary programs in El Paso County include case management, parent involvement activities, parent education, and transportation services. CCCEP uses a wraparound practice model (WRAP). In their response to PEI's RFP, CCCEP described the intent of WRAP as "to provide coordinated, holistic, family-driven care that is community-based and culturally competent."[138] Under the contract with PEI, WRAP is an ancillary service, although the program is considered an evidence-based practice by the Substance Abuse and Mental Health Service Administration (SAMHSA) and is included in their National Registry of Evidence-based Programs and Practice. In El Paso County, service to families started in spring 2016.

BELL COUNTY

To date, UWSA was acting as the fiscal agent for the contract in Bell County. STARRY is the main subcontractor and provides the Parents as Teachers (PAT) program, counseling services, basic needs support, case management, and group connections for PAT families. Ancillary services in Bell County include parent support groups, connections to individual or group counseling, and other services provided by STARRY. In addition, Boys & Girls Clubs of Central Texas also provides programs and services (STEM programming, college readiness classes, mentoring, outdoor activities, etc.) to military-connected teens. Subcontractors in Bell County began to serve families in fall 2016.

CHAPTER 3: METHODOLOGY

Data Sources and Measures

PEIRS DATABASE

The MVP program sites are required to collect and enter administrative data for each program participant into the Prevention and Early Intervention Reporting System (PEIRS) database. The PEIRS database contains registration information including demographic characteristics, service data (e.g., services provided, when and for how long families participated), and outcome data (Protective Factor Survey pretest and posttest data). CFRP analyzed these data to provide descriptive information on the programs and to assess outcomes.

The Protective Factors Survey (PFS) is a 20-item survey designed for use with caregivers receiving services for the prevention of child maltreatment. The PFS was developed in 2005 by the FRIENDS National Resource Center in collaboration with the University of Kansas Center for Public Partnerships and Research and with the input from a working group of Community-Based Child Abuse Prevention (CBCAP) program grantees, parents, researchers, administrators, workers, and experts in the field.[139] The PFS was designed to be used in the assessment of multiple protective and risk factors associated with child abuse and neglect.

The PFS measures caregivers' protective factors in five areas: family functioning/resiliency, social support, concrete support, nurturing and attachment, and knowledge of parenting/child development.[140] The PFS was administered to families participating in MVP twice: shortly before or at the start of the first service session and again at the end of service, "when the family meets the timeframe for completing per the performance measure."[141] In the survey, parents self-report the frequency that the PFS statements are true for their family or their level of agreement with the statements using a seven-point scale. A higher subscale score indicates a higher presence of the protective factor.

One of PEI's performance measures for the MVP program is that 75 percent of clients served by the program must demonstrate an absolute increase in the score on at least one protective factor subscale (family functioning/resiliency, social support, concrete support, and nurturing and attachment) between pretest and posttest.[b] The definitions of each protective factor, including the number of survey items in each factor subscale are shown below in Table 2.

[b] The PFS creators do not recommend calculating a knowledge of parenting subscale. For additional details, see the PFS User Manual (p. 24) available at https://friendsnrc.org/jdownloads/attachments/pfs_user_manual_revised_2012.pdf

Table 2. Protective Factors

Protective Factor	Definition
Family functioning/ Resiliency (5 items)	"Having adaptive skills and strategies to persevere in times of crisis. Family's ability to openly share positive and negative experiences and mobilize to accept, solve, and manage problems."
Social support (3 items)	"Perceived informal support (from family, friends, and neighbors) that helps provide for emotional needs."
Concrete support (3 items)	"Perceived access to tangible goods and services to help families cope with stress, particularly in times of crisis or intensified need."
Child development/ Knowledge of parenting* (5 items)	"Understanding and utilizing effective child management techniques and having age-appropriate expectations for children's abilities."
Nurturing and attachment (4 items)	"The emotional tie along with a pattern of positive interaction between the parent and child that develops over time."

Source: Friends National Center for Community-Based Child Abuse Prevention (n.d.). Overview of the Protective Factors Survey. Retrieved from https://friendsnrc.org/jdownloads/attachments/PFS%20Overview.pdf
Note: The PFS creators do not recommend calculating a knowledge of parenting subscale.

IMPACT DATABASE

CFRP also used data collected from the "Information Management Protecting Adults and Children in Texas" (IMPACT), DFPS's database for collecting and storing information about the children and adults the agency protects.[142] One of PEI's primary goals with the MVP program is to prevent child abuse and neglect within participating families and to ensure children are safe. A successful outcome measure of the MVP program will indicate that the primary caregivers are not designated as a perpetrator of an incident of child abuse or neglect occurring while registered in and receiving services through MVP. To examine the association between program participation and subsequent child abuse or neglect, CFRP analyzed data from IMPACT and the PEIRS database to identify recorded instances of child abuse or neglect for MVP program participants prior to, during, and after program participation. This allowed CFRP to identify families who are high risk (those with a history of child abuse and neglect), as well as whether or not families had a report of child abuse or neglect during or following program participation.

QUARTERLY AND ANNUAL REPORTS

PEI requires contractors and subcontractors to submit annual and quarterly reports on their progress. These reports are a key component of qualitative data analyzed for the evaluation. Quarterly reports include data on the number of families served by which branch they are affiliated with, collaboration with community and FAP partners, outreach and awareness, services available, service delivery, use of the PFS survey, major accomplishments and challenges, and volunteer support. Annual reports by communities include these subjects plus information on:

new initiatives, parent engagement and leadership, use of evidence-based programs, program strengths, program challenges, complaints, and reporting on output and outcome measures. Each community has submitted one annual report (for fiscal year 2016) and at least three quarterly reports covering through quarter three of fiscal year 2017.

INTERVIEWS AND FOCUS GROUPS

CFRP also collected qualitative data from interviews (through phone calls and site visits) and a focus group with program participants. Participants in these activities included contractor and subcontractor leads, program staff, and MVP program participants. Table 3, below, lists each qualitative data sources by community.

Table 3. Qualitative Data Sources by Community

Community	Qualitative Research
Bell County (Fort Hood)	• Reports: 3 quarterly, 1 annual • Calls: 2 with contract lead (9/2016, 3/2017)
Bexar County (Joint Base San Antonio)	• Reports: 4 quarterly, 1 annual • Calls: 1 with contract lead (3/2016) • Site visits: 3 with supervisors of subcontractors (9/2016, 4/2017, 5/2017) • Focus group with 12 participants (5/2017)
El Paso County (Fort Bliss)	• Reports: 3 quarterly, 1 annual • Calls: 3 with contract lead (4/2016, 9/2016, 6/2017) • Site visits: 3 with contractor (program staff: 7/2016, contract leads: 6/2016, 3/2017), 1 with subcontractor (7/2016)

Analytic Sample

The analytic sample for this study included data from 409 primary caregivers participating in the MVP program in Bexar and El Paso counties in FY 16 and FY 17. Insufficient data were available from Bell County to be included at this time. Demographic characteristics for the overall sample and by site are provided in Table 4. Approximately three-quarters of the sample are families at the Bexar County site and most primary caregivers participating in the program are the child's mother. The sample is largely Hispanic, married, and English-speaking and nearly one-quarter have a college degree or higher. Only one site difference emerged—a higher percentage of primary caregivers in El Paso were the child's father compared to primary caregivers in Bexar County.

Complete pre- and post-PFS data were only available for 131 primary caregivers. Analyses of PFS data are limited to these families. IMPACT data were matched with all 409 primary caregivers.

Table 4. Select Demographic Characteristics of MVP Analytic Sample

	Overall	Bexar	El Paso
Site (N= 407)			
Bexar	72.2%	--	--
El Paso	27.8%	--	--
Primary Caregiver (PC) Gender (N=409)			
Female	73.4%	74.8%	70%
Male	26.7%	25.2%	30%
PC Relationship to Child (N=364)*			
Mother/Stepmother	66.8%	66.8%	66.7%
Father/Stepfather	22.5%	19.8%	30.2%
Foster Parent	1.7%	2.2%	0%
Other relative	9.1%	11.2%	3.1%
PC Race Ethnicity (N=401)			
White, Non-Hispanic	27.4%	28%	25.5%
Black, Non-Hispanic	17.2%	16.3%	20%
Hispanic/Latino	48.4%	50.2%	44.6%
Other	7.0%	5.5%	10%
PC Education (N=359)			
Less than High School	7.5%	9.1%	3.2%
High School Diploma/GED	19.5%	18.5%	22.3%
Some College	46%	44.2%	51.1%
College Degree +	27%	28.3%	23.4%
PC Marital Status (N=356)			
Single, Never Married	9.0%	10.8%	4.2%
Married	62.9%	63.1%	62.5%
Separated/Divorced/Widowed	28.1%	26.2%	33.3%
PC Primary Household Language (N=361)			
English	96.1%	97.0%	93.6%
Spanish	3.6%	3.0%	5.3%
Other	0.3%	0.0%	1.1%

*Note. *Significant difference between Bexar and El Paso (p<.05)*

Data Analysis

The three research aims guiding this evaluation require both quantitative and qualitative data analyses. Changes in protective factors, measured through the Protective Factors Survey, required a one-group pretest-posttest design. This analysis allowed us to measure the change in outcomes between time 1 (near enrollment) and time 2 (at the end of the program, or after approximately one year of the program). To examine the association between program participation and subsequent child abuse or neglect, CFRP analyzed data from the IMPACT database to identify recorded instances of child abuse or neglect for MVP program participants both prior to and during program participation.

Information collected through quarterly and annual reports, focus groups, and interviews were coded using MAXQDA software. Researchers coded the data through an iterative process, conducting thematic analyses. Examples of the coding themes and sub-categories are presented in Table 5. The information is coded first for large themes (e.g., does the information relate to recruitment, unique needs, program goals, etc.) and second for more specific themes (e.g., does the information provide insight about how recruitment of a military-connected population varies from the recruitment of the civilian population?).

Table 5. Coding Methodology for Qualitative Data

Coding Theme	Sub-Categories
Recruitment Strategies	Challenges (lack of information available, buy-in and connections at military bases, stigma and trust issues); differences in strategies: civilian vs. military families; outreach/recruitment strategies (community outreach, how participants report finding programs)
Unique Needs of Military Families	Military life schedules, deployment, isolation; military families with multiple needs; differences in needs between military and veteran families
Program Modification	Similarities to serving civilian families; strategies for catering to military population
Meeting Program-Specific Goals/Outcomes	Collaborating/coordinating with partners; enrollment and waitlists; outcomes and participation; retention; program purpose; service delivery (leadership and staffing, special populations, importance of military connection, challenges of service delivery)
PEI Program Goals	Program impact on child abuse and neglect, program impact on protective factors
Other/Misc.	Unmet needs/missing services; difficulties with finding/receiving services; program training: activities and needs; funding; why organization took the contract; retention; leadership changes

Data Limitations

Pretest-posttest designs without a comparison group, as used to measure changes in protective factors, are susceptible to multiple sources of bias. First, internal validity can be threatened by maturation, or changes or growth that would have occurred naturally regardless of participation in the program. A second potential source of bias that threatens any self-reported data, is social desirability bias, or the tendency of survey respondents to answer questions in a way that will be viewed favorably by others.[143] Social desirability bias can be particularly concerning for pretest-posttest designs if participants over report "good behavior" on the pretest, but are more realistic on the posttest (participants may feel more comfortable responding truthfully or accurately after developing a rapport with the program providers). If this bias occurs, regardless of whether the participant's behavior actually improved, the change in behavior reflected in the pretest and posttest scores may be negligible, or worse, the opposite of what was intended by the program. Evidence of social desirability bias was reported by MVP providers and is discussed in greater detail in Chapter 6.

These biases, combined with serving only a fraction of the military community at each site for a short period of time, make it difficult for the programs to demonstrate large increases in protective factors and decreases in rates of child abuse and neglect. As such, this evaluation was designed to primarily focus on the unique needs of military and veteran families, how programs can successfully recruit, engage, and retain military and veteran families, and what modifications to program curricula or design are important for meeting the needs of these families.

CHAPTER 4: THE UNIQUE NEEDS OF MILITARY AND VETERAN FAMILIES

Intervention, Not Prevention

Military and veteran families face challenges that are often distinct from the challenges faced by civilian families. As detailed in Chapter 1, military families face frequent moves; isolation from friends, family, and broader communities of support; challenges associated with separation and deployment (e.g., PTSD, increased stress, challenges of reintegration); and many parents are young with young children. Despite varying contexts at each MVP site, the needs of military and veteran families varied little across the sites. Service providers in each MVP program shared similar insights into the challenges facing military and veteran families.

Many providers were surprised by the breadth and depth of intervention, rather than prevention, services needed among military and veteran families. The most surprising was the number of military and veteran families who need assistance meeting their most basic needs, such as housing (especially for veterans) and utility assistance; reliable transportation and child care; items such as car seats, school supplies, and medical supplies; and even food. However, because their incomes are often slightly above the eligibility thresholds, many of these military and veteran families do not qualify for federal and state benefits that could provide crucial support. One focus group participant commented about financial struggles: "A lot of people don't understand military. I don't like the stigma of everybody. Growing up, people were like 'Oh you've got money, you're rich because your dad is in the military.' And I'm like, 'No, we struggle.'"

When military and veteran families are connected to local resources, they enter the same waiting lists as the general public, which often lack sufficient funding to meet the needs of those who require assistance. Providers frequently cite the financial strain that military and veteran families are under, particularly lower-ranking members of the military. One provider in Bexar County identified a "common misconception that just because you are in the military, you have access to all sorts of services." One focus group participant commented: "A lot of the military…already struggle with financial issues and things like that because they say they give us enough to live off of, but basically you have to have like no phone, no car."

Varying Needs among Military Family Members

NEEDS AMONG ACTIVE-DUTY OR ENLISTED MILITARY

The deployment of active-duty service members creates challenges for military families. Two Texas communities have faced deployment in recent years – Fort Hood in Bell County and Fort Bliss in El Paso County. Deployment imposes stresses on military families related to separation and combat stressors, and the challenges of reintegration for families.[144,145] One provider noted that they often dealt with young parents with inadequate skills to handle the challenges of everyday life, exacerbated by deployment. Additionally, providers note that active-duty service

members have a need for mental health services, a need that is shared with veterans. Active-duty service members also have difficult schedules outside of deployment due to training and/or work schedules, which can interfere with their ability to receive services (e.g., attend parenting classes). One focus group participant highlighted the stigma that active-duty military members feel when seeking services and the challenges they face when trying to participate in MVP programs: "Then you have to schedule your work time around the time they can come and then your job will hate that you have to take time off for that, so you are risking your job."

NEEDS AMONG VETERANS

Veterans and their families have needs that are distinct from those of active-duty families. Providers in Bexar County report a large veteran community that is largely disconnected, meaning that veterans may lack access to resources to assist with their needs. According to some providers, dishonorably discharged military personnel have some of the highest needs, including assistance navigating the criminal justice system, financial support, and access to mental health or substance abuse treatment. Because of their status, they are unable to receive many of the supports the military offers to veteran families, and often must navigate systems on their own. Providers frequently noted veterans' housing challenges: veteran homelessness is particularly a problem in Bexar County and many veterans are in need of housing assistance, especially with rent and utilities. For families transitioning from military service to civilian life, providers noted that assistance with employment, mental health services, and housing are needed.

Providers also reported that veteran families do not have access to the same military-sponsored services and supports available to many active-duty families, thus face more challenges in meeting needs. One focus group participant highlighted the challenges of navigating the health care system, noting the difficulty in receiving services through VA medical centers. Other focus group participants noted the difficulty finding services to meet their needs: "You have to be looking. No one is going to give you a pile of papers when you retire and say, 'here, look this is what you're going to need to survive.'" Another participant echoed this sentiment: "They should provide you with it on your last day of service. 'Here is a package that is going to help you.' But they don't."

NEEDS AMONG MILITARY-CONNECTED FAMILY MEMBERS

Two of the most frequently cited needs of spouses of active-duty service members are child care, including respite care, and social support. When service members are separated from their families (e.g., during deployment, training), the civilian spouse is left as the only parent in the household, taking on numerous responsibilities on their own. Child care was mentioned as a need in all three counties as it could offer military spouses a chance to attend parenting classes, seek/receive other support services, or simply offer a brief time for the parent to relax. Feedback from the focus group of program participants indicated that a desire among military-connected parents was a night out for a break from family and work responsibilities.

Providers also expressed concern about military spouses' lack of social support networks. When military families move frequently, social networks are often lost and take time to rebuild in a new place. Military spouses may be located far from family and friends, and this may be exacerbated if a spouse is separated due to deployment or training. One participant in a focus group reflected on transferring locations: "so again I'm going to be in a place where I don't have anybody." Commenting on parents' need for social support, one focus group participant noted that support was needed "especially if you don't have family around, because like here, I don't have a family and my son is special needs so it's a struggle…It's sometimes just having someone to talk to or having five minutes by yourself." Frequent relocations can also be particularly challenging for military-connected family members when they have health issues. One focus group participant cited the difficulty with maintaining consistency of care or even just transferring medical records across military stations.

For spouses who separate from or divorce an active-duty spouse, financial assistance is also needed. One provider noted that they "continue to see a trend of military spouses who are separating from their spouses, unable to get the support they need because most are unemployed and undereducated or do not have access to the service member's paperwork."

The concerns of MVP service providers with regard to military-connected youth echo the challenges indicated in the research literature on military youth. Frequent moves – experienced as often as every two or three years and more frequently than youth in civilian families[146] – can be challenging by upsetting family routines, disrupting schoolwork and education, causing discontinuities in health care, and "isolating children from family and close friends," something that may be especially difficult for adolescents at a stage when peers are especially important.[147] Difficulty making friends may even lead to bullying, a concern brought up by providers in El Paso County. Deployment can also impact military-connected youth. Contractors and subcontractors reported recent deployments in two MVP communities. Research finds that deployment can be a time of stress and uncertainty[148] and is associated with increased internalizing and externalizing behavior problems, difficulty in school,[149] and increased home responsibilities.[150]

Unmet Needs Can Become Risk Factors

Providers and program participants agree – many families receive valuable services through MVP, however, families still have unmet needs. In El Paso County, providers report a need for an on-base shelter in cases of child maltreatment, financial planning and budgeting courses for families, utility and rent assistance, and legal assistance. In Bexar County, providers repeatedly highlight an extensive problem with veteran homelessness. Providers also note families' needs for affordable child care and respite care, social support, and psychiatric services. Some providers report that families seek services that do not exist – such as free child care and furniture. In Bexar County, providers report that although "Military Navigators are often successful in finding resources for families, it is important to mention that the available funding to support basic needs services is limited and military families enter the same waiting list as the general population, with funds often running out early each month."

The MVP program has highlighted the multitude of challenges and stressors facing military families. Although the program works to meet many of these needs, many needs remain unmet because of unavailable or inaccessible resources. One provider in Bexar County noted, military families "have the same needs as so many other [civilian] families, so they have to get in the same line for the limited resources as everyone else." Unmet needs, particularly basic needs, remain significant sources of stress in military families' lives and contribute to the rising risk of child maltreatment. Another provider in Bexar County articulated a challenge of service delivery was "understanding and being prepared for the depth of the challenges and issues these families have. You can't have high volume caseload. This is family stabilization, not family visitation."

Summary

The breadth and depth of intervention, rather than prevention services needed among military and veteran families surprised many providers across the MVP sites. The most surprising was the number of military and veteran families who need assistance meeting their most basic needs, such as housing (especially for veterans) and utility assistance; reliable transportation and child care; items such as car seats, school supplies, and medical supplies; and even food.

The evaluation also identified needs unique to different groups of military and military-connected populations, such as: active-duty members – deployment, veterans – homelessness and mental health, spouses – child care and social support, and youth – frequent moves, among other needs identified for each group. Providers and program participants agree – many families receive valuable services from MVP providers, however, families still experience unmet needs. These unmet needs are a source of stress in the lives of military and veteran families and may contribute to increased risk of child maltreatment.

CHAPTER 5: SERVING MILITARY AND VETERAN FAMILIES

How the MVP Program Supports Military Families

MATCHING SERVICES TO FAMILIES' NEEDS

In each of the MVP communities, programs aim to serve the needs of the military population in their area. The most prominent challenge highlighted for active-duty military members was deployment. Programs offering counseling, psychiatric and mental health services, and even parenting classes may offer benefits to active-duty members returning or preparing for deployment. Although it may be difficult for active-duty members to participate in these programs (e.g., due to deployment, training, work schedules), they may still reap benefits from the participation of a spouse or other family member in these programs. For example, if a spouse is taking a parenting class, knowledge from the class can be shared with the active-duty partner at home. Additionally, providers report making an effort to target E6 and E7 soldiers (mid-level enlisted ranks) for program participation, to give unit leaders knowledge of the resources available to subordinate soldiers.

Meeting the needs of veterans appeared to be the most difficult for providers. The needs of veterans reported by providers were severe, including homelessness and mental health problems. Providers report making an effort to serve veterans by connecting veterans to MVP programs or other programs within the community. Unfortunately, providers reported that waiting lists for mental health and psychiatric services are long. In Bexar, where there is a large veteran community, providers highlighted difficulty serving some veterans because of a less-than honorable discharge status, making them ineligible for a range of services available to other veterans or active-duty service members.

Many of the MVP programs seemed the best equipped to serve military-connected family members, including spouses and children. A range of services in MVP communities target these groups: parent education, counseling, mentoring programs, programs for families of children with special needs, case management, and wraparound services. Many of these programs simultaneously meet the needs of these populations, while also making efforts to achieve overarching PEI program goals of increasing protective factors and keeping children safe.

SERVING FAMILIES: MEETING NEEDS BY MODIFYING PROGRAMS VS. MODEL FIDELITY

One of the research questions of this evaluation centered on whether providers modified programs to better fit the needs of military populations. In both Bexar and Bell Counties, most providers did not report modifying program content to more effectively meet the needs of families. Rather, programs reported that many programs continued with "business as usual," but additional funding through the MVP program allowed for expanded and targeted outreach efforts to recruit military families to participate in existing programs.

When providers did modify their program to fit the needs of military and veteran families, modification largely centered on accommodating the schedules of active-duty service members and their families. One provider offered lunch with the programming to make it easier for military and veteran families to attend during their lunch breaks. Another provider, aware of the difficulty active-duty service members face in committing to an extended program, tried to adapt a 7-week class into an all-day class for 7 hours to meet the needs of active-duty military who cannot commit to a 7-week class. The model developer did not approve of these changes, due to concern over fidelity. Instead, the model developer suggested two classes per week, maintaining time for application of the material between chapters, but also allowing for the program to be condensed into a shorter time period.

Providers reported using several strategies to make their programming more accessible to military families in response to special needs, such as lack of transportation or child care. In some cases, parenting programs were delivered in home, one-on-one to ensure families were retained in a program. Providers report offering services on the weekend and during the evening "after hours" to accommodate those who are working or otherwise busy during the daytime. Finally, providers in El Paso report that Socorro Independent School District developed a plan allowing STEP programs to be delivered at school, with the objective of delivering the program in a convenient location closer to home. The school district also offered to provide food for families in attendance, if held at the schools.

PROGRAM SUCCESSES

Providers shared feedback from parents and program staff on the early successes of the programs. A parent in Bexar reported that a parenting program that brought another adult into the house was nice, because she had another adult to talk with who understands what she is going through and can who act as a confidential source of support. Positive feedback and signs of success for parenting programs included a desire of parents to continue participating even after the parenting class had ended, the ability of participants to self-reflect on strengths and weaknesses as parents, and parents' developing and building an array of parenting skills, such as stress management, self-control, building positive relationships, and communication, among others. Providers report that at the start of services, families seem reserved and reluctant to participate. However, within a few sessions into a parenting class one provider in El Paso County noted, "they start to see the sessions are working…they see their family is happier or that they are getting along with their spouse better. They also see that they aren't the only ones going through this."

Another provider shared a success story of a parent experiencing domestic violence, who was unemployed, lacked child care and social support at the start of services. After receiving services through MVP, this parent was employed full time, moved into a new home, re-enrolled in school, and has child care; she credits her success to the MVP program. Providers also report benefits to families through their participation in programs for children with Autism and healthy living programs, referrals to outside agencies able to assist families in meeting basic needs, and

participation in prescription assistance programs, aiding families with children who have special needs. Providers also report that they are available to families in times of crises – seeking to meet families' most basic needs and connect them to resources in times where intervention, not prevention is needed. One provider in El Paso highlighted that "the WRAP program is what I think is truly beneficial…long-term results come out of the WRAP program."

Challenges Supporting Military Families

MVP PROGRAMS CONTINUE TO FACE BARRIERS TO RECRUITMENT

Despite success in serving families and meeting identified needs, contractors and subcontractors routinely acknowledged that recruitment and referrals are a major program challenge. The most common barrier to recruitment reported by providers in all three communities were issues of privacy, confidentiality, and stigma around seeking help. Within the military, needing to rely on social service organizations is often perceived as a weakness or dependency; seeking services on base can affect prospects for job security and promotions because the information is not confidential and is placed in soldiers' records. As a result, military families face stigma for accessing help from outside the military or from known social service organizations, such as Child Protective Services (CPS), Army Community Services (ACS), or the Family Advocacy Program (FAP). Parents attending the focus group said it was important for services to be off base and that there was less stigma for the spouse to receive services. Providers noted, however, that even if services are offered off base, families still feared that their participation was not confidential and would have negative consequences, despite program staff's repeated assurances of confidentiality.

Underscoring this point, one of the providers noted that the program in their community that was having the greatest success recruiting families served children with disabilities, because a disability is perceived as not being the family's fault, and does not have the same stigma attached to it. Similarly, success was reported with recruiting for youth mentoring programs, as one provider noted that families felt there was "not shame in admitting that a mentor could help an older child." Staff in both El Paso and Bexar Counties also reported that being affiliated with certain organizations or agencies could inhibit their ability to recruit families, since families perceive the program as being only for families in crisis or in need of CPS, further contributing to the stigma. One provider said that they created special ID badges that did not include the names of their organizations for when staff were working on the military installations. Providers also sought to erase the stigma of accessing help outside of the military by trying to connect with the families and show that they genuinely care and want to help. They reported that this process of building trust with the families can take a long time, up to a year of regularly visiting with them at their homes to see how they are doing. Despite efforts to build trust, providers continue to report concerns around stigma and confidentiality related to recruitment and retention.

Programs reported that on-base access is critical to recruiting families, but could be difficult: sponsors are needed to get on base, military staff were not always supportive of programs'

efforts, and programs faced difficulties when active-duty staff on base changed and connections needed to be reestablished. A supportive on-base military staff that buys in to the value of the MVP program services made recruitment much easier.

Providers also highlighted other barriers to recruitment. For example, providers reported challenges due to a lack of knowledge and understanding of military culture, a lack of knowledge of the right people to network with within the military communities, internal staffing transitions, as well as the duration of some MVP programs. For example, one program found that families were hesitant to commit to a year-long parenting program and had greater recruiting success when describing the program as "bi-weekly parenting program that can go up to one year."

Recruiting veteran families also proved challenging. One community reported difficulty recruiting veteran families because many veterans in their area tended to be older, past childbearing ages, or have adult children, making them ineligible for many MVP services. Other providers noted that it can be difficult to identify veteran families, because they do not live on base and their children are not identified by their schools, unlike the children of active-duty service members. This is especially concerning, because veteran children may be at the highest risk of need, given the high proportion of veterans who have PTSD. One participant in a focus group of individuals receiving MVP services reported that there was a lack of knowledge within the community about MVP programs and the services provided to military and veteran families. Some providers also reported difficulty finding target populations for their primary evidence-based intervention. For example, a provider in Bell County reported receiving referrals from the FAP, but that these referrals tended to be for children who were too old for PAT, but were eligible for other services.

PROVIDERS' STRATEGIES FOR SUCCESSFUL RECRUITMENT

Providers reflected on the importance of knowing how to frame and "sell" the program to military families, keeping in mind the cultural differences that make it difficult for military families to ask for or use this kind of program. One strategy is to positively frame the program's image or message for the military culture. For example, one provider described their program as a "strength-based" program, in which the program works with the family as a team to help them use their current resources toward their individual family goals. This approach appeals to military families who do not want to rely heavily on outside resources or case management. Another provider suggested reaching out to veterans by describing the programs as another way to serve their country.

Another strategy that providers employ is tailoring their message to their audience. For example, one provider reported changing the way they describe the program based on their knowledge of the families they were recruiting. They differentially emphasize specific aspects of the program, such as parenting classes, strength-based wraparound services, and/or case management depending on their audience. Other programs hold "give-aways" for families where they distribute car seats and school supplies, to help them connect with and recruit military and veteran families by meeting their needs.

In a similar vein, providers know the logistic challenges of serving active-duty members of the military. Their on-base commitments and frequent deployments make it difficult for providers to meet with them consistently. Instead, providers often sought out the military-connected spouses and youth for their programs. Not only are family members of active-duty military members more available for services, they also face less stigma for needing and receiving services.

Providers often highlighted the importance of military connections for successful recruitment. One provider felt that military connections among their MVP program staff were critical to successful recruitment because this connection provides access to people in a different way and establishes trust with families more easily. Military connections of program staff were also important; providers reported recruitment success through on-base programs such as the New Parent Support Program, through engaged staff on base (e.g., chaplain), and through military liaisons at local schools.

Several providers reported that traditional outreach methods were used, but were "stepped up" because of programs' desire to serve military families. For example, providers recruited through schools, churches, military events, child care and Head Start centers, and other organizations within the community. Subcontractors in Bexar County reported a collaborative attitude and referrals between MVP programs. These subcontractors reported that word of mouth was very important to successful recruitment. This echoes findings from a focus group of parents receiving services through MVP programs: participants reported hearing about programs through Facebook and other social media, as well as organizations such as Operation Homefront and Wounded Warriors.

DIFFERENCES IN RECRUITMENT STRATEGIES: MILITARY AND VETERAN VS. CIVILIAN FAMILIES

Generally, providers did not report using distinct recruitment strategies for military families as compared to civilian families. Many traditional outreach methods were used, although programs incorporated more military-specific events or reached out to military-connected organizations and individuals. Providers often reported that connecting with military families was often more difficult than connecting with civilian families, reporting "you have to know the language" and "you have to go to the right places and talk to the right people." Another program noted that "a little more courtship" was required for recruiting military families as compared to civilian families. However, once military families were enrolled in the program, providers reported that they tended to be more likely to actually participate.

RETENTION NOT YET AN ISSUE

Overall, many providers reported not yet having issues with retention, due in part to the hard work of dedicated staff. Providers did highlight, however, the challenges that can limit military families' engagement with the programs. Active-duty service members are typically unable to commit to long-term or extended programs due to demanding military schedules, field-training requirements, and the need for permission to be off base from commanding officers. Deployments and frequent moves can also interrupt program commitments. Families may face

additional stressors during these times and find program participation difficult. Providers at Fort Bliss and Fort Hood have both reported major deployments, which cause difficulty for service delivery and retaining participants in programs. Fort Bliss is also a large training site, therefore may have active-duty members arriving alone without their family and only residing on base for duration of time that is not long enough for full program delivery.

Providers also identified unmet needs of military families, such as transportation and/or child care as barriers to participation. Providing transportation vouchers or options would increase the programs' ability to reach people, given that some spouses do not drive, lack reliable transportation, and/or live in areas without public transportation. Offering low-cost (or free) child care during parenting classes or events would allow parents who have deployed spouses, single parents, or parents who lack social supports to attend programming.

In addition, the time required to travel to service providers and the lack of transportation present what can be insurmountable barriers to participation. One provider identified that some families enroll in a parenting program in order to receive WRAP services. However, when families seek only services ancillary to the parenting program (e.g., the flex funding that programs have available to use as financial assistance), they are less likely to remain engaged in the main parenting program and instead will drop out after receiving other services.

LEADERSHIP AND STAFFING CHANGES CREATE ADDITIONAL CHALLENGES

Leadership and staffing changes within the organizations providing services to families and within the military at the local installations can disrupt or stall recruitment and service delivery. Staff turnover, which is ubiquitous across social programs, occurred in both El Paso and Bell counties. In El Paso, the Executive Director of the primary contracting organization resigned for a new position, the project director changed twice, the parent educator left, but has since returned, and the outreach coordinator left. In Bell, the project director has changed and a number of contracting issues led to delays in hiring and training of staff.

There is some variation in how providers report that staff turnover affects recruitment and service delivery. At times, providers reported that service delivery was affected by turnover among program staff. However, at other times, providers reported that other staff have been able to step in and fill gaps in service delivery until new program staff are hired. However, providers more frequently report that staff turnover, particularly in outreach positions, impede program recruitment efforts.

COLLABORATION AMONG MVP PARTNERS IS MOSTLY SUCCESSFUL

None of the MVP communities reported major challenges coordinating with contractors and subcontractors. In both El Paso and Bexar, providers reported collaborative attitudes. Providers used joint branding on materials, rather than using individual organization names. Another provider reported, "Our greatest strength this first year has been the ability to collaborate and work as a team." Particularly in communities with several subcontractors, where there might be

potential for competition among MVP providers to recruit families. Communities generally reported positive experiences collaborating with partners, although one provider did note that opportunities for collaboration outside of monthly supervisors meetings were limited.

One collaboration challenge that providers did highlight was around the way providers are contractually obligated to count families in programs. Families may enroll for services with one provider, but also need services offered by a different provider. Although the second provider can serve those families, they cannot count those families towards their numbers for PEI because the families are already enrolled in a different program with another MVP provider. As a result, this system either discourages providers from spending the necessary time or effort on a family that can only be counted by another program or motivates competition between organizations that should be working together to provide comprehensive services to families and their children.

MIXED SUCCESS COLLABORATING WITH LOCAL MILITARY INSTALLATION

The communities vary in their relationship with their local military installation. During the course of building and launching their MVP programs, communities needed to understand how to work with the FAP at the post or base to serve the military and veteran community. Providers reported some difficulty trying to determine who to contact at the FAP and how to build relationships there. Some hypothesized that the FAP may be lacking resources and connections to the military community, since they provide so few referrals. Another provider suggested that the FAP may not have the right staff to support families, and that some FAP staff have been there for so long that they are not aware of the needs of contemporary military families.

In Bell County, the Family Advocacy Program (FAP) at Fort Hood voiced support for the MVP program from the beginning. The FAP is a part of Bell County's coalition and has provided several referrals. In El Paso County, Fort Bliss and the city of El Paso have been well integrated for many years; there was initial resistance from the FAP that has largely dissipated. The MOU with Fort Bliss was slow to process, but providers report a positive relationship after the MOU received approval from the Garrison Commander. Providers in El Paso County have received referrals from the New Parent Support Program (NPSP) and Victim Advocacy from the FAP. In addition, program staff with NPSP have allowed the outreach specialist with MVP to accompany home visitors to meetings for new client enrollments. Providers have also formed a working relationship with the Army Community Services (ACS). Families who seek more confidentiality in receiving services are being referred by ACS to MVP providers. During the third quarter in FY17, providers reported that "our strongest collaborative partner this quarter was Army Community Services," signaling positive relations on base.

In Bexar County, the Joint Base San Antonio includes both an Army post and two Air Force bases, and providers faced initial challenges in developing a relationship with the FAP. The FAP initially requested that the United Way provide data on which specific families are served, but the United Way, committed to the privacy and confidentiality of the families they serve, did not agree to the request. The two parties have since come to an agreement on sharing aggregate

data on families served. Providers reported a positive relationship with JBSA – ChildSafe trained staff at JBSA, military navigators connected with the FAP, and the Family Service Association was invited to attend "New Comers" briefings at Fort Sam Houston. As of the third quarter of FY17, an MOU with the FAP has yet to be formalized. Providers reported that FAP staff at the JBSA are moving offices and the MOU between FAP and United Way is a low priority until the completion of the move. Without an MOU, providers in Bexar County have had difficulty gaining access to the base.

COLLABORATION WITH COMMUNITY PARTNERS IS KEY

MVP providers also partner with a diverse array of organizations within their community for outreach, recruitment, and service delivery. For example, providers report partnerships with local school districts by offering classes at local schools to be more conveniently located for parents. These partnerships have been beneficial both for recruitment (through a military liaison) and service delivery. Local partners have also provided financial assistance and in-kind donations. In Bexar, providers were able to connect with their local PBS station (KLRN) and participate in their early childhood events to connect with military and veteran families. Providers also report partnering with local and state government organizations, charities, the USO, veterans organizations. Some providers have formed or joined military coalitions in their areas. These connections have allowed providers to spread the word about their own programs, while also collecting information on services in the community that may be beneficial to the families they serve.

CHANGING MILITARY LEADERSHIP OFTEN DISRUPTS PROGRESS

Frequent relocations also impact the ability of the community providers to maintain relationships with officials on base (or post). It can take several months for the community providers to develop strong, trusting relationships with high-ranking officials at the local military installation. The hard work invested in developing relationships with high-ranking officials becomes null as soon as a transition occurs and new staff arrive at the installation. Community providers have to start over building new relationships. These issues can present problems for access to the base, which is essential for both recruitment and promoting active engagement among families. On-base service delivery challenges have also been reported due to issues regarding base access. For example, the FAP at JBSA in Bexar County has not yet signed the MOU agreement, meaning that MVP program staff only receive one-day visitor access. This limitation in access creates problems in recruiting and retaining families and would be eased if MVP providers had permission for long-term access to JBSA.

MILITARY CULTURE COMPLICATES SERVICE DELIVERY

Programs also report that stigma around asking for help also affects program participation. Military culture often promotes self-sufficiency and families' reluctance to seek help may limit their engagement in programs. Providers reported that privacy and confidentiality issues surface during program delivery. Clients, particularly active-duty members, may be reserved for fear of

information being reported back to superiors on the base or may be slow to open up due to the private nature of many families on base. Some providers have found that military connections of program staff eased these issues somewhat: military-connected staff "know the language" of the military better and families may feel more comfortable knowing military-connected staff understand and share their experiences. One focus group participant, a military spouse, highlighted how helpful the military experience of a provider who was retired military and married to an active duty service member was: "it helps a lot. Like a lot of the things that I was going through [she] was able to connect with me."

MILITARY FAMILIES' NEEDS INTERFERE WITH SERVICE DELIVERY

Providers have also identified needs of families that act as barriers to participation. Transportation and child care are frequently cited as critical needs of families. In addition, providers in Bexar noted that many families are struggling financially, but have incomes high enough they do not qualify for public assistance. Families are in need of assistance with food, housing, utilities, transportation, and mental health services. Families with children with disabilities also reported unmet medical assistance needs. Veteran homelessness was also cited as a challenge in Bexar County. Providers needed to respond with crisis intervention, not prevention services for these families. Providers reported that "the critical issues of families who are seeking basic needs often outweigh the importance of their participation in our programs and it becomes difficult to keep families engaged when they are so vulnerable."

STRUCTURAL AND CONTRACTUAL BARRIERS COMPLICATE SERVICE DELIVERY

Challenges to service delivery due to structural or contracting issues were also reported. Providers report frustration with how families are counted – only one MVP subcontractor can count a family receiving services, even if a family is in need of and receives services from another MVP subcontractor as well. Providers also expressed a desire to provide ancillary services, such as wraparound services, but were limited in the provision of these services by how families entered onto caseloads or by the duration of primary, evidence-based programs on their contracts. For example, in El Paso, once a participant completes the post-PFS at the conclusion of parenting programs, providers reported no longer being able to report the additional WRAP services families receive in the PEI database.

Providers in Bexar and El Paso Counties also report the following challenges: stigma attached to particular organizational names or logos, challenges compensating staff due to state regulations, long or burdensome administrative processes (e.g., MOU approval, background checks, and paperwork), funding shortfalls at subcontractors, and difficulty delivering services during weekday hours to families who are employed or seeking employment. In addition, Bell County experienced some challenges in service delivery due to delays in staff training for all populations eligible to receive the PAT program. UWSA also recently received notice that Boys Town will be closing Texas operations and may face service delivery challenges going forward as their clients transition to receiving services from other MVP providers.

Summary

In each of the MVP communities, programs aim to match services to the diverse needs of the military population in their area. Many of the MVP programs seemed best equipped to serve military-connected family members, such as spouses and children, rather than active-duty service members and veterans. The MVP communities target military-connected spouses and children, simultaneously meeting the needs of these populations, while also making efforts to achieve overarching PEI program goals of increasing protective factors and keeping children safe.

One of the research questions of this evaluation centered on whether providers modified programs to better fit the needs of military populations. Two counties reported operating "business as usual," with additional funding through the MVP program allowing for expanded and targeted outreach efforts in order to recruit military families to participate in existing programs. When providers did modify their program to fit the needs of military and veteran families, modification largely centered on accommodating the schedules of active-duty service members and their families.

MVP programs continue to face barriers to recruitment. Most commonly reported by contractors and subcontractors are issues of privacy, confidentiality, and stigma around seeking help. Challenges recruiting families were experienced by providers both on and off base, although buy-in from military leaders and base staff reduced recruitment barriers. Providers also reported challenges in recruiting veteran families, as their children are often older and families of veterans may be harder to identify. Many providers reported utilizing traditional outreach methods, but modifying them by changing the framing of the program to match values in military culture and tailoring their message to specific audiences. Military connections of MVP program staff were often important in building trust and connections with families during the recruitment process.

Overall, many providers reported not yet having issues with retention, due in part to the hard work of dedicated staff. However, providers reported retention challenges related to work and training schedules of active-duty service members, deployments, frequent moves, and the unmet basic need of families, especially transportation and child care. The length of several of the evidence-based programs ran counter to the transient nature of military families, meaning families often moved before completing the program.

Leadership and staffing changes within the organizations providing services to families and within the military at the local installations can disrupt or stall recruitment and service delivery. At times, providers reported that other staff have been able to step in and fill gaps in service delivery until new program staff are hired. However, providers more frequently report that staff turnover, particularly in outreach positions, impede program recruitment and service delivery efforts.

Community collaboration is an important part of the MVP program. None of the MVP communities reported major challenges coordinating with contractors and subcontractors and

the communities experienced mostly successful collaboration among MVP partners. However, communities found mixed levels of success in collaborating with local military partners. Communities often faced challenges formalizing collaboration efforts. However, in communities where partnerships were successfully formed, these relationships were fruitful for recruitment and service delivery. MVP providers also benefited from partnering with a diverse array of organizations within their community for outreach, recruitment, and service delivery.

Problems identified as challenges for recruitment and collaboration reappear as service delivery challenges reported by providers (e.g., stigma around seeking help, frequent moves of military families, etc.). Providers frequently reported that unmet basic needs of military and veteran families often made it difficult for families to participate in programs and often required providers to focus on intervention, rather than prevention. Providers also reported structural and contractual barriers to service delivery.

CHAPTER 6: MEETING MVP PROGRAM GOALS

Do Families Participating in MVP Increase Their Protective Factors?

To test the association of MVP program participation with changes in protective factors, service providers administered the Protective Factor Survey (PFS) to families before and after receiving services. One of the desired outcomes of the MVP program was for providers to demonstrate improvement by 75 percent families on at least one of the PFS subscales (family functioning/resiliency, social support, concrete support, nurturing and attachment) between the pretest and posttest. PFS data from PEIRS show that nearly 90 percent of the 131 families for whom complete pre- and post-PFS data were available demonstrated improvement in at least one protective factor. As shown in Table 6, more than 10 percent of primary caregivers demonstrated improvement in all five subscales.

Table 6. Total Number of PFS Subscales with Demonstrated Improvement from Pre to Post

Number of PFS Subscales Primary Caregivers Demonstrated Improvement	Percent Primary Caregivers Demonstrating Improvement (N=131)
0	10.7%
1	12.2%
2	16.0%
3	29.8%
4	19.9%
5	11.5%

Primary caregivers were most likely to demonstrate improvement in family functioning and the least likely to demonstrate improvement in nurturing (Table 7).

Table 7. Improvement from Pre to Post by PFS Subscale (n=131)

Protective Factor Subscale:	Average Score (SD) on the Pretest (range 1-7)	Average Score (SD) on the Posttest (range 1-7)	Percent Primary Caregivers Demonstrating Improvement
Family Functioning	5.0 (1.1)	5.4 (1.1)	59.5%
Social Support	5.3 (1.4)	5.8 (1.3)	51.9%
Concrete Support	4.9 (1.6)	5.5 (1.6)	53.4%
Knowledge Child Development*	5.4 (0.9)	5.8 (0.9)	59.5%
Nurturing and Attachment	6.1 (0.8)	6.3 (0.6)	45.8%

**The PFS creators do not recommend calculating a knowledge of parenting subscale. For additional details, see the PFS User Manual (p. 24) available at https://friendsnrc.org/jdownloads/attachments/pfs_user_manual_revised_2012.pdf*

One challenge to increasing protective factors is that parents and caregivers are scoring high on the PFS pretest. Providers report that this is occurring "because the trust has not been built with the parent educator and they do not want to seem like an inadequate caregiver," that parents have a "fear of judgement or stigma if they score low," and that parents do not yet understand "that it is acceptable to admit when help is needed and that they will not be considered an inadequate caregiver." However, at the time of the PFS posttest, providers report that families are scoring lower, because they feel more comfortable with parent educators/counselors and are "more open and reflective once they have completed the program." These issues are consistent with social desirability bias, in which participants may over report "good behavior" on the pretest, but are more realistic on the posttest after developing a rapport with program providers.[151] Providers also report that some families have expressed concerns about privacy and confidentiality of the data. In an effort to curb biases in scoring and reduce concerns about privacy and confidentiality, service providers walk through the PFS to ensure parents understand the material; explain to parents that the PFS is a tool for improvement, not a means to "shame or diminish a parents' skills;" and reassure families that responses are confidential and will not be shared with on-base military personnel or other military groups. However, these problems continue to be reported.

Another concern that emerged centers on the administration of the Protective Factors Survey (PFS) posttest relative to when families complete the evidence-based program versus when they complete receiving any ancillary services. The PFS posttest is supposed to occur at the conclusion of the evidence-based programming; once a family completes the post PFS, some providers believe they are considered exited out of MVP. Families can complete the evidence-based programming but still be in need of ancillary services, which they would no longer be able to receive once they take the PFS posttest. As a result, the PFS posttest will not truly capture the benefit of participating in MVP for families if they have to take the survey immediately after completing the evidence-based programming instead of after they are no longer receiving ancillary services. In response to this issue, some providers reported keeping families' cases open within the evidence-based program to continue ancillary services, even if the family is no longer receiving the primary, evidence-based program services any longer. Any change from the PFS pretest to posttest, therefore, was better understood as evaluating how families were responding to providers' "menu of services," rather than just the primary, evidence-based program. Providers suggested that the PFS given at the conclusion of both types of services may provide a clearer and interesting set of results on the change in protective factors associated with MVP program participation.

Other challenges that providers report with respect to demonstrating an increase in protective factors include: the difficulty with showing positive change over the course of a program of a short duration, confusion among ancillary service providers as to who has to collect PFS data, and difficulty collecting PFS posttest due to retention challenges (e.g., families moving, leaving the program early, or difficulty contacting families). In response to retention issues, some providers have started collecting PFS data every six months, repeating the PFS posttest if the family is still

enrolled at the conclusion of the program. This way, the program has a posttest to use as a means to measure this program goal.

Does participation in MVP keep children safe?

Given the objectives of the MVP programs, service providers delivered programs to military and veteran families aimed at preventing child abuse and neglect. Prevention can be difficult to measure and qualitative data presented limited evidence on the effectiveness of MVP programs. Providers in each community reported extensive service delivery in an effort to keep families safe. As detailed in previous chapters, services included parenting programs, services to meet basic needs and reduce family stressors, youth mentoring, and broader community education efforts, among other services. Providers in Bexar County reported providing safety resources to families, such as fire extinguishers, smoke and carbon monoxide detectors, locks, baby gates, car seats, booster seats, and emergency-preparedness information. In addition, providers reported teaching numerous groups on how to spot and report abuse, including families, mentors, child care providers, and children and youth.

Data from IMPACT identified the share of primary caregivers who were designated as a perpetrator of an incident of child abuse or neglect occurring before, during, and after receiving services through MVP. Nearly one-quarter (23%) of the 409 MVP primary caregivers were identified as a designated perpetrator *prior* to program participation. The vast majority of MVP primary caregivers were not identified as a designated perpetrator during or after their participation in the program (99.2%). However, three primary caregivers (0.7%) were identified as a designated perpetrator, and one of the three primary caregivers had a report both before their participation and during or after their participation.

Summary

The majority of MVP primary caregivers demonstrated improvement on at least one protective factor. Complete pre- and post-data were only available for one-third of the analytic sample. Providers reported challenges in administering the PFS consistent with social desirability bias. In addition, another major concern that emerged from qualitative data centered on the administration of the PFS posttest relative to when families complete the evidence-based program versus when they complete receiving any ancillary services.

Given the objectives of the MVP programs to keep children safe, service providers delivered programs to military and veteran families aimed at preventing child abuse and neglect. Prevention can be difficult to measure and qualitative data presented limited evidence on the effectiveness of MVP programs. Less than one percent of MVP primary caregivers were identified as designated perpetrators either during or after their participation in the MVP program, despite nearly one-quarter having a history of child abuse or neglect prior to their participation.

CHAPTER 7: LESSONS LEARNED AND RECOMMENDATIONS

This report serves as the final evaluation report by CFRP on the Military Families and Veterans Pilot Prevention Program (MVP). Specifically, this report reviewed the unique context of each military community participating in the program and outlined the structure each community created for their MVP program. At the time of this report, two of the three communities were in their second year of serving families (the third community had a delayed start). This report focused primarily on implementation findings—identifying the unique needs of military and veteran families and highlighting the ways in which programs adapt to meet the needs of military and veteran families. In addition, this report included preliminary evidence on communities' progress toward meeting PEI goals for the MVP programs. We draw on the findings presented throughout this report to identify overarching lessons learned from MVP program implementation to date, and associated policy recommendations for future implementation efforts.

Lessons Learned and Recommendations

MANY MILITARY AND VETERAN FAMILIES HAVE CHALLENGES MEETING BASIC NEEDS

Many military families, particularly active-duty members in the lower ranks of the military and veterans, have challenges meeting their most basic needs. Providers were surprised by the number of military and veteran families who needed assistance finding resources around housing (especially for veterans) and utility assistance; reliable transportation and child care; items such as car seats, school supplies, and medical supplies; and even food. These unmet basic needs make it difficult for families to participate in programs. Rather than focusing on prevention and parenting support, providers often reported focusing their time with families on intervention services to address meeting these basic, unmet needs. Providers and program participants both highlighted the common misconception that because families are associated with the military, they have access to abundant services; in reality, families struggling to meet their basic needs often rely on the same services as the general public, often encountering waiting lists particularly for housing and mental health needs. Some military families may have earnings just above eligibility thresholds for assistance programs, therefore are ineligible to receive services to help meet these basic needs.

Based on these findings, CFRP recommends that programs designed to support military and veteran families include strategies for crisis management and identifying resources to meet basic needs as central required components of the program, not as ancillary or optional components. Additionally, families need to be linked to services as soon as possible, given their transitory nature and linked to additional, ongoing resources and services once participation in MVP programs is over. Incorporating the need for crisis management and intervention services into the original design of the program may allow programs to be better prepared, or at least as prepared as possible to meet these needs as they arise.

MODIFICATION IN MVP PROGRAMS FOCUSED ON RECRUITMENT AND PROGRAM STRUCTURE

Most programs modified recruitment efforts and program structure to reach and accommodate military and veteran families, but did not modify program content to meet the unique needs of these families. Providers reported that MVP funding allowed expanded and targeted outreach efforts to recruit military families to participate in existing programs. When providers did modify their programs to fit the needs of these families, modification largely centered on accommodating the schedules of active-duty service members and their families. Programs adjusted the overall length of their program by shortening the time between classes, offered lunch with the program so families could attend on their lunch breaks from work, or delivered classes in families' homes on a one-on-one basis. Providers did not report modification of program content and none of the evidence-based and ancillary programs employed by MVP providers were designed specifically for military and veteran families. The lack of modification around program content and service delivery was largely due to concerns around maintaining model fidelity.

CFRP recommends that to best meet the needs of military families, communities identify programs that have an evidence-base for serving military families, or have content specific to military life and culture. Several existing resources, including The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP), and Penn State University's Clearinghouse for Military Family Readiness, provide information on the effectiveness of programs for military and veteran families.[152,153] Additionally, communities and programs need to recognize how needs vary across members of the military and military families (e.g., active-duty, veteran, spouse, youth).

BARRIERS TO RECRUITMENT REMAIN, BUT MILITARY CONNECTIONS MATTER

Privacy, confidentiality, and stigma are major barriers to recruitment reported in all three MVP communities. Within the military, needing to rely on social service organizations is often perceived as a weakness or dependency; seeking services on base can affect prospects for job security and promotions because the information is not confidential and is placed in soldiers' records. As a result, military families face stigma for accessing help. Programs also reported that on-base access is critical for creating buy-in and for recruiting families, but could be difficult. Communities had mixed success establishing MOUs and relationships with FAP providers. Stable military connections help create buy-in from military leaders and on-base staff, which reduced recruitment barriers and improved base access for MVP providers. Additionally, connections of MVP program staff to the military (e.g., veterans, spouses of military members) aided with building trust and connections with families during recruitment.

We recommend that the state do more to facilitate and maintain relationships between military leaders and base staff and community-based organizations providing services. Facilitating these relationships is especially helpful when military leadership changes and may also help ease the challenges with establishing MOUs between FAP and community-based providers.

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2300 Red River Street, Austin, Texas 78712 | 512-471-3536 | Toll Free 855-471-CFRP (2377) | cfrp@austin.utexas.edu