Department of Defense (DoD) | Defense Health Agency (DHA)

Sexual Assault Survivor Listening Session –

Draft Facilitation Guide (Deliverable 51)

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Introduction

The Independent Review Commission on Sexual Assault in the Military (IRC) report "Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military"[1] outlines recommendations detailing the need to expand victim service options to meet the needs of all survivors of sexual assault and sexual harassment. Sub-recommendation 4.2 b (modified) states that the "Department of Defense (DoD) will explore whether allowing Service members full access to Veterans Affairs (VA) services, without a referral is feasible, mitigates stigma associated with help seeking, and does not adversely impact the Services' ability to receive readiness-impacting feedback from VA health care providers."

In support of the IRC recommendation, the Listening Sessions support team will design, facilitate, and assess with the assistance of active duty survivors, MTF behavioral health care providers[2], Sexual Assault Prevention Response (SAPR) and Family Advocacy Program (FAP) personnel, and additional stakeholder groups specific barriers and facilitators of help seeking. The purpose of the Listening Sessions is to gain additional insights and identify themes on the complex nuances and perspectives of active duty Service members leveraging victim services (including VA services without referral). The Listening Session participants will include stakeholder groups within and across different stages of the referral and help seeking processes to consider the environment holistically.

Site selection for the Listening Sessions is in progress. Sites may be "promising" sites identified by their respective Service for promising practices, or sites identified to have a high prevalence of sexual assault or sexual harassment.[3] Once input from Services in response to the site selection tasker is received, proposed sites will be reviewed by government leadership and confirmed. Additional data and consultation with other offices such as the Sexual Assault Prevention and Response Office (SAPRO), FAP, and Personnel and Readiness (P&R) may be requested to understand demographics, prevalence rates and prior findings from On-Site Installation Evaluation (OSIE) efforts. Additional/other sites may be requested if there is a need for increased representation from an underserved or unique demographic.

This document serves to outline the facilitation approach, identify key stakeholder groups to engage in the Listening Session process, and draft Listening Session questions, including standard questions and tailored stakeholder group questions, which align to the Listening Session purpose. The Facilitation Guide (Deliverable 51) is part of the "Design" phase of the Sexual Assault (SA) Listening Session Implementation Approach.

Facilitation Approach

Best practices for Listening Session facilitation will be leveraged and include considerations such as sharing a clear purpose statement; creating clear, unambiguous and bias-free discussion questions; scheduling of the time, place, necessary equipment, and setting ground

[1] Independent Review Commission on Sexual Assault in the Military. (2023). Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military.
[2] "Mental health" is used when quoting from the Independent Review Commission, whereas "behavioral health" is used otherwise to follow Defense Health Agency terminology. "Medical behavioral health" will be used in discussions with the Marine Corps.
[3] Data on prevalence and reporting rates was retried by the Sexual Assault Prevention and Response Office.

rules and an agenda; and obtaining commitments from potential participants.[4] Participants will be selected from various demographic backgrounds to ensure appropriate and inclusive sampling.[5] Particular consideration will be given to ensuring minority and underrepresented voices are included.

The Listening Session support team will be drafting an implementation and facilitation approach, coordinating, and preparing with the Site POC in advance of the site visit, organizing logistics, and capturing key insights and themes during the Listening Session itself to inform analysis and trip reports. Government leaders will provide subject matter expertise and approval of the proposed implementation and facilitation approaches, facilitate the discussion during the Listening Sessions, asking questions from the standard and tailored question sets, and redirecting the conversation as needed. The Site POC will serve as the point of contact for scheduling and preparing for the site visit, scheduling Listening Sessions times and recruiting/identifying participants for the Listening Sessions.

The participating stakeholder groups were identified in the IRC recommendation as well as from the Listening Session support team's knowledge of the various roles in the help seeking process. These groups were included in the Listening Session design in order to better understand different facilitators and barriers that survivors encounter when determining how to engage with mental health care. Given the sensitivity of the content to be discussed, it will be important to establish trust with the various stakeholder groups. Strategies to enhance trust[6] include:

1. **Balancing of power dynamics** - Power dynamics will be balanced with regard to the selection of participants and makeup of the Listening Sessions to ensure that all participants feel comfortable sharing their honest opinion and experience.
2. **Transparency of Listening Session goals and motivations -** To establish transparency, Listening Session purpose, goals, and use of the collected information will be stated both before at the point of participant recruiting as well as during the Listening Session facilitation.
3. **Confidentiality of responses** - Facilitators will share in outreach and recruitment artifacts that Listening Session input is valued and will be kept confidential. Additionally, confidentiality will be ensured by noting that the discussion will not be recorded, responses will be aggregated and non- attributional.[7]
4. **Cultural humility** - Facilitators will be aware of cultural differences and sensitivities that may be present within the stakeholder group. Facilitators will maintain a neutral and non-biased stance. Underrepresented voices will be included, and efforts made to ensure all participants feel their input is valued.
5. **Effective communication**- Recurring, transparent communication will be woven throughout the Listening Session design and execution process to ensure Site POCs are well prepared to assist with coordination based on intended Listening Session purpose and goals. This will also assist in ensuring that participants have a strong awareness and are prepared to contribute to the Listening Sessions. After the Listening Sessions, participant feedback will be sought, and facilitators will emphasize that their involvement was meaningful and essential to shaping future recommendations around help seeking.

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[4] Klagge, Jay. (2018). Guidelines for Conducting Focus Groups. 10.13140/RG.2.2.33817.47201.
[55] Data Collection Methods: Semi-Structured Interviews and Focus Groups (rand.org)
[6] Wilkins CH. Effective Engagement Requires Trust and Being Trustworthy. Med Care. 2018 Oct;56 Suppl 10 Suppl 1(10 Suppl 1):S6-S8. doi: 10.1097/MLR.0000000000000953. PMID: 30015725; PMCID: PMC6143205.
[7] Data Collection Methods: Semi-Structured Interviews and Focus Groups (rand.org)

Our facilitation approach will be flexible and adaptable based on the individual sites selected to participate in the Listening Sessions as well as the number and background of the participants we are able to engage.

Logistics

Site POCs and Listening Session participants will be provided with contextual information and an overview of the SA Listening Session effort ahead of participating in order to provide informed consent either through email or a brief introductory call (as determined by government leadership). To demonstrate sensitivity and value the privacy of participants, rooms and signage should be discreet so that non-participants are not aware of the purpose of the Listening Sessions. During the in-person site visit, disclaimers will be shared with the participants ahead of the Listening Session about the purpose of the Listening Session, sensitivity of the content, and confidentiality. All participation in the Listening Session effort will be voluntary, and participants can opt out at any time, for any reason.

The length of each Listening Session will be kept to under an hour due to the sensitivity of the content and to show respect for participants' time and competing priorities. **Of note, the question sets detailed in the subsections below are estimated to exceed the time allocation for the Listening Sessions. Facilitators will leverage the question bank detailed in the Facilitation Guide (Deliverable 51) to select which questions are most relevant for each conversation.** Each Listening Session will have up to two facilitators and one notetaker. This small number of support team members is intentional to keep the focus on the participant experience. Listening Session participant size will also be kept smaller to allow for optimal participation. Listening Session groups will be kept to 10 participants or less which aligns with SAPRO efforts as well as research on optimal size of Focus Groups (ranges from 6 to 11 participants[8]). The final size and length of Listening Sessions will be based on site response and government leadership determination. Individual listening sessions for survivors may be considered based on participant preference.

Standard Questions

Across all Listening Sessions and stakeholders, facilitators will leverage a set of standard questions to investigate facilitators and barriers to help seeking. These questions will then be coupled with select tailored/nuanced questions based on the stakeholder group detailed in the next section. Standard questions for facilitators to draw from may include:

- What have you observed or experienced that facilitates or encourages help seeking behaviors (for the purposes of these listening sessions, help seeking indicates seeking out behavioral health care, either at the MTF or some other location) after experiencing sexual trauma (for the purposes of these listening sessions sexual trauma will be defined as sexual assault, sexual harassment or intimate partner sexual abuse)?
    - For Non-Survivor Groups:[9] Are those who report their sexual trauma experience more likely to engage in help seeking behaviors, or is there no difference with

[88] Data Collection Methods: Semi-Structured Interviews and Focus Groups (rand.org)

[9] Non-Survivor Groups include Behavioral Health Care Providers, Legal Entities, Chaplains, Command Leadership, and Sexual Assault Prevention Response (SAPR) and Family Advocacy Program (FAP) Personnel.

those who do not make a report?
    - For Non-Survivor Groups: Do you see a difference in help seeking behavior based off who the accused is (e.g., intimate partner, command, etc.)?
    - For Non-Survivor Groups: Do you see a difference in help seeking behavior for survivors based upon the type of sexual trauma they experienced (e.g., Sexual assault, intimate-partner sexual abuse or sexual harassment)?
- Are active duty Service members generally aware/informed of the options available to them for behavioral health care? Of the potential benefits of seeking help for behavioral health?
- Who are the trusted personnel/resources when considering seeking help and why?
    - Where do you seek resources?
- How can the military better support help seeking behaviors?
- How can the command better support help seeking behaviors?
- How can the environment better support help seeking behaviors?
    - Do you have insights regarding other barriers or resources that we have not considered?
- What barriers have you observed or experienced which deter help seeking behaviors after sexual trauma?
    - What are stigma-related factors that may impact help seeking after sexual trauma?
    - What do you think will address stigma with seeking behavioral health?
- Does, or would, having an opportunity to go to a different care system outside of DoD/MHS change your perception of stigma?
- How would you describe any parts of the help seeking process or experience (including behavioral health care or military justice system) that place undue burden on the victim?
- What are the additional factors or considerations to keep in mind for supporting victims from an underrepresented or minority race, ethnicity, sexual orientation, or gender identity in the military?
    - How might we mitigate these factors?[10]

Tailored Questions by Stakeholder Group

Given the complexity of sexual trauma prevention, it is important to understand the perspectives of different stakeholders in the DoD/MHS environment. The IRC report emphasizes that the legal system must be equipped to respond to special victim crimes, commanders must play a key role in the culture of sexual violence and victim help seeking, and ample resources and time should be dedicated to victim care and support[11]. The questions below are designed for the following stakeholder groups: 1) Active Duty Survivors[12], 2) Behavioral Health Care Providers,

[10] Follow-up questions which are not be part of the facilitation guide but may be asked by leadership as appropriate.

[11] Independent Review Commission on Sexual Assault in the Military. (2023). Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military

[12] Active Duty Survivors include individuals who have experienced sexual assault, intimate partner abuse, and/or sexual harassment. Site visitors will engage directly with SARCs, FAP personnel and SVCs/VLCs to solicit volunteers wishing to participate. Survivors will have options to participate in groups, individual

3) Legal Entities, 4) Forensic Health Examiners, 5) Chaplains, 6) Command Leadership, and 7) SAPR and FAP personnel. Tailored questions for each stakeholder group are designed to elicit nuanced insights based on the different experiences and roles of each group.

Active Duty Survivors

- What is your understanding of behavioral health care?
    - What is important to you about behavioral health care?
    - How do you value your behavioral health care?
    - What is your understanding of how behavioral healthcare can help or support someone who has experienced sexual trauma?
    - Outside of behavioral healthcare, did you use any other avenues for help or support?
- At any time after your experience, did you consider seeking mental/behavioral healthcare? If so, why? If not, why?
    - How did you think through or evaluate your options for support services? How did you come to a decision? What influenced your decision?
    - If you didn't consider seeking behavioral healthcare, was there someone else you felt more comfortable reaching out to meet this need?
- After your experience, who were you most likely to share with or reach out to, if anyone (or service)? (e.g., Chaplains, peer, command, etc.)
    - If you were to seek mental/behavioral health care, what, if any, preferences do you have relating to providers? For instance, would you prefer to seek a provider on/off installation? Does gender, racial/cultural background, or type of DoD personnel matter?
- What is your understanding of what stigma is? When you hear that word what do you think of?[13]
    - Do you think there is stigma associated with seeking behavioral healthcare?
- How did you perceive any stigma associated with seeking behavioral healthcare within the DoD?
- How did you perceive any stigma associated with seeking behavioral healthcare outside the DoD (either in the community or at VA)?
- What DoD/MHS services are you aware of that may offer support after sexual trauma?
- What VA services are you aware of that may offer support after sexual trauma?
    - If you were able to go to the VA, without a referral, would that support help seeking? Why or why not?
- If you did seek behavioral healthcare, what parts of the experience made you feel comfortable or supported? We are interested in learning more about what encourages help seeking behaviors.
- What parts of the experience made you feel uncomfortable or unsupported? We are interested in learning more about what discourages help seeking behaviors.

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meetings or phone calls, to accommodate their individual preferences.

[13] Stigma is defined in the Merriam-Webster dictionary as a set of negative and unfair beliefs that a society or group of people have about something. The IRC report recognizes stigma as a "significant barrier to seeking behavioral health services in the military community because the culture sets the expectation that Service members should be able to handle problems on their own. A major obstacle to survivors of sexual assault seeking long-term support for trauma is the fear of losing benefits or being declared "unfit for duty"' (pg. 40).

    - Were there any parts of the experience that made you feel like you could not be fully honest about what you experienced or seek the resources you needed?
- What advice would you give to other active duty survivors who were thinking about seeking behavioral healthcare after experiencing sexual trauma?
    - Is there feedback you would want to provide to the department on this experience?
- Do you feel that the victim service options for behavioral healthcare presented to you met your needs? If so, why? If not, why?
    - Did you feel that the options to seek behavioral health care met your needs? Where did you access behavioral health care (a military treatment facility (MTF) or somewhere else)?
    - If you sought care outside of a MTF, how did this compare to the victim service options?
- Did you feel like the victim service options presented and available to you were culturally relevant? If so, why? If not, why?
    - Did you state a preference for a provider that triaged (conducted your initial assessment)? Did you state a preference for a male or female therapist?
- For survivors of intimate partner sexual abuse, did you feel the options presented and available to you (including non-medical counseling) met your needs?

MTF Behavioral Health Care Providers

- What do you hear from your active duty patients relating to decision making factors for help seeking behaviors?
    - Is stigma a consideration? If so, how?
    - Is confidentiality a consideration? If so, how?
    - What do you hear about the referral process?
- If an active duty client is already engaged with behavioral health care utilization prior to experiencing sexual trauma, how does that impact help seeking behaviors relating to their sexual trauma?
- What is the interaction between behavioral health and command relating to sexual trauma?
- What is the interaction between behavioral health and Chaplains relating to sexual trauma?
- What is the interaction between behavioral health and legal entities relating to sexual trauma?
- What concerns do you have about the point in time at which active duty survivors seek behavioral care?
- What, if any, preferences have you observed in active duty patient selection of providers for behavioral health or medical care?
    - Do active duty patients state preferences for male or female providers?
    - How does the availability of telehealth or remote behavioral health support impact help seeking behaviors?
- Is there ever a circumstance in which you would recommend the active duty Service member seeks care outside of the DoD/MHS?
    - How do you determine where and when to refer the active duty Service member outside of DoD/MHS?

    - How do you engage with providers outside of the DoD/MHS for information sharing purposes to ensure continuity of care for active duty Service members?
- Are there other resources or supports outside of behavioral health care that might benefit an active duty survivor (peer support groups, additional leave, etc.)? If so, please describe.

Legal Entities

Special Victims Counsel (SVC)/Victims Legal Counsel (VLC)

- What do you hear from your active duty clients around behavioral health needs or concerns?
    - What concerns do you have as legal advisors when working with active duty survivors relating to seeking behavioral health care?
- What do you advise your clients around help seeking as it relates to behavioral health care and the legal process?
    - Are there instances or scenarios where you would advise active duty survivor s not to engage in help seeking behaviors?
    - What considerations do you discuss with your active duty survivors about help seeking and is this dependent on whether there is an ongoing legal case?
    - In what instances or scenarios would you encourage help seeking behaviors?
- How is information relating to active duty survivor engagement with behavioral health care utilized by Special Victims Counsel?
- Does SVC provide recommendations for what type of report the active duty Service member should make based on their specific circumstances? If so, how?
- If an active duty Service member is engaged with behavioral health care utilization prior to their sexual trauma experience, does this influence what type of report legal recommends making? If so, how?
- Is there anything legal advisors would like for behavioral health care providers to know or be aware of (documentation, privacy considerations, etc.)?

Special Trial Counsel

- What do you hear from active duty survivors around behavioral health needs or concerns?
    - What concerns do you have when working with active duty survivors relating to seeking behavioral health care?
- How may information relating to survivor engagement with behavioral healthcare be utilized by Prosecutors?
    - Is there ever a concern relating to pulling records and/or credibility issues for trial?
- If there is an ongoing legal case, what is the preference or consensus as to when someone (the active duty survivor) should seek behavioral healthcare (before, during after?)
    - Does this recommendation change depending upon circumstances, such as drug-related sexual trauma? Do you have any concerns or opinions about engaging in behavioral healthcare?

Defense Attorneys

- What do you hear from your active duty clients (regardless of whether they are the alleged perpetrator or survivor) around behavioral health needs or concerns?
    - What concerns do you have as legal advisors when working with sexual trauma alleged perpetrators relating to seeking behavioral healthcare?
    - What concerns do you have as legal advisors when working with sexual trauma alleged survivors relating to seeking behavioral healthcare?
- What do you advise your active duty clients around help seeking as it relates to behavioral health care and the legal process?
    - In what instances or scenarios would you advise against help seeking behaviors?
    - In what instances or scenarios would you advise help seeking behaviors?
- How is information relating to active duty survivor engagement with behavioral health care utilized by Defense Attorneys?
- Is there ever a concern relating to pulling records and/or credibility issues for trial when your active duty client is engaged in behavioral health care?

Forensic Health Examiners

- What concerns do active duty survivors share with you about their behavioral health needs?
- How do you talk about behavioral health with the person you are examining and/or collecting evidence from?
- Where do you refer active duty survivors who express an interest in receiving behavioral health?
- What do you think are barriers to help seeking among active duty survivors? What do you hope has been done already by the time the person gets to you?

Chaplains

- In addition to providing spiritual guidance, how often do you engage with active duty Service members relating to behavioral health needs after experiencing sexual trauma?
    - What are you hearing from those you counsel on why someone would not want to seek behavioral health care within the MHS?
    - What are you hearing from those you counsel on why someone would want to seek behavioral health care within the MHS?
- Given the confidentiality of seeing Chaplains, what are you hearing that survivors do not feel comfortable sharing with others (command, medical staff, etc.)?
- When you are working with someone who has experienced a SA and they need support beyond Chaplaincy, are you aware of what resources exist to refer them to?
    - What are the facilitators to sending active duty Service members to these resources?
    - What are the barriers to sending active duty Service members to these resources?
    - Are you aware or engaged with any offerings for active duty survivors that are unique to Chaplains (e.g., Chaplains Religious Enrichment Development Operation)?
- What is the connection and interface between Chaplains and behavioral health?
    - What is the referral process from Chaplains to behavioral health?
- What is the connection and interface between Chaplains and FAP?

- What is the connection and interface between Chaplains and SAPR?
- What is the connection and interface between Chaplains and Military Equal Opportunity programs (MEOs)?

Command Leadership

- What do you hear from your active duty Service members with regards to why they might report sexual trauma to you as command or to the unit SARC, SAPR VA, or Domestic Abuse Victim Advocate (DAVA) or FAP Clinician or MEO?
- When do you direct an active duty Service member to go to behavioral health care?
    - How do your active duty Service members talk about this?
    - How do you perceive any stigma around this?
    - How frequently do you receive updates from behavioral health on this?
- How do you communicate and build trust with your active duty Service members relating to behavioral health and help seeking?
    - Is there anything you wish that your active duty Service members knew regarding help seeking after sexual trauma?
- What is the connection and interface between command and behavioral health?
- What is the connection and interface between command and SAPR?
- What is the connection and interface between command and FAP?
- What are the key considerations for command when allowing an active duty Service member to leave and get care (of any kind)?
    - What are the key considerations for seeking care within DoD or the Military Health Service (MHS)?
    - What are the key considerations for seeking help outside DoD/MHS (VA or community)?
- If an active duty Service member seeks care outside the DoD/MHS, what are the command concerns relating to mission performance or deployment readiness?
    - When your active duty Service member returns to the unit after experiencing sexual trauma and seeking support resources, what factors do you consider when assessing their mission readiness and adjustment back to duty?
- How would a self-directed referral by your active duty Service member positively and negatively impact the command's mission?

Sexual Assault Prevention Response (SAPR) and Family Advocacy Program (FAP) Personnel

- When an active duty Service member comes to SAPR/FAP, what factors are considered when sharing an overview of victim service resources available to that person and making referrals?
- What do you hear from active duty Service members relating to decision making for help seeking behaviors?
    - What are you hearing from active duty Service members on why someone would not want to seek behavioral health care within the MHS?
    - What are you hearing from active duty Service members on why someone would want to seek behavioral health care within the MHS?
- When SAPR/FAP personnel make recommendations to Service members, are options both within and outside of DoD/MHS shared?

    - What are the key considerations for seeking care or resources within DoD/MHS?
    - What are the key considerations for seeking help or resources outside DoD/MHS (VA or community)?
- What are the facilitators to sending active duty Service members to these resources?
- What are the barriers to sending active duty Service members to these resources?
- What is the connection and interface between SAPR and FAP?
    - What is the referral process from SAPR to FAP or from FAP to SAPR?
- What is the connection and interface between SAPR and behavioral health?
    - What is the referral process from SAPR to behavioral health?
- What is the connection and interface between FAP and behavioral health?
    - What is the referral process from FAP to behavioral health?
- If an active duty Service member seeks care outside the DoD/MHS, are there any concerns relating to mission performance or deployment readiness? If so, how are these mitigated?
    - How does SAPR/FAP engage with providers outside of the DoD/MHS for information sharing purposes to ensure continuity of care for active duty Service members?

Conclusion

Government leadership and the Listening Session support team will leverage this Facilitation Guide (Deliverable 51) for reference and organization of the facilitation approach, Listening Session logistics and comprehensive question bank. This document provides both standard questions for all Listening Session participants to better understand barriers and facilitators to help seeking behaviors as well as more nuanced questions for specific stakeholder groups to better understand the experiences of different roles and communities.

The Listening Session facilitation approach and question selection are designed to gather critical information and insights to assist Government leadership to make informed recommendations and decisions relating to victim service options and help seeking pathways relating to the IRC report. Given the sensitive nature of the content and the many demands on Service member and providers' time, the facilitation guide seeks to optimize and streamline the focus of the Listening Session discussions while reducing the burden of the Listening Session participants.