

Domestic Abuse in the Armed Forces

Improving Prevention and Outreach

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About These Appendixes

Domestic abuse among members of the U.S Armed Forces is a public health issue with severe consequences for military personnel, their families, and, potentially, unit readiness. The Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy is sponsoring a RAND National Defense Research Institute (NDRI) study on military-specific risk factors for domestic abuse, best approaches for coordinated community response systems, and sustainable solutions for preventing violence before it occurs. The study will address Department of Defense priorities and meet Congress’s request for independent recommendations on domestic abuse in the armed forces per Section 549C of the Fiscal Year 2021 National Defense Authorization Act.

As part of this larger project, we are conducting research to identify gaps between recommended and existing approaches to domestic abuse prevention. During the first phase of the project, we focused on identifying recommended domestic abuse prevention practices through (1) a systematic scoping review of the literature and (2) expert panels. The main report on these phase one efforts identifies recommended domestic abuse prevention practices and is available at www.rand.org/t/RRA1550-1.

These appendixes support the main report by describing in detail the methods used to conduct online expert panels to identify potential strategies that the Department of Defense could apply to domestic abuse prevention practices (Appendix A), presenting the original language of the proposed 18 strategies that the panel experts rated and discussed (Appendix B), providing a detailed scoping review of the methods and findings found in the literature (Appendix C), and furnishing a list of the studies included in the scoping review (Appendix D).

In the second phase of the research, we will review existing military approaches to domestic abuse prevention, describe areas of congruence and gaps between current and recommended practices, and describe the barriers that hinder implementation.

The research reported here was completed in December 2022 and underwent security review with the sponsor and the Defense Office of Prepublication and Security Review before public release.

RAND National Security Research Division

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Staff, the Unified Combatant Commands, the Navy, the Marine Corps, the defense agencies, and the defense intelligence enterprise.

For more information on the RAND Forces and Resources Policy Program, see www.rand.org/nsrd/frp or contact the director (contact information is provided on the webpage).

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Appendix A. Detailed Expert Panel Methods Description

This appendix describes the methods used to conduct online panels to explore potential agreement across a diverse group of experts on strategies that DoD could use to help (1) prevent domestic abuse among service members and their spouses and partners, (2) provide outreach to and communicate with individuals who might have risk factors for domestic abuse, and (3) measure and evaluate the effectiveness of these strategies in the military context.

After providing background information on the ExpertLens platform, this appendix describes the process for recruiting experts, gathering preliminary input, and conducting the three-round expert panel. It describes the qualitative and quantitative approaches to analyzing the data, characteristics of the experts who participated, and the analytic sample's ratings of 18 proposed strategies (see Appendix B for the complete text of those strategies).

The ExpertLens Online Modified Delphi Platform

The Delphi process for estimation and decisionmaking was originally developed in the 1950s–1960s as a structured forecasting technique in operations research and has origins in a RAND Air Force project (Dalkey and Helmer, 1962). This process relies on iterative data collection from a group of experts to address issues for which exact knowledge does not exist. In the original Delphi, the rounds continued until consensus was reached, which could take several months or even years. The modified Delphi approach establishes a predetermined number of rounds to help identify areas of agreement and disagreement and uses a validated measure of consensus (Fitch et al., 2010).

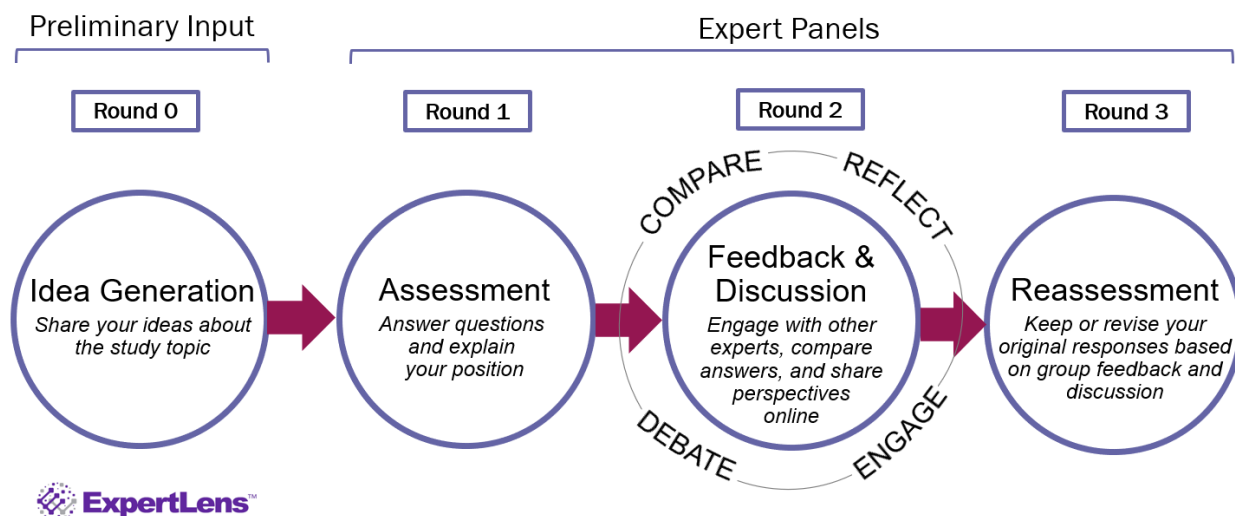
The expert panels in this project were designed to be conducted online using a RAND-developed and previously evaluated ExpertLens platform and methodology (Dalal et al., 2011; Khodyakov et al., 2011; Khodyakov, Grant, et al., 2016; Khodyakov, Grant, et al., 2017). This iteration of modified Delphi panels allows for anonymity, larger panels with more-diverse expertise, minimized participant burden (e.g., no travel, asynchronous participation across time zones), and expedited data collection and analysis.

ExpertLens has been used in more than three dozen studies to engage a wide variety of experts and stakeholders, including clinicians, patients, policymakers, and subject-matter experts, among others. Recent projects include the development of the National Suicide Prevention Research Strategy (Claassen et al., 2014), standardized clinical definitions of Neonatal Abstinence and Neonatal Opioid Withdrawal Syndrome (Faherty et al., 2021; Jilani et al., 2022), and metrics to detect and decrease low-value prescribing in older adults (Radomski et al., 2022).

As an online modified Delphi platform, ExpertLens uses a series of data collection rounds that allow the experts to provide preliminary input in an open-ended format (round zero), answer

closed-ended questions developed based on the preliminary input and explain their responses (round one), compare participant responses and discuss them using a moderated discussion board (round two), and revise the responses if needed (round three) (see Figure A.1).

Figure A.1. ExpertLens Process in This Study



SOURCE: Authors' adaptation of figure in Khodyakov, Kinnett, et al., 2020, p. 22.

We chose ExpertLens because it allowed us to engage large and diverse groups of experts and stakeholders as opposed to soliciting input from a small number of individuals who have to meet in person. The use of ExpertLens also did not require experts to travel to a centralized location to discuss initial panel results, helped busy experts provide input at a time that was convenient to them and to contribute to the discussion anonymously, and did not force the development of consensus because participants were not required to change their responses if they did not want to (Dalal et al., 2011). The virtual option was especially valuable given that the panels were held during the coronavirus disease 2019 pandemic, that military programs and services in some locations were short-staffed relative to the demand, and that military personnel and employees would have had to manage bureaucratic hurdles to seek travel authorization to participate in-person. We anticipated that the anonymity would support a freer exchange of ideas than an in-person setting where statuses, such as age, gender, race, ethnicity, military rank, or military affiliation, would have been more visible. Moreover, the experts did not have to complete a round in a single session, which gave them time to reflect on proposed strategies and to take breaks as needed.

Recruitment

Previous research shows that the optimal size for online expert panels should be between 40 and 60 experts, not exceeding 80, to allow for nonresponse and attrition that are common in the online Delphi process while ensuring that experts do not become overwhelmed during the asynchronous discussion process (Khodyakov et al., 2011). We planned to organize either one or two panels of the same size and with similar participant characteristics, depending on how many volunteers we aimed (and would be able) to recruit.

Our goal was to engage experts who could represent the perspectives of four key stakeholder groups:

- domestic abuse survivor experts and advocates
- domestic abuse scholars
- military program and service providers and practitioners
- military leaders who have dealt with domestic abuse cases or coordinated with FAP.

Expertise was gauged in a number of ways, including referral by others, experience, professional reputation, and academic record.

In January and February 2022, we requested expert nominations and sent information about the study to select experts. For each recruitment strategy described in this section, we asked nominators of potential panelists to consider that we had a project goal of being inclusive of service member and family member domestic abuse issues and inequities that might relate to culture, race, ethnicity, gender, sexual orientation, or other demographic factors. We asked nominators to provide the nominee's name, position and organization, work email address, and a bullet point or a few sentences highlighting the special expertise the nominee could bring to the advisory panel. Although there were a few duplicate nominations from across our sources, most recommendations were unique. We kept confidential which individuals were invited to participate and which individuals ended up participating.

The next sections provide further information about *recruitment* for each expert category. Information about *participants* is provided later in this appendix.

Survivor Experts and Advocates

We recruited experts to help ensure that survivor perspectives were represented in the discussion of strategies for prevention and outreach, such as leaders of domestic abuse survivor advocacy groups.¹ To help identify experts in this category who had some knowledge of military settings and populations, we invited representatives from the sponsor's office (DoD-level FAP) and the Service FAP leads to recommend external domestic abuse advocacy or support groups with which they had worked.

¹ Note that our other expert categories also include survivor experts, such as certain scholars and military FAP advocates.

Through web searches, we identified national civilian advocacy and support organizations focused on domestic abuse, including groups focused on specific audiences (such as racial or ethnic subgroups or LGBTQ+ populations). We also added groups supporting military or veteran populations, in case they might be aware of advocates for military or veteran domestic abuse survivors. We shared a working list of organizations with our sponsor, which prompted some discussion and additional recommendations.

Overall, we emailed 35 civilian organizations requesting nominations and sent a follow-up reminder and final request, as needed. To convey the types of expertise sought, we asked these organizations to

nominate up to 3 domestic abuse experts in your organization, or who work with your organization, who are domestic abuse survivor activists, lobbyists, organizers, scholars, program evaluators, or others with expertise in any of the following:

- Domestic abuse survivor experiences, perceptions, needs, and help-seeking barriers and pathways (preference for those who have worked with military populations)
- Domestic abuse prevention strategies, including (but not limited to) outreach and communication to adults with risk factors for domestic abuse
- Types of measures, metrics, and approaches that could be used to evaluate the reach and effectiveness of domestic abuse prevention activities
- Aspects of the military setting relevant for domestic abuse prevention, such as military policies, programs, and services; challenges reaching and engaging family members; chain of command responsibilities and authorities; and military culture and organization.

We used contact information that we already had, that was listed on the organization's website, or that we had received from nominators and sent follow-up reminders as needed. Twenty organizations responded, with 17 organizations submitting one or more nominees. All 29 of the experts recommended were selected and invited to review the informed consent statement and to indicate whether they would be willing to volunteer for a panel; 83 percent of those experts volunteered (see Figure A.2).

Figure A.2. Recruitment of Survivor Experts and Advocates from Non-Military Organizations



Scholars

Relevant scholars were identified through their body of published research or known expertise in domestic abuse prevention, including outreach, communication, risk factors, and measurement and evaluation of domestic abuse prevention efforts. This approach included scholars already known to the research team, scholars identified through the scoping literature review task described in Appendix C, and scholars affiliated with or recommended by survivor advocacy and support organizations. We also invited representatives from the sponsor's office and the Service FAP leads to nominate domestic abuse prevention scholars and domestic abuse program evaluators with whom they had worked. To prioritize less familiar perspectives, the sponsor's office recommended excluding scholars who were already deeply enmeshed in DoD FAP's efforts. Figure A.3 shows that 28 scholars were invited to review the informed consent statement and indicate whether they would be willing to volunteer for a panel; 54 percent volunteered (although one ended up withdrawing when the panel started due to competing obligations).

Figure A.3. Recruitment of Scholars with Relevant Expertise



Military Providers, Practitioners, and Leaders

To recruit experts from within DoD, our research sponsor requested that each Service FAP lead provide us with a list of installation FAP managers and to alert those managers to our project and that we might be contacting them for assistance identifying experts for our study.

For each Service, we randomly sorted an Excel file list of installation FAP managers and examined the first 15 installations. We observed that the random sort met our goal of capturing installations that were diverse according to size, primary mission and function, major commands, U.S. regions and international locations, and remote and isolated locations, as well as locations near large cities.

In late January and early February 2022, we emailed the FAP managers from each of those installations to introduce the study and to request that they nominate up to one expert in each of the following three categories:

- experienced installation FAP staff who interact directly with the military population, including clinical providers, home visitors, victim advocates, and prevention and education specialists
- non-FAP service providers or practitioners at their installation who are U.S. military personnel or civilian employees and are known to have domestic abuse expertise (e.g., domestic violence counselor certification, victim advocate training and experience)
- U.S. military commanders, first sergeants, or senior NCOs at their installation who have dealt with several domestic abuse incidents and/or have had active coordination with FAP.

We requested that the FAP managers provide us nominees' names, positions and organizations, work email addresses, and a bullet point or a few sentences highlighting the special expertise the nominees could bring to the advisory panel. For those installation FAP managers who did not respond to the initial request, we sent follow-up reminders and requested that the Service FAP leads also send reminders. We received nominations from 37 of 60 installation FAP managers (63 percent); the subset of 37 still represented a broad variety of types of installations and locations.

Table A.1 shows recruitment numbers for military providers, practitioners, and leaders overall and broken out by Service and personnel type. Marine Corps and Navy personnel were most responsive and willing to participate. Despite significant effort, the number of nominations from Army FAP manager nominations across different installations fell a bit short. Given that our nominators were FAP managers, it is not surprising that FAP staff nominations were more common than nominations for non-FAP providers and practitioners or military leaders. As Table A.1 shows, 85 military providers, practitioners, and leaders were invited to review the informed consent statement and indicate whether they would be willing to volunteer for a panel, and after doing so, 80 percent volunteered.

Table A.1. Recruitment of Military Providers, Practitioners, and Leaders

	Installation FAP Managers Who Were Sent a Nomination Request (<i>n</i>)	Installation FAP Managers Who Nominated Experts (<i>n</i>)	Experts Nominated (<i>n</i>)	Experts Who Were Sent a Recruitment Message (<i>n</i>)	Experts Volunteered (<i>n</i>)	Experts Declined (<i>n</i>)	Experts not Reached or No Reply (<i>n</i>)
Total	60	37	98	86	68	6	12
Air Force/ Space Force	15	8	20	20	15	0	5
Army	15	6	21 ^a	14 ^a	9	2	3
Marine Corps	15	12	29	28	23	2	3
Navy	15	11	28	24	21	2	1
FAP staff			47	39	30	2	4
Non-FAP providers or practitioners			26	22	19	2	4
Military leaders			25	25	19	2	4

^a One FAP manager sent a list of ten nominees from their location, so we selected three (our maximum for a single site) from among those experts nominated.

Preliminary Input

We sent the nominated individuals an introductory email requesting that they visit a web page to review the informed consent statement and to express their willingness to participate in the expert panel. Those who consented to participate were then asked a short series of questions designed to assist us with panel composition and design. As part of round zero preliminary input, the questions asked for (1) information about their expertise and experience with domestic abuse prevention, (2) characteristics such as military affiliation, and (3) suggestions for possible strategies that the panel members should collectively consider. Demographic information about experts' gender, race, ethnicity, and age could not be collected within the study time frame because of DoD and Office of Management and Budget requirements, as questions about these are considered sensitive and would have required additional approval steps and time to review.

In total, 108 individuals expressed interest in participating in the online expert panel. We assigned each registered expert to one of the two panels, taking care to balance the panels in terms of invited experts' self-reported characteristics of the primary stakeholder group (e.g., scholar, military leader), whether they had previously openly identified themselves as survivors of domestic abuse, military affiliation (e.g., service member, service member's spouse, civilian employee or contractor), primary military organization (e.g., Army, Navy), region in which they

reside (e.g., U.S. South, Europe), years of experience with domestic abuse–related issues or activities, and subgroups for which they have specialized expertise in tailoring prevention activities, including outreach and communication strategies (e.g., racial and ethnic subgroups, age groups, LGBTQ+).

One of the primary goals of this effort was to fill gaps in the literature on approaches that would be appropriate for the military setting and populations. Thus, to better tailor the panel agenda toward that goal, it was important for us to gather preliminary input to illuminate some of the potential challenges and solutions not readily apparent in the literature. Three open-ended questions invited the volunteers to offer preliminary suggestions for strategies that might help the military

- prevent domestic abuse among service members and their spouses or partners before it occurs
- conduct outreach and communicate to reach individuals who might have risk factors for domestic abuse
- measure or evaluate how well its domestic abuse outreach, communication, and prevention activities are working.

We reviewed all the provided suggestions for domestic abuse prevention, outreach, and evaluation strategies and coded them thematically using an inductive approach to identify the most-common suggestions. We also sought to identify differing perspectives (e.g., whether there should be more training or any mandatory requirements). The research team then derived a set of proposed strategies, which was refined as we compared the expert-suggested strategies with those thus far identified through the scoping literature review. Other subject-matter experts at RAND and the research sponsor also reviewed and provided feedback on the drafted strategies. We aimed to develop fewer than 20 proposed strategies for expert panel consideration and ended up with 18.² The first 15 proposed strategies focused on domestic abuse prevention activities, including outreach to individuals with risk factors for domestic abuse, and the last three strategies focused on ways the military can measure or evaluate how well its domestic abuse prevention activities are working.

After the proposed strategies were programmed into the ExpertLens platform, we conducted a pilot test with other project team members not working directly on this task and with a military officer who was a RAND fellow for the year. This test of the functionality, programming, and discussion moderator tools also resulted in some minor refinements to the appearance and language of the items.

² Two of the proposed strategies were combined into a single strategy in the report, for a total of 17 strategies. The combined strategies were to (1) *develop* a prevention curriculum and (2) *deliver* the curriculum.

Expert Panels

The selected experts who consented to participate were invited by email to a three-round ExpertLens process. Both panels were conducted using the same data collection protocol and procedures described below. Experts could enter the panel space repeatedly within a given round and skip to specific strategies of their choosing using a navigation bar. They were not required to answer all questions.

Throughout the process, the experts were sent updates or reminders by the team (e.g., that the ExpertLens administrator would be emailing login instructions, that the current round would be ending shortly) and login instructions, tips, and reminders from the ExpertLens administrator. Two members of the project team staffed a shared mailbox to answer the experts' substantive questions about the study or process, and the ExpertLens team staffed a mailbox to provide technical support.

Round One

In round one, open from March 28 to April 6, 2022, the experts were invited by email to log into the ExpertLens platform to review 18 proposed domestic abuse prevention, outreach, and evaluation strategies; rate each of the strategies in terms of importance, feasibility, and impact; and explain their ratings using open text boxes provided below each rating question (see Figure A.4). For each proposed strategy, we provided the experts with a strategy title, a brief overview, and examples of how the strategy might work in practice (see Appendix B for the strategies as worded when rated and discussed by the experts.). While prevention and outreach strategies were shown to participants in a random order, the evaluation strategies appeared as the last three strategies.

Figure A.4. Format of Round One Questions for Each Proposed Strategy

Strategy: Confidentially screen for risk factors for domestic abuse and offer confidential assistance and intervention planning to prevent abuse from occurring.

Overview: Use the military health care system and TRICARE health care providers for confidential risk factor screening. Providers would not have any new reporting requirements tied to the screening results.

How it might work:

- Screen all incoming service members and new spouses for risk factors, and screen during annual physicals.
- Screeners offer options for confidential assistance to those who have past experiences (either as victim or perpetrator) with domestic abuse, sexual abuse, child abuse, or other forms of abuse that may be risk factors, or who currently have other risk factors for domestic abuse, such as marital stress.
- Coordinate across programs, if necessary, to develop confidential intervention plans for those with several risk factors.

How *important* is it that DoD use this strategy?

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Not important at all Very important

Please provide the rationale behind your answer here. Please do not include any personally identifying information in your response.

How *feasible* is it for DoD to use this strategy?

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

Not at all feasible Very feasible

Please provide the rationale behind your answer here. Please do not include any personally identifying information in your response.

What *impact* could this strategy have on DoD's ability to reach and assist individuals with risk factors for domestic abuse?

1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---

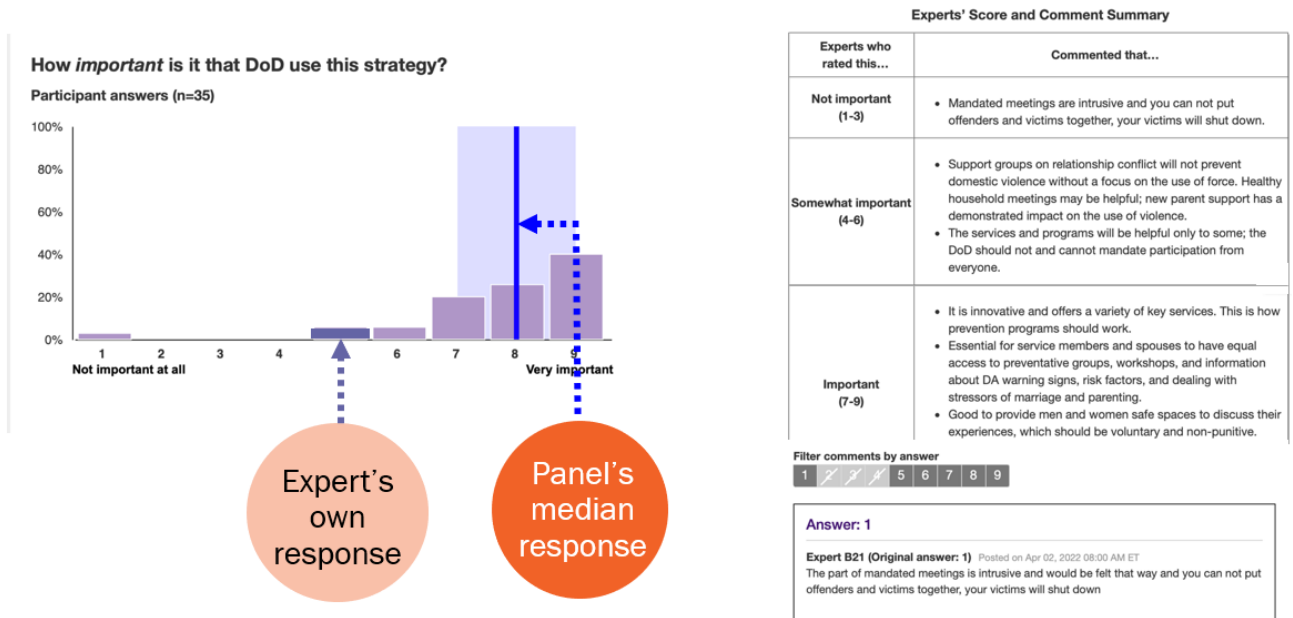
No impact Great impact

Please provide the rationale behind your answer here. Please do not include any personally identifying information in your response.

Round Two

In round two, which was open from April 14 to April 25, 2022, the experts reviewed the round one results—the distribution of their panel’s responses to each rating question, the panel’s median response, and the interquartile range. The experts were also able to see how their own response compared with those of other panelists. They were able to view the summary highlights of the round one comments from other panel members that explained their ratings and drill down to see each individual comment (see Figure A.5).

Figure A.5. Round One Results as Presented in Round Two



SOURCE: Authors' presentation of the research data.

In addition to reviewing the round one results, the experts were asked to discuss them using an asynchronous and moderated online discussion forum. The moderator followed discussion facilitator guidance that was developed for ExpertLens panels (Khodyakov, Grant, et al., 2020) and asked open-ended, non-leading questions designed to obtain more information from the experts, shed additional light on their perspectives, and explore areas of disagreement (see Figure A.6). The discussion was completely anonymous. The experts were assigned an identification code that revealed only their panel (e.g., Expert A01, Expert B12); however, each panel participated in its own discussion forum.

Figure A.6. Round Two Discussion Board

Moderator 01 Posted on Apr 14, 2022 11:25 AM ET

Some experts thought the mandatory aspect was infeasible and would undermine participant buy-in, while others thought it important for outreach and communicating that DoD takes domestic abuse seriously. Are there ways to mitigate the downsides of making it mandatory, or good alternatives that would reach more service members and spouses/partners than DoD is able to today?

[Reply](#)

Expert B41 Posted on Apr 18, 2022 01:21 PM ET

In-processing to a base is often mandatory and this would allow for the base SME to present DV info. One difference is overseas at in-processing your spouse was "highly encouraged" especially if there was driving privileges information. In-processing overseas was a week long. Its only a day at my CONUS base. I think we could really improve our "welcome to this new base" with more engagement in new personnel and spouses. Especially if there was child care offered. This would give the option for families to attend, show that the base really cared, and could connect new spouses together and with agencies. In processing is often with the new service member has the most free time to be away from the work center. In processing could be so much more than it is. If we were to show the importance of welcoming a family to the base it may be more believable the military takes its members and their families seriously.

Expert B43 Posted on Apr 18, 2022 02:32 PM ET

I agree that it would be best to tie this to an existing program or event. Mandatory for family members will be a problem no matter what. The military cannot "require" them to attend anything. It can be tied to a benefit or privilege, but I think that is heavy-handed and would not be received well. One way of increasing reach is to offer the content on multiple types of platforms and be flexible about hours, child care, etc.

Expert B38 Posted on Apr 19, 2022 12:13 PM ET

When checking in to new base provide resource packets to spouses including general safety issues: weather, hazards, housing safety, family safety (FAP and counseling services), chaplains, USO, MWR etc so that a variety of info is obtained at housing, chapel, rec centers, gyms, youth center, commissary, NEX, CYP etc to ensure that all get information.

Expert B51 Posted on Apr 20, 2022 12:32 PM ET

While many military families feel entitled to many things, education about resources should be a mandatory entitlement. The more you know, the more successful and stress free the life of the family will be. Everyday we see families lost in the military system with so many resources available. DOD is lacking on information availability to families. Many times because the military member don't share such important information.

Expert B06 Posted on Apr 24, 2022 09:43 PM ET

Some people focused on what to do when people check in to a new base and hold the training then. But what about the spouse of the troop who didn't meet their significant other until after they got to the base? What about the person that was only dating someone when they arrived to the base? The answer may be give them the training at their next duty location but someone people like myself may stay at one base for over a decade. What to do then? Still cannot make training mandatory for dependents, only highly encourage.

Expert B27 Posted on Apr 24, 2022 10:44 PM ET

I agree with B06. A better strategy must be put in place.

SOURCE: Authors' presentation of the research data.

Round Three

In round three, which took place from April 25 to May 9, 2022, the experts could keep or revise their original responses based on the round two feedback and discussion and could offer additional explanations or final thoughts. The proposed strategies were not modified between the rounds. Although the previous rounds were closed, the participants were still able to read the comments and ratings from the previous rounds for reference during round three.

Mixed-Methods Approach to Data Collection and Analysis

By design, the ExpertLens methodology allows for a seamless integration of quantitative (rating data) and qualitative (explanations of ratings and discussion comments) data. In the next sections, we describe quantitative and qualitative approaches to the analysis of the ExpertLens data, designed to identify whether experts reached agreement regarding the strategies and to explain how and why their perspectives might have varied on each strategy.

Quantitative Data Analysis

To determine whether there was agreement among the experts on the importance, feasibility, and impact of each strategy in round one and round three, we first analyzed the rating data for each rating question in each panel. As is typically done in ExpertLens panels that use 9-point Likert-type rating scales, we used a three-step approach described in the RAND/UCLA

Appropriateness Method manual to determine if the experts reached agreement and what they agreed on (see Figure A.7) (Fitch et al., 2001).

Figure A.7. A Three-Step Statistical Approach to Analyzing Rating Data

Step 1: Calculate Interpercentile Range (IPR)

- $IPR = 70^{th} \text{ percentile} - 30^{th} \text{ percentiles}$

Step 2: Calculate IPR Adjusted for Symmetry (IPRAS)

- $IPRAS = 2.35 + (AI * 1.5)$

AI is Asymmetry Index, or the distance between the central point of the IPR and 5 (the central point of the 1-9 rating scale)

Step 3: Determine the Existence of Disagreement/Agreement and Panel Decision

- **If $IPR > IPRAS$, there is disagreement.**

Disagreement automatically produces uncertain group decision

- **If $IPR < IPRAS$, there is no disagreement.**

If a median score is between 6.5 and 9, then the strategy is important, feasible, or of high impact

If a median score is between 3.5 and 6, then the strategy is of uncertain importance, feasibility, or impact

If a median score is between 1 and 3, then the recommendation is not important, feasible, or of low impact

SOURCE: Authors' application of Fitch et al., 2001.

To develop a rank-ordered list of strategies, we sorted them based on the median ratings on all three rating criteria in the following order: importance, feasibility, and impact on outreach.

Qualitative Data Analysis

Our maximum variation purposive sampling was designed to bring many different perspectives and insights to light. The purpose of the qualitative data analyses was to better understand how and why the proposed prevention, outreach, and evaluation strategies might or might not be important for DoD, identify potential barriers and facilitators to implementation in military settings or populations, and explore whether and how they might enable DoD to better reach and communicate with those who have risk factors for domestic abuse.

Therefore, to better explain experts' perspectives on the importance, feasibility, and impact of the draft recommendations, we thematically analyzed their explanations of the ratings and discussion comments. As is standard for ExpertLens panels (Khodyakov et al., 2019; Khodyakov, Stockdale, et al., 2017), after round one, we grouped all comments explaining the experts' ratings for each strategy and rating question based on the numeric answers provided

(ratings 1–3, 4–6, and 7–9, which correspond to low, medium, and high levels of importance, feasibility, and impact). Doing this is consistent with the mixed-methods nature of the ExpertLens methodology because we could see, for example, what the experts who rated the feasibility of this strategy as low said. Color-coding assisted in identifying similar sentiments across experts with ratings in the same tertile (e.g., comments such as “too expensive,” “costs too much,” and “not enough funding” would be highlighted) and in writing a short summary. From there, the team drafted a few bullets for each category to share with the experts in round two (see Figure A.5). The goal was for the bullets to capture common points and issues for discussion, not to represent every single point that had been raised, since in round two, the experts would have access to the full set of remarks from their panel and could highlight a point through round two remarks.

Three research team members experienced with coding ExpertLens comments, trained and supervised by the ExpertLens coding team leader, coded all round one explanations inductively to identify common emergent themes. Coders coded the data for the same proposed strategies in both panels to ensure consistency. The ExpertLens coding team leader reviewed all coding results to ensure consistency between coders and panels, and the task leader with relevant subject-matter expertise for the topic and setting reviewed the results to ensure correct interpretation of the comments. The team discussed coding inconsistencies or discrepancies until they reached consensus. Comment summaries were programmed into ExpertLens before the start of round two.

The ExpertLens platform enabled us to review the round two discussion comments grouped according to the strategy to which they referred. Similarly, we reviewed any final comments experts offered in round three sorted by strategy and criterion (importance, feasibility, impact on outreach) they referred to. A review of the comments provided in rounds two and three revealed overall theme consistency with round one. Thus, repeating the labor-intensive coding of all of the content from rounds two and three was unwarranted. Instead, we reviewed those comments for additional examples and nuance not captured in the round one summaries that could also be beneficial to integrate. Synthesis of the comment summaries, ratings, and literature provided the basis for the findings in the main body of the report.

Participants

Of the 108 registered experts who agreed to participate, 53 were assigned to panel A and 55 were assigned to panel B. When we updated the experts about when the panels would be starting, one withdrew due to additional competing obligations. Of the 107 remaining experts, 80 (75 percent) participated in the expert panel process by providing input in at least one round. The characteristics of the participating experts are presented in Table A.2. Each panel and the overall group consisted of participants who brought diverse types of expertise and experiences to the process.

Table A.2. Participant Characteristics

Characteristics	Total <i>n</i> = 80		Panel A <i>n</i> = 42		Panel B <i>n</i> = 38	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Type of expert						
Scholar	22	28	13	31	9	24
U.S. military program or service provider	49	61	27	64	22	58
U.S. military commander or senior noncommissioned officer	13	16	7	17	6	16
Domestic abuse survivor activist, lobbyist, organizer, or member of civilian advocacy or support groups	13	16	4	10	9	24
Has openly identified as a survivor of domestic abuse						
Yes	14	18	6	14	8	21
U.S. military affiliation						
Current service member	16	20	8	19	8	21
Current service member's spouse	8	10	5	12	3	8
Current military civilian employee or contractor	36	45	20	48	16	42
Former service member	9	11	5	12	4	11
Former service member's spouse	12	15	4	10	8	21
Former military civilian employee or contractor	5	6	2	5	3	8
None of the above	14	18	8	19	6	16
U.S. military organization affiliation						
Air Force	16	20	9	21	7	18
Army	13	16	8	19	5	13
Marine Corps	19	24	9	21	10	26
Navy	24	30	9	21	15	40
Space Force	1	1	1	2	0	0
Office of Secretary Defense	3	4	1	2	2	5
Coast Guard (Department of Homeland Security)	3	4	3	7	0	0
Not provided or no military affiliation	15	19	9	21	6	16

Characteristics	Total n = 80		Panel A n = 42		Panel B n = 38	
Region						
Midwest	12	15	8	19	4	11
Northeast	5	6	2	5	3	8
South	28	35	11	26	17	45
West	29	36	18	43	11	29
U.S. territories	0	0	0	0	0	0
None of the above or another country	6	8	3	7	3	8
Years of experience with domestic abuse–related issues or activities						
Less than 5 years	11	14	6	14	5	13
5–9 years	17	21	8	19	9	24
10–19 years	19	24	11	26	8	21
20 years or more	33	41	17	41	16	42
Specialized expertise in tailoring prevention activities, including outreach and communication strategies, to different racial or ethnic subgroups						
Mexican, Mexican-American, Chicano, Puerto Rican, Cuban, or other Spanish/Hispanic/Latino populations	26	33	12	29	14	37
American Indian or Alaska Native populations	8	10	6	14	2	5
Asian American populations	10	13	7	17	3	8
Black or African American populations	30	38	13	31	17	45
Native Hawaiian or Other Pacific Islander populations	6	8	4	10	2	5
White populations	49	61	26	62	23	61
Specialized expertise in tailoring prevention activities, including outreach and communication strategies, to different age groups						
16–19 years old	31	39	19	45	12	32
20–29 years old	48	60	30	71	18	47
30–39 years old	38	48	25	60	13	34
40–49 years old	29	36	18	43	11	29
50+ years old	18	23	10	24	8	21

The characteristics of the participants were generally similar to those who were invited to join the panel. All notable differences were still within 10 percentage points. For example, a higher proportion of our 80-person sample, compared with the full sample of 107 experts,

represented military program service provider and practitioner perspectives (61 percent versus 54 percent, respectively) and a smaller proportion represented external civilian survivor experts and advocates (16 percent versus 24 percent). The proportion of civilian contractors working for the military was slightly higher in the group that participated than in the invited group (45 percent versus 38 percent).

Of the 80 participants, 74 (93 percent) participated in round one; 50 (63 percent) participated in round two (of these, roughly half [$n = 24$] posted 241 discussion comments and 40 new discussion threads); and 41 (51 percent) participated in round three. Thirty participants (38 percent) participated in all three rounds.

Results

Analysis of Ratings Across the Rounds Results

Experts in both panels reached agreement on the importance, feasibility, and impact of all 18 proposed strategies in both rating rounds (there was no disagreement among them) (data not shown). Overall, experts in both panels rated the strategies highly on all criteria. Median round one ratings were between 7 and 9 for all three criteria for 15 of the 18 strategies in one panel and for 16 strategies in the other panel. The remaining strategies were rated as uncertain by both panels. Comments and discussion in round two helped address refinements or concerns with a specific portion of a strategy or examples, but did not radically alter the pattern of overall agreement and positive ratings.

Of the 108 rating questions asked across the two rating rounds (18 strategies $\times$ 3 rating criteria $\times$ 2 rating rounds),³ the two panels reached different conclusions on four questions (4 percent). More specifically, they rated the *feasibility* of “expanding relationship and parenting supports” and “engaging peers and survivors in information awareness campaign efforts” differently in round one. They also rated the *importance* of “confidential screening for risk factors and offering assistance” and the *feasibility* of “expanding relationship and parenting supports” in round three differently. The median differences between the panel ratings in all these cases were small (0.5 or 1) and the ratings were on the borderline of uncertain and important or feasible.

Because the panel differences were few and minor and because the experts’ perspectives showed stability between the two rating rounds, we created an analytic sample by combining round one responses from those who did not answer a particular question in round three with round three responses from those who did. There were just a few cases of median ratings in round three or the analytic sample crossing the line between the upper bounds of uncertain and

³ It is a coincidence that 108 is also the number of experts who provided input in round zero.

lower bounds of positive assessments.⁴ Because of this consistency and because in round three participants were only encouraged, and not required, to revise their original responses, we used the larger analytic sample as our final dataset. This analytic approach has been used in previous ExpertLens panels (Bodnar et al., 2021; Claassen et al., 2014; Khodyakov, Mikesell, et al., 2016).

Table A.3 presents the results for a combined analytic sample that includes data from both panels. We grouped the prevention and outreach strategies but kept the evaluation strategies separate. We rank-ordered strategies within each of these two groups by sorting them based on the median ratings on importance and feasibility and then impact on outreach.

In general, experts rated the importance and impact of the proposed strategies higher than their feasibility. They considered all proposed strategies to be important and of high impact but were uncertain about the feasibility of two outreach strategies (“expand relationship and parenting supports” and “confidentially screen for risk factors and offer assistance”), both of which were at the bottom of the rank-ordered list of prevention and outreach strategies. Moreover, more participants skipped the feasibility questions than the importance and impact questions in both rating rounds, which make sense given that some experts were external to DoD and that those who were internal to DoD could still have some uncertainties.

⁴ We first examined round three ratings for each panel separately. In two out of 108 ratings across the two panels, determinations went from uncertain in round one to positive in round three, and in eight cases, the determinations went from positive in round one to uncertain in round three. We also compared the round three results to the analytic sample results. In a few cases (six out of 108), the determination went from uncertain to a positive rating because the analytic sample median ratings were slightly higher (by 0.5 or 1) than if we relied on round three results alone. In just one case, the median feasibility rating was higher by 2 (5 versus 7).

Table A.3. Final Expert Panel Results

Rank	Proposed Prevention and Outreach Strategies	Importance			Feasibility			Impact		
		Decision	Median	N	Decision	Median	N	Decision	Median	N
1a	Integrate domestic abuse focus into other violence prevention activities	+	9	73	+	8	72	+	8	70
1b	Partner with community organizations	+	9	73	+	8	71	+	8	72
2	Increase number of prevention specialists and staff focused on addressing risk factors	+	9	75	+	7	72	+	9	73
3	Improve efforts to protect those with risk factors who are concerned about safety	+	9	75	+	7	73	+	8	72
4	Improve prevention by holding perpetrators and leaders accountable	+	9	76	+	7	75	+	7.5	70
5	Coordinate and promote available financial supports	+	8	75	+	8	72	+	7	69
6a	Focus on preventing partner isolation and dependency risk	+	8	77	+	7	76	+	8	73
6b	Prepare military leaders with education, training, and guidance	+	8	76	+	7	73	+	8	75
6c	Develop cohesive education and training curriculum	+	8	76	+	7	72	+	8	75
6d	Ensure universal military-specific prevention education and training	+	8	74	+	7	70	+	8	73
6e	Engage peers and survivors in info awareness campaign efforts	+	8	76	+	7	74	+	8	73
7	Address military power and control dynamics inappropriate at home	+	8	75	+	7	74	+	7	72
8	Expand relationship and parenting supports	+	8	75	U	6	73	+	8	70
9	Use language that reduces stigma	+	7	76	+	8	73	+	7	73
10	Confidentially screen for risk factors and offer assistance	+	7	76	U	6	74	+	7	74

Rank	Proposed Evaluation Strategies	Importance			Feasibility			Impact		
		Decision	Median	N	Decision	Median	N	Decision	Median	N
1	Collect data on prevention activities and potential impacts	+	8	70	+	8	67	+	7	68
2	Conduct population surveys	+	8	72	+	7	71	+	7	71
3	Conduct surveys and interviews with prevention resource users	+	7	71	+	7	70	+	7	71

NOTE: Experts used 9-point Likert scales from 1 (not important at all, not at all feasible, or no impact) to 9 (very important, very feasible, or great impact).

The table reflects analytic sample data pooled from panel A and panel B.

Panel decisions were determined using the RAND/UCLA Appropriateness Method approach (Fitch et al., 2001).

+ indicates that experts agreed that a strategy is important, feasible, or of high impact (the median panel rating was 6.5 or higher).

U indicates that experts agreed that a strategy is of uncertain importance, feasibility, or impact (the median panel rating was between 3.5 and 6).

Appendix B. Proposed Strategies as Written for the Expert Panel Rating and Discussion

This appendix offers transparency on the original language of the proposed 18 strategies the experts rated and discussed. These strategies were derived from qualitative data analyses of preliminary input provided by the experts prior to the panel and refined following review by subject-matter experts within RAND and the research sponsor's office. The strategies as discussed in the main report reflect the experts' feedback as they rated and discussed the proposed strategies and the RAND teams' analyses and consideration of the scoping literature review results.

The first 15 proposed strategies about prevention and outreach were presented to each expert in a random order. Evaluation strategies were always shown to the participants last. All of the following strategies appear in the ranked order as they are listed in Table A.3 in Appendix A.

Proposed Strategies for Prevention and Outreach and Experts' Ranking

Rank 1a. Strategy: Integrate domestic abuse prevention activities within other violence prevention programs and other efforts to reduce risk factors.

Overview: Military domestic abuse prevention and education specialists regularly coordinate efforts across military programs and support providers to integrate domestic abuse prevention strategies.

How it might work:

- Family Advocacy Program prevention specialists meet at least quarterly with other prevention specialists, allied professionals that offer prevention education services, and support providers (e.g., counselors, nurses, chaplains) to plan, discuss, and assess integrated prevention activities.
- Prevention programming focused on drug and alcohol abuse, sexual assault, sexual harassment, self-harm and suicide, and child abuse and neglect addresses domestic abuse (including sexual abuse or assault) and how it relates to those issues.
- Treatment and other efforts to reduce risk factors (e.g., drug and alcohol abuse treatment, anger management classes) serve as outreach channels for education on domestic abuse and raising awareness of prevention resources, such as relationship support and parent programs.
- Military chaplains are educated and involved in prevention activities so their efforts (e.g., premarital/marital counseling, faith/spiritual interventions) are informed by and contribute to domestic abuse prevention efforts.

Rank 1b. Strategy: Partner with community organizations to facilitate outreach and avenues for those who are afraid to seek help on the installation.

Overview: Family Advocacy Program domestic abuse prevention and education staff identify and build mutually beneficial relationships with relevant civilian community organizations where installation personnel and their families live.

How it might work:

- Ensure that prevention training and messaging includes contact information for non-military community resources, including local agencies and religious organizations. Make it known to members and their spouses/partners that local agencies can support them through stressful life situations like parenting young children and experiencing relationship conflicts.
- Engage community organizations, including religious organizations, so that they are aware of the military's prevention activities and resources for service members and their families and so they can participate in installation prevention activities as appropriate (e.g., health fairs, awareness campaigns).

*Rank 2. Strategy: Increase the number of prevention and education specialists and providers to increase capacity to focus on prevention **before** domestic abuse occurs.*

Overview: Identify where prevention and education specialist and provider capacity does not support a meaningful level of effort toward prevention activities or reducing risk factors, and increase authorizations or position fill rates where position authorizations already exist.

How it might work:

- Increase the number of Family Advocacy Program staff across military installations so a subject-matter expert at each can be dedicated full time to planning, coordinating, carrying out and assessing prevention activities across the installation for different types of populations and risk factors.
- Increase the number of medical, mental health, and substance abuse providers so that service members with risk factors do not have to wait months for an appointment and have ready access to quality support and services.

Rank 3. Strategy: Improve efforts to help those with risk factors who are concerned about their safety.

Overview: Focus on the safety needs of service members and spouses/partners who are worried about the risk for domestic abuse or violence. This would include individuals who are concerned that abuse or violence they have seen directed toward others will be turned toward themselves.

How it might work:

- Seek and/or grant protective orders/no contact orders as a preventative measure.

- Ensure that policies on early return of dependents from overseas accommodate those seeking distance from their spouses because of domestic abuse risk factors.
- Establish or partner with local safe houses near each installation where people and/or their children can stay for a limited time while they work with available supports to make a plan to remove themselves from situations they fear are dangerous.

Rank 4. Strategy: Improve prevention by increasing efforts to hold perpetrators convicted of the crime of domestic violence and their leaders accountable for their actions. [The phrase “crime of domestic violence” included a hyperlink to a PDF of DoD definitions of domestic abuse, domestic violence, and intimate partners that are described and cited in Chapter 1 of this report.]

Overview: Demonstrate to service members with risk factors for domestic abuse perpetration the importance of seeking help before behavior escalates by following through with accountability for those convicted of the crime of domestic violence.

How it might work:

- Through education, training, and messaging campaigns, ensure that service members and spouses/partners are aware that domestic violence is a crime under Article 128b of the Uniform Code of Military Justice.
- Create and enforce policies that hold abusers accountable. Follow through with the punishment if a service member is convicted of domestic violence. Ensure compliance with firearm restrictions for those convicted of domestic violence.
- Create and enforce policies that hold commanders accountable for their actions or inaction in domestic abuse cases.

Rank 5. Strategy: Coordinate and promote efforts to help relieve family financial stressors that can be risk factors for domestic abuse.

Overview: Integrate into domestic abuse prevention activities information about possible sources of financial support and other assistance for families struggling with food insecurity, spouse/partner unemployment, child expenses, debt, foreclosure, bankruptcy, and other financial challenges. Similarly, financial support activities integrate references to domestic abuse prevention resources.

How it might work:

- Messaging, training, literature, websites, and other domestic abuse prevention and financial support activities and materials include content related to the relationship between domestic abuse and economic control and/or financial stressors, and help publicize organizations and resources that can help.

Rank 6a. Strategy: Focus on spouse/partner supports and community integration to counter isolation and dependency risk factors.

Overview: Integrate awareness of and access to social, legal, and economic supports into domestic abuse prevention activities.

How it might work:

- Promote many, varied opportunities for families to engage in the military community and build social networks to avoid isolation and facilitate outreach.
- Ensure spouses are aware of and can access legal and financial resources so they can be or become self-sufficient. Financial resources would include financial literacy courses, advice from financial planners, existing programs to support spouse employment, and help applying for financial aid/assistance. Legal supports can assist with separation, divorce, child custody, and immigration issues.

Rank 6b. Strategy: Prepare military leaders to actively participate in prevention activities and convey the expectation that they will participate.

Overview: Provide officers and noncommissioned officers with the education, training, guidance, and incentives they need to help advance domestic abuse prevention efforts in the armed forces.

How it might work:

- Educate all junior and senior military leaders about what constitutes domestic abuse and how to
 - identify risk factors for domestic abuse
 - proactively discuss domestic abuse throughout the year
 - dispel myths about domestic abuse
 - approach/guide service members or spouses/partners experiencing risk factors
 - encourage service members to utilize relationship support and other domestic abuse prevention resources
 - incentivize service members to invite family members to community events.
- Annually train military leaders about the various courses of action they can take toward someone exhibiting adverse behaviors that are risk factors for domestic abuse (e.g., legal, disciplinary, reporting and referrals) and available community resources for domestic abuse prevention.
- Encourage leaders to raise awareness of the Family Advocacy Program and other domestic abuse prevention resources within preexisting orientation, commander's calls, trainings, professional military education, common military training, or briefing opportunities.

Rank 6c. Strategy: Develop a military-specific domestic abuse prevention education and training curriculum for service members and their spouses/partners.

Overview: The Department of Defense should develop a cohesive series of military-specific education and training modules addressing

- safe and healthy relationships, including equity, consent within relationships, communication skills, problem-solving, and conflict resolution
- unsafe and unhealthy relationships, including domestic abuse definitions and behaviors; individual, relational, community, and societal risk factors for domestic abuse; power and control tactics; early warning signs; and harmful impacts of domestic abuse
- stress management, anger management, emotion regulation, coping mechanisms, and managing the effects of trauma (e.g., military trauma, trauma from childhood)
- positive masculinity
- military domestic abuse and domestic violence policies and regulations, military and community resources available to address risk factors for domestic abuse, bystander intervention, reporting channels and processes (e.g., who will be informed?), protection and services for victims, and consequences/accountability for abusers.

How it might work:

- Subject-matter experts develop and deliver the material and periodically refresh the content to keep it current.

Rank 6d. Strategy: Ensure all service members and their spouses/partners receive military-specific domestic abuse prevention education and training.

Overview: Deliver prevention education and training to everyone. This approach will reach individuals with risk factors for domestic abuse without having to identify and single them out. It will also reach bystanders, leaders, and individuals who will develop risk factors in the future.

How it might work:

- mandatory
 - for all entry-level service members
 - for all new spouses (linked to accessing military benefits such as family housing)
 - annually for all service members
- open to all spouses/partners
- delivery through a variety of modes (e.g., webinar, in person, online video/film)
- dissemination must include options for anonymous and on-demand access to instructional materials (e.g., guides, videos)
- materials easily accessible across multiple military and nonmilitary platforms at any time (e.g., on military websites, social media such as YouTube, posters and literature posted in locations frequented by military families, military television networks, emails to service members and spouses).

Rank 6e. Strategy: Engage peers and survivors in planning, implementing, and assessing domestic abuse prevention education, training, and information awareness campaigns.

Overview: Identify influential peers and survivors to work with Family Advocacy Program and other prevention staff in developing tailored and effective prevention activities, outreach, and communication.

How it might work:

- Solicit input and feedback from domestic abuse survivors on messaging and strategies, including survivors from marginalized groups.
- Involve influential peers and popular opinion leaders to better tailor efforts and reach diverse populations, such as different age groups, genders, groups living overseas, individuals with limited English proficiency, and communities with different barriers.
- Engage peers and survivors in developing culturally sensitive messaging tailored to communities within the military (e.g., racial/ethnic, sexual minority).

Rank 7. Strategy: Address intimidation, coercion, threats, abuse of authority, and other dynamics occurring in military units that are inappropriate to emulate at home.

Overview: Develop strategies to address power and control dynamics within the military that unintentionally reinforce/model behavior that may be appropriate in other settings (i.e. combat) but would be inappropriate outside of those settings.

Click **here** to see the Power and Control Wheel model and **here** for a version adapted for the military setting. [The two **here** references provided hyperlinks to one-page PDFs displaying the models distributed by the National Center on Domestic and Sexual Violence from 2018 and 2003, respectively]

How it might work:

- Coordinate with military training and professional military education commands so they understand the potential harm of misuse of power and control dynamics and can address it within military training and education.
- Integrated violence prevention training would help service members understand abuse of authority and workplace violence within military units and how to address or report it.

Rank 8. Strategy: Expand the types of services available to support individuals and couples struggling with relationship and parenting issues.

Overview: Provide opportunities beyond individual and couples counseling for relationship support to intervene in unhealthy behaviors—opportunities that are nonpunitive and do not jeopardize the service member’s career.

How it might work:

- Provide separate support groups for male and female service members who are struggling with relationship stress, conflict, infidelity, impending divorce or relationship ending to help them before an abusive incident can occur.
- Provide prevention forums or workgroups for populations with risk factors for domestic abuse.
- Host local “healthy households” meetings, required monthly or quarterly for on-installation residents and open to those who live off the installation, in which relationship skills are taught/discussed, and “toxic” dynamics are explored.
- Ensure that programming to help new parents deal with the stress of having young children includes responsible fatherhood programs and home visitation for new parents.

Rank 9. Strategy: In military messaging, outreach, and interactions, use language that can reduce stigma, normalize experiences, and encourage help-seeking.

Overview: Review and choose language carefully. Avoid language focused on criminality, investigations, and punishment. Use language that normalizes the experiences of stress, violence, and relationship struggles and that promotes relationship support and enhancement.

How it might work:

- Rather than “domestic abuse” and “domestic violence,” prevention activities encourage help-seeking by using language that emphasizes conflict that has become “physical” or couples “fighting a lot” or partner behavior that worries you or scares you. Communicate about conduct rather than using criminal labels for people. Recognize that many people who have experienced domestic abuse do not consider themselves “victims.”
- Promote a “growth mindset” that frames people as capable of change.
- Publicize the results of an anonymous survey on domestic abuse so individuals experiencing abuse or using abuse know they are not alone.
- Develop a clear, succinct, memorable message or key phrase, similar to the mantra “see something, say something.”

Rank 10. Strategy: Confidentially screen for risk factors for domestic abuse and offer confidential assistance and intervention planning to prevent abuse from occurring.

Overview: Use the military health care system and TRICARE health care providers for confidential risk factor screening. Providers would not have any new reporting requirements tied to the screening results.

How it might work:

- Screen all incoming service members and new spouses for risk factors, and screen during annual physicals.
- Screeners offer options for confidential assistance to those who have past experiences (either as victim or perpetrator) with domestic abuse, sexual abuse, child abuse, or other

forms of abuse that may be risk factors, or who currently have other risk factors for domestic abuse, such as marital stress.

- Coordinate across programs, if necessary, to develop confidential intervention plans for those with several risk factors.

Proposed Strategies for Evaluation of Prevention and Outreach Activities and Experts' Ranking

Items in this section related to measuring and evaluating the types of activities described in the other 15 strategies were presented after those other proposed strategies. Here, they appear in the order they were rated by the analytic sample (see Table A.5 in Appendix A for details) but in the order displayed to each participant, the first strategy here was presented last.

Rank 1. Strategy: Collect data on domestic abuse prevention activities/resources and potential impacts.

- Creation of an incident database compatible across DoD and able to be cross-referenced. This would include the Family Advocacy Program Central Registry and law enforcement and legal databases that include actions taken to hold abusers accountable.
- Quarterly reports tracking data such as
 - *Participation*: Number participating in activities, frequency and type of activities, command participation in prevention activities, command engagement with Family Advocacy Program staff, statistics on website/social media views and information downloads.
 - *Capacity*: Number of Family Advocacy Program prevention specialists dedicated to prevention activities, hours of service for programs/providers, and wait list/wait times to use prevention resources.
 - *Risk factors*: Aggregated data from health care provider screening for risk factors.
 - *Incidents*: Number and type of reported incidents (to hotlines, the Family Advocacy Program, law enforcement), timeline for processes to address reported incidents, incident determinations/service recommendations, and number of cases without further issues/recidivism.

Rank 2. Strategy: Conduct population surveys with service members and spouses and partners.

- Anonymous or confidential population surveys to measure knowledge and understanding of domestic abuse, risk factors, experiences with domestic abuse (including type, frequency, severity), awareness of and attitudes toward domestic abuse prevention activities/resources and reporting channels, barriers to help-seeking, command buy in-/involvement in prevention.
- Longitudinal surveys to measure changes over time.

Rank 3. Strategy: Conduct surveys or interviews with users of domestic abuse prevention resources.

- Surveys before and after education and training to assess participant understanding of the material, awareness of support resources, and willingness to use available resources.
- Surveys or interviews with users of relationship support programs on how they learned about those programs, their experiences with and attitudes toward those programs, perceived program quality, and self-reported impacts on the reduction of risk factors for domestic abuse.
- Interviews with survivors on domestic abuse prevention–related policies and resources.
- Interviews with providers/practitioners involved in prevention activities (e.g., instructors, relationship counselors, screeners for risk factors).

Appendix C. Detailed Scoping Review Methods and Findings

Scoping reviews are a key component in the knowledge translation process. These reviews map the literature, describe core themes within the collective knowledge on a topic, and identify gaps. Results of scoping reviews can inform decisionmaking about the pursuit of systematic reviews or meta-analyses on interventions and programs to provide practical guidance in clinical and professional practice. As contrasted with unformalized forms of research synthesis (e.g., literature reviews), the scoping review described in this appendix was conducted systematically, meaning that the research team employed searches, screening practices, and reporting of the evidence based on a standardized and internationally recognized set of methods to promote transparency and consistency (Peters et al., 2015; Tricco et al., 2018). These reviews also used detailed protocols to guide how the review was conducted and to track deviations from intended methods. By using a systematic and standardized approach, we promoted the integrity of this review and produced a product that is more comprehensive, less biased, and more meticulously documented than unsystematic or more-targeted approaches.

What We Did

We conducted a scoping review of the literature to describe and evaluate the current evidence base on two topics of broad importance to domestic abuse prevention:

1. evidence-informed or research-based *prevention strategies* to reduce the incidence of domestic abuse
2. evidence-informed or research-based *outreach strategies* to reach populations with risk factors for domestic abuse.

Under these topics, we designed the review to focus on the following key questions: What strategies have been implemented to prevent domestic abuse among adults and what were their outcomes? What are the measures used to evaluate domestic abuse prevention strategies? What outreach strategies are used to reach individuals with risk factors for domestic abuse? How is effectiveness evaluated for domestic abuse outreach?

The focus of this review was on efforts designed to prevent domestic abuse before it initially occurs, often referred to as primary prevention. Primary prevention directed toward an entire population can be resource intensive. For this reason, some primary prevention programs prefer to target relationships or individuals with risk factors for domestic abuse, but who have not yet experienced abuse. Consistent with this focus, we prioritized research on programs targeting individuals or relationships before any abuse is reported or is readily apparent to members of the institution or community. This delimitation aligned with the identified strategies that are

considered primary and secondary prevention under the FAP logic model for preventing domestic abuse and child abuse and neglect (FAP, 2021).¹

The remainder of this appendix lays out the methodology used to conduct the scoping review and catalogs the findings in detail. Appendix D lists the 104 articles and reports selected for inclusion in our analysis.

Methodology

Search Strategy

This review began with a search of academic databases to identify potentially relevant studies published on or after January 1, 2001. We applied a comprehensive set of search terms across the following electronic databases: PubMed, PsycINFO, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Campbell Collaboration Library of Systematic Reviews, Cochrane Database of Systematic Reviews (CDSR), Cochrane Central Register of Controlled Trials (University of California and Central South), Business Source Premier, and Proquest Sociological Abstracts.

To capture studies or reports that may not have been indexed in the above databases, we conducted a targeted secondary search for articles and reports through non-academic information sources, including the Defense Technical Information Center, Military REACH Library, RAND.org, and a general web search using Google advanced search. We also did a targeted search of the FAP website, the RAND publications database, and the CDC website. Finally, we hand-searched the reference lists in any relevant systematic reviews to help ensure a comprehensive review of relevant studies.

Our searches paired terms to capture the concepts of domestic abuse, relationship education, or intimate partner with terms related to prevention, outreach, and the military. For the following list of terms, we also searched variations of the terms (e.g., prevent, prevention, preventing; soldier and soldiers; service member and servicemember):

- domestic abuse: domestic abuse, domestic violence, marital abuse, marital violence, partner abuse, partner violence, spousal abuse, family violence, relationship aggression, intimate partner rape, marital rape, emotional abuse, psychological abuse, economic abuse, economic control
- relationship education
- intimate partner AND sexual
- prevention: prevent, deter, screen, empower, train, workshop, intervene, program
- outreach: outreach, awareness, communicate, educate, campaign, community engagement

¹ Development of this logic model is noted in DoD, 2021.

- military: military, soldier, marine, sailor, airman, guardians, guardian, veteran, armed forces, army, navy, air force, coast guard, reserves, national guard, service member, servicemember, troops, servicemen, servicewomen.

Additionally, because we expected the literature on outreach to be particularly thin, we paired terms in that category not only with the domestic abuse terms, but also with interpersonal violence.

Eligibility Criteria

To screen records identified in the search, we defined an eligibility criteria protocol. Study inclusion and exclusion criteria are summarized using an adaptation of the PICO framework for specifying review scope:² populations, interventions, comparators, outcomes, time frames, settings, and study designs (Butler et al., 2017). Parameters for the inclusion and exclusion criteria are presented in Table C.1.

Table C.1. Inclusion and Exclusion Criteria for Prevention Strategies

	Inclusion Criteria	Exclusion Criteria
Populations	Adults or adult couples (18 years of age or older) without documented history of domestic abuse in the past year	Samples primarily composed of individuals or couples less than 18 years of age; individuals or couples with a documented history of domestic abuse in the past year
Interventions	Studies that describe domestic abuse prevention strategies or efforts	Studies focused • on strategies for treating the immediate or long-term consequences of domestic abuse • on reducing recidivism among documented cases of domestic abuse • solely on describing the prevalence or incidence of domestic abuse • solely on measuring the harms and impacts of domestic abuse • primarily on the design, implementation, and benefits of screening for ongoing cases of abuse
Comparators	No comparison or control groups required	None
Outcomes	• All forms of domestic abuse, including physical, emotional, sexual, economic, restriction of movement, neglect, injury, and death • Domestic abuse risk factors • Relationship conflict • Relationship satisfaction	Child or elder abuse
Timeframes	Studies published on or after January 1, 2001	Studies published prior to January 1, 2001
Settings	United States or Canada	None

² The Population, Intervention, Comparison, Outcome (PICO) framework is commonly used or adapted in developing public health or clinical research questions for systematic reviews (Carande-Kulis, Elder, and Matson-Koffman, 2022).

	Inclusion Criteria	Exclusion Criteria
Study design	Primary research that may be qualitative, observational (e.g., recording prevention strategies); longitudinal (e.g., the effectiveness of prevention strategies over time); or intervention studies	Conceptual or theoretical research, case studies based on one individual, editorials, literature reviews, letters to editors, books, theses, conference abstracts

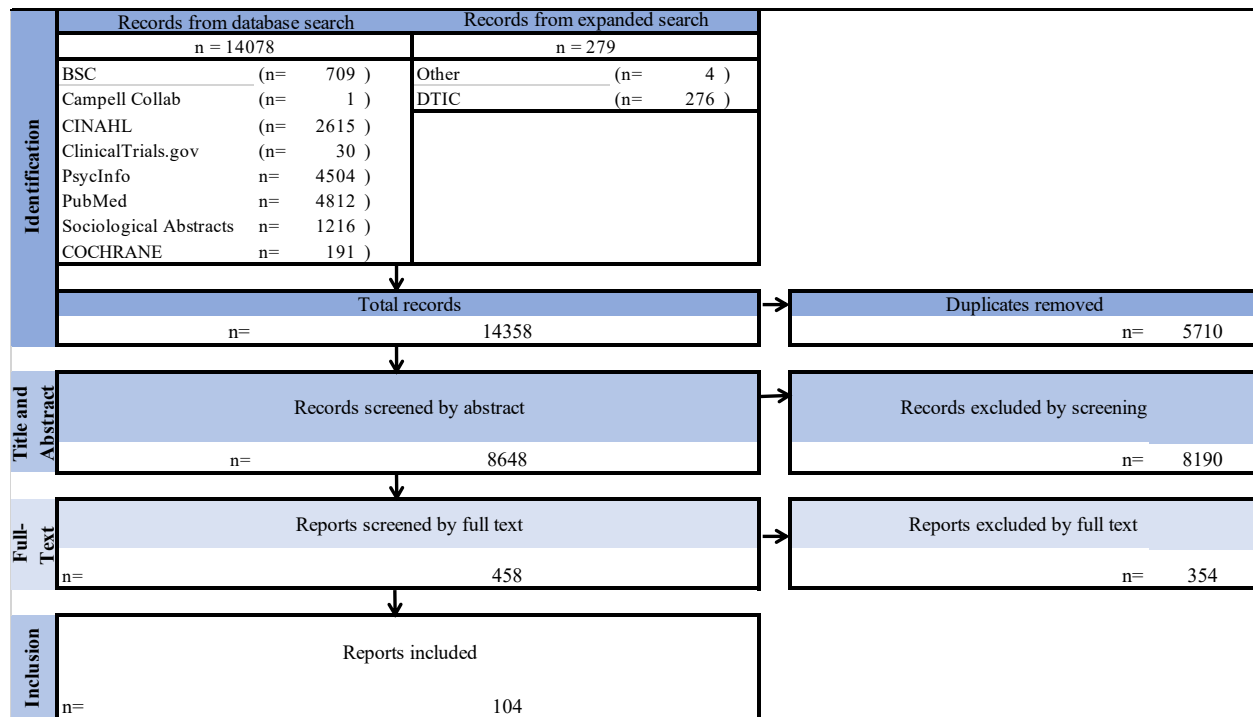
Inclusion Screening

The initial search yielded more than 14,000 records.³ Records were retrieved from the first database searched; identical records found in other databases were removed as duplicates when the search was being completed, yielding 8,647 unique records. To manage the review, title and abstracts of unique records were imported into DistillerSR, an online data abstraction program for systematic reviews. The results of the literature searches and inclusion screening decisions are documented in a PRISMA flow diagram (Figure C.1) (Moher et al., 2015). Once titles and abstracts were retrieved, three reviewers screened batches of 30 records at a time and compared responses to promote consistency. During this stage, some of the most frequent reasons for exclusion were non-U.S. population (setting), tertiary prevention strategy (intervention), and records focused exclusively on measuring the harms of domestic abuse (intervention).

Records deemed relevant in the title and abstract screen stage were then obtained as full text reports ($n = 457$). Four additional duplicates were identified and removed. At this stage, each report was screened by two independent reviewers. Discrepancies or conflicts were automatically flagged in DistillerSR and were resolved through discussion among the research review team. In the full-text review, 354 reports were excluded. The most common reasons for exclusion were the lack of a specific prevention or outreach strategy studied (intervention), type of study design (e.g., commentary, literature reviews), a tertiary prevention strategy (intervention), and the study was primarily composed of participants under 18 years of age (population). Following full-text review, 104 reports were identified for data abstraction.

³ Here, we adopt the nomenclature recommended in the most recent Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. *Records* are items identified in a search of academic or other databases, and items retrieved in full-text form are *reports*, which may include any document providing potentially relevant information, including journal articles and government reports. Research determined to be in scope for the review and included in the analysis are referred to as *studies*. In some cases, a single report may include multiple relevant studies, such as when the methods and results of two independent experiments are published in a single report, or a single study may produce several reports, such as when a protocol or preliminary results are published in a separate document.

Figure C.1. PRISMA Flow Chart of Literature Search and Screening



SOURCES: RAND analysis, authors' application of Moher et al., 2015.

NOTE: BSC = Business Source Complete; DTIC = Defense Technical Information Center.

We created abstraction forms to use when reviewing each of the 104 reports to ensure consistent and comprehensive data collection processes. In one case, two studies were described in a single report, so data were separately abstracted for each study in the report (and thus, 105 studies described in 104 reports were included). Reviewers tested the abstraction form to promote consistent interpretation of form instructions and data entry. The team discussed concerns and incorporated revisions into the form. One reviewer abstracted data that were checked by a second, experienced reviewer; the reviewers discussed and resolved discrepancies.

Analysis

To structure our analysis, we grouped prevention strategies into five major categories, drawing from the CDC Division of Violence Prevention technical package on preventing IPV across the lifespan (Niolon et al., 2017). The five categories, with titles modified slightly to fit this study, are (1) teach safe and healthy relationship skills, (2) engage influential community members, (3) create protective environments, (4) strengthen economic supports, and (5) integrate approaches with other prevention and risk reduction efforts. Studies within each major category were further grouped into minor categories based on common strategy features. Within each minor category, we group findings of the strategies by prevention target: strategies to prevent victimization, strategies to prevent perpetration, and strategies to prevent both victimization and

perpetration. Table C.2 lists and defines the five major categories and associated minor categories we used to organize the scoping review results on prevention strategies.

Table C.2. Domestic Abuse Prevention Strategy Categories and Definitions Used to Organize the Research

Prevention Strategy Categories	Definition
Teach safe and healthy relationship skills	• Directly improving skills (including knowledge) among potential victims or perpetrators that help prevent domestic abuse
Individual skills	• Strategies promoting individual skills to prevent domestic abuse perpetration or victimization
Relationship skills	• Strategies promoting relationship skills among individuals or couples to prevent relationships from becoming abusive
Skills for parents	• Strategies promoting parenting skills, either individually or at the family level, to prevent domestic abuse among families with children
Engage influential community members	• Engaging community leaders and peers to promote positive relationship expectations, beliefs, and willingness to intervene when domestic abuse is encountered
Bystanders or peers	• Strategies that promote positive relationship expectations and willingness to intervene in domestic abuse among bystanders or peers
Military leaders	• Strategies that target leaders and key personnel in the military to prevent domestic abuse from occurring among military populations
Faith leaders	• Strategies that train and educate faith leaders to integrate domestic abuse prevention into the messaging and services provided at places of worship
Create protective environments	• Shaping community environments (e.g., through rules, policies, programs) to foster the prevention of domestic abuse
Workplace strategies	• Strategies that make changes to the workplace environment
Public policy	• Public, policy-based approaches to prevention
Community engagement	• Strategies that seek to engage community members to promote protective environments through community-led prevention efforts
Organizational or professional coordination and capacity building	• Strategies that focus on improving the ability of organizations or professionals to effectively implement prevention strategies
Strengthen economic supports	• Providing support to prevent domestic abuse through means that reduce financial stress, instability, inequality, or dependence
Cash transfer policies	• Strategies that provide direct financial assistance

Prevention Strategy Categories	Definition
Welfare reform	Strategies that encourage employment among welfare recipients
Integrate approaches with other prevention and risk reduction efforts	Strategies that cointegrate domestic abuse prevention within other behavioral health interventions
Cointegration with substance use disorder interventions	
Cointegration with HIV interventions	

SOURCE: Authors' application of Niolon et al., 2017.

Within each type of prevention strategy, we report on the number of strategies that were taken, variations we observed in those strategies by subgroup, the kinds of measures used to evaluate those strategies, the outcomes of those measures, and any variation observed in those outcomes by subgroups of interest. We documented the findings, as reported by the authors of the source documents, in terms of whether an association was detected between the prevention strategy and the outcomes related to strategy success. Therefore, the results should not be interpreted as indicators of strength of evidence but as a description of the reported findings within the body of identified literature.

Because of the wide variability in measures, time points, and application of analytic methods (e.g., statistical adjustment, subgroup analyses) we often grouped types of findings by a common descriptor to ease interpretability and the identification of patterns, even though underlying measures may vary study by study. In general, within a category of outcomes for each study, we recorded an association as being detected if at least one component of that outcome was reported to be statistically significant in the main analysis. For example, a study finding a reduction in physical IPV but not psychological IPV would be recorded as having detected an association in the occurrence of IPV. In our discussion of the findings in the next section, we report variation in the results by subgroup separately; we also report variation across time points or other, more-nuanced analyses determined to be of interest.

To analyze articles with relevance to outreach to populations with risk factors for domestic abuse, we describe strategies by common category of risk factor that were observed in the abstracted results, and we also describe common measures used to evaluate the effectiveness of outreach and delivery strategies along with results of those evaluations when reported.

Detailed Cataloguing of the Findings on Prevention Strategies

Using the five major categories described in Table C.2, we sorted the primary domestic abuse prevention strategies targeting adults over 18 years of age that were identified through our literature review. Of the studies reviewed, 48 investigated strategies focusing on teaching safe and healthy skills related to avoiding domestic abuse, 19 focused on engaging influential community members, 14 focused on creating protective environments, 5 focused on providing

economic support, and 7 consisted of combined strategies. In this appendix, we use these categories to catalog the broad spectrum of domestic abuse prevention strategies evaluated in the academic and gray literature as identified by our search.

Teach Safe and Healthy Relationship Skills

We examined 48 studies investigating strategies focused on directly teaching skills and knowledge to empower potential victims or perpetrators to prevent domestic abuse from occurring in their own lives. Strategies in this category generally focused on one of three kinds of skills: those intended to help individuals reduce their personal risk of domestic abuse, those intended to reduce the risk of domestic abuse within a relationship, and those intended to reduce the risk of domestic abuse within families with children. Table C.3 describes the strategy target and the associated aims, measures, and outcomes for strategies identified in the literature for each of these categories.

Individual Skills

Seventeen studies evaluated strategies to provide individuals with information and training to prevent becoming victims or perpetrators of domestic abuse (Bridges, Karlsson, and Lindly, 2015; Cavanaugh, Solomon, and Gelles, 2011; Creech et al., 2021; Davila et al., 2008; Decker et al., 2017; Dill-Shackleford et al., 2015; El-Mohandes et al., 2008; Ernst et al., 2011; Finkel et al., 2009; Fuchsel et al., 2016; Gilbert et al., 2016; Jack et al., 2019; Keller and Honea, 2016; Keller, Wilkinson, and Otjen, 2010; Weir et al., 2009; Wenzel et al., 2009; West, 2013). Two studies focused solely on strategies for the prevention of perpetration, seven studies focused solely on strategies for the prevention of victimhood, and seven studies focused on both. Both perpetration-focused studies tested the efficacy of improving self-regulation skills, one through counseling and one using a brief task under experimental conditions (Cavanaugh, Solomon, and Gelles, 2011).

The victimization-focused strategies included efforts to reduce a victim's domestic abuse or related behavioral risks through empowerment (El-Mohandes et al., 2008; Gilbert et al., 2016; Fuchsel et al., 2016), increasing knowledge about IPV (Fuchsel et al., 2016; West, 2013), educating potential victims on domestic abuse resources (Decker et al., 2017), or a combination of two or more of these approaches (Wenzel et al., 2009). In two studies, domestic abuse was just one of a broader set of risk behaviors being targeted (e.g., sexual, drug, and alcohol risks) (Creech et al., 2021; Wenzel et al., 2009). Modes of delivery varied, including brochures (El-Mohandes et al., 2008), in-person discussions with a health provider, group sessions, internet modules, and mass media (West, 2013). Strategies targeting both potential victims and perpetrators included efforts to raise awareness and increase knowledge about domestic abuse (such as what constitutes abuse and the role of coercion and control) and to dispel domestic abuse myths. Modes included live theater, mass media, passive informational handouts, and computer-based materials.

Table C.3. Summary of Domestic Abuse Prevention Strategies that Teach Safe and Healthy Relationship Skills

Strategy's Primary Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Individual skills				
Potential victims	To increase knowledge of domestic abuse and associated resources; improve domestic abuse attitudes and norms; and reduce behavioral risks through empowerment	1. Domestic abuse knowledge (2/3) 2. Attitudes and norms (0/1) 3. Self-esteem (1/1) 4. Occurrence of domestic abuse (2/5)	1. Decker et al., 2017; Wenzel et al., 2009 2. – 3. Fuchsel et al., 2016 4. Creech et al., 2021; Gilbert et al., 2016	1. Fuchsel et al., 2016 2. Davila et al., 2008 3. – 4. El-Mohandes et al., 2008; Jack et al., 2019; Weir et al., 2009
Potential perpetrators	To reduce risk of domestic abuse perpetration by improving self-regulation skills and/or empathy skills	1. Anger management skills and risk for eruptive violence (1/1) 2. Abusive language use (1/1)	1. Finkel et al., 2009 2. Cavanaugh, Solomon, and Gelles, 2011	1. – 2. –
Both potential victims and potential perpetrators	To raise awareness and knowledge of domestic abuse and dispel myths	1. Domestic abuse knowledge (3/3) 2. Endorsement of domestic abuse myths (1/1) 3. Attitudes and norms (2/2) 4. Knowledge of domestic abuse services (1/1)	1. Bridges, Karlsson, and Lindly, 2015; Dill-Shackleford et al., 2015; Ernst et al., 2011 2. Dill-Shackleford et al., 2015 3. Bridges, Karlsson, and Lindly, 2015; Ernst et al., 2011 4. Keller, Wilkinson, and Otjen, 2010	1. – 2. – 3. – 4. –
Relationship skills				
Potential victims	To prevent domestic abuse by teaching individual-oriented relationship skills when couple participation is impractical and to empower women in relationships	1. Domestic abuse awareness (2/2) 2. Conflict resolution skills (0/1)	1. Carlson, Wheeler, and Adams, 2018; Fuchsel, Marrs, and Hysjulien, 2013 2. –	1. – 2. Carlson, Wheeler, and Adams, 2018

Strategy's Primary Target	Objective	Measured Outcomes^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
		3. Empowerment (1/1)	3. Fuchsel, Marrs, and Hysjulien, 2013	3. –
Potential perpetrators	To prevent domestic abuse through positive relationship attitudes, communication skills, and self-regulation skills	1. Negative communication (1/1)	1. Khalifian et al., 2019	1. –
		2. Interpersonal confidence (1/1)	2. Khalifian et al., 2019	2. –
		3. Occurrence of domestic abuse (1/1)	3. Khalifian et al., 2019	3. –
Both potential victims and potential perpetrators	To prevent domestic abuse by improving relationship satisfaction, confidence in relationships, and intimacy; improve communication and conflict resolution skills; teach couples supportive and empathetic skills; identify and address controlling behaviors; detect relationship health deterioration for early intervention	1. Communication (4/4)	1. Antle et al., 2011; Antle et al., 2019; Antle et al., 2020; McCabe et al., 2016	1. –
		2. Knowledge and attitudes (2/2)	2. Antle et al., 2011; Antle et al., 2020	2. –
		3. Relationship satisfaction (2/4)	3. Antle et al., 2019; Rhoades, 2015; Roddy, Georgia, and Doss, 2014	3. Taft et al., 2014; Williamson et al., 2015
		4. Relationship aggression events (1/1)	4. Rodriguez, Stewart, and Neighbors, 2021	4. –
		5. Relationship conflict (1/1)	5. Georgia Salivar et al., 2020	5. Georgia Salivar et al., 2020
		6. Occurrence of domestic abuse (10/11)	6. Antle et al., 2019; Braithwaite and Fincham, 2009; Braithwaite and Fincham, 2014; Khalifian et al., 2019; McCabe et al., 2016; Nowlan, Georgia, and Doss, 2017; Owen, Antle, and Quirk, 2017; Rhoades, 2015; Taft et al., 2014; Taft et al., 2016	6. –
		7. Termination of abusive relationships (1/1)	7. Cigrang et al., 2016	7. –

Strategy's Primary Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Skills for parents				
Potential victims	To offer harm reduction strategies to reduce risk for pregnancy; offer education on reproductive coercion; empower women to acquire skills and knowledge to avoid domestic abuse	1. Awareness and knowledge of resources (1/2) 2. Self-efficacy to enact harm-reduction behaviors (1/1) 3. Reproductive coercion (1/1) 4. Occurrence of domestic abuse (1/3)	1. Miller et al., 2016 2. Miller et al., 2016 3. Miller et al., 2011 4. Feder et al., 2018	1. Miller et al., 2011 2. – 3. – 4. Miller et al., 2011; Miller et al., 2016
Potential perpetrators	To prevent domestic abuse through education and screening delivered through responsible fatherhood programs	1. Prevention program staff views (1/1)	1. Karberg et al., 2020	1. –
Both potential victims and potential perpetrators	To prevent domestic abuse by: enhancing the coparenting relationship; improving relationship functioning and parenting discipline and monitoring; supporting positive, effective parenting; developing family resilience; improving couple's communication, problem-solving skills, and access to needed resources and services	1. Communication (1/1) 2. Relationship satisfaction (1/2) 3. Parenting satisfaction (1/1) 4. Conflict behaviors (2/2) 5. Conflict resolution skills (1/1) 6. Occurrence of domestic abuse (4/6)	1. Charles, Jones, and Guo, 2014 2. Charles, Jones, and Guo, 2014 3. Heyman et al., 2020 4. Charles, Jones, and Guo, 2014; Heyman et al., 2019 5. McKinley and Theall, 2021 6. Charles, Jones, and Guo, 2014; Feinberg et al., 2016; Heyman et al., 2020; McKinley and Theall, 2021	1. – 2. Heyman et al., 2020 3. – 4. – 5. – 6. Heyman et al., 2019; Jacobs et al., 2016

SOURCE: RAND analysis of scoping review data.

NOTES: Strategies are grouped into whether they were largely designed to target potential victims, perpetrators, or both. This grouping is not our assessment of the relevance of the content for specific audiences. Objective shows one or more examples that are representative of the types of strategies within the grouping. Measured outcomes present outcomes across the identified literature used to evaluate strategy effectiveness. Qualitative measures or outcomes with no test of impact are not included in this table. Full references for citations are listed in Appendix D.

^a Parentheses contain the number of included studies that reported a positive impact or impacts for that outcome over the total number of studies using the outcome.

Two articles described a prevention approach that catered to a specific subgroup. In both interventions, the curriculum was designed to reflect relevant cultural characteristics of Spanish-speaking Latinas, such as subordination-based gender role norms (*marianismo*) and the importance of family (*familismo*) (Fuchsel et al., 2016). In addition to cultural considerations, one article also applied intersectionality frameworks to the curriculum, and sought to interpret issues of gender through the lens of systems of oppression or discrimination (Fuchsel et al., 2016). Other prevention efforts had specific approaches that varied by gender. For example, one program was tailored for female veterans, using videos of other female veterans in their content (Creech et al., 2021).

Measures of Impact and Outcomes

Perpetrator-focused studies were evaluated for their impact on potential risk factors for future domestic abuse, including measures of anger management skills, risk of eruptive violence (Cavanaugh, Solomon, and Gelles, 2011), and the verbal articulation of IPV-related thoughts in response to stimuli (Finkel et al., 2009). Anger management counseling was found to reduce the risk for eruptive violence (Cavanaugh, Solomon, and Gelles, 2011), and brief interventions to boost self-regulation showed a reduction in IPV verbalization post-intervention relative to a control group (Finkel et al., 2009). Studies focused on preventing victimization evaluated strategies by measuring reactions to resources and information, measurement of knowledge change, change in self-esteem (Fuchsel et al., 2016), and reductions in self-reported domestic abuse. To measure occurrence of domestic abuse, four studies used validated self-reported surveys (Conflict Tactics Scale or CTS [El-Mohandes et al., 2008; Gilbert et al., 2016; Wenzel et al., 2009], Composite Abuse Scale [Jack et al., 2019]), one used a physician-administered screening tool (Women Abuse Screening Tool [Creech, 2021]), and one study relied on personal interviews (Weir et al., 2009).

Two out of three studies exploring impact on improving knowledge of domestic abuse found positive impacts (Decker et al., 2017; Wenzel et al., 2009); however, a lower proportion of studies found effects on domestic abuse attitudes or in reductions in domestic abuse itself (measured via self-report). Two out of five studies examining impact on domestic abuse occurrence found reductions among their study populations (Creech et al., 2021; Gilbert et al., 2016). Studies focused on preventing both victimization and perpetration of domestic abuse evaluated strategies based on changes in domestic abuse knowledge (e.g., definitions, occurrence rates, who is affected); beliefs in domestic abuse myths, attitudes, and norms; and knowledge of domestic abuse services. All studies detected positive impacts across these measures.

Three studies noted outcomes that varied by subpopulation. Two separate studies of a mass communication strategy found different outcomes for men and women (Keller and Honea, 2016; Keller, Wilkinson, and Otjen, 2010). The earlier study, which focused on television and billboard ads that aimed to broaden perceptions of what constitutes abuse, found that women's perceptions of abuse severity increased while men's perceptions decreased (Keller, Wilkinson, and Otjen,

2010). In a qualitative follow-up study, the authors identified male unwillingness to view abuse in the context of gender inequality and a resentment of gender stereotypes as contributing factors (Keller and Honea, 2016). One study reported on differences in prevention effectiveness by ethnicity but did not detect a difference in the effectiveness of psychoeducation on domestic abuse knowledge between Latinos and non-Latinos (Bridges, Karlsson, and Lindly, 2015).

Relationship Skills

Twenty studies focused on prevention strategies aimed at increasing relationship skills among individuals or couples (Antle et al., 2011; Antle et al., 2019; Braithwaite and Fincham, 2009; Braithwaite and Fincham, 2014; Carlson, Wheeler, and Adams, 2018; Cigrang et al., 2016; Fuchsel, Marrs, and Hysjulien, 2013; Georgia Salivar et al., 2020; Khalifian et al., 2019; McCabe et al., 2016; Negash et al., 2016; Nowlan, Georgia, and Doss, 2017; Owen, Antle, and Quirk, 2017; Rhoades, 2015; Roddy, Georgia, and Doss, 2018; Rodriguez, Stewart, and Neighbors, 2021; Taft et al., 2014; Taft et al., 2016; Webermann et al., 2020; Williamson et al., 2015). Given the focus on couples, most strategies studied were intended to prevent both victimization and perpetration. Only one strategy focused solely on reducing perpetration of domestic abuse within a relationship (Skills for Healthy Adult Relationships) (Khalifian et al., 2019; Webermann et al., 2020). The strategy used a series of group meetings that taught negative and positive communication, ability to manage conflict, and improving attitudes and self-regulation.

Two strategies focused solely on preventing victimization through relationship education delivered in a series of group sessions (Fuchsel, Marrs, and Hysjulien, 2013). One program focused on female empowerment among recent immigrants from Mexico (Carlson, Wheeler, and Adams, 2018), while the other took an individually oriented approach to relationship education for instances when couple participation may be impractical or counterproductive (Fuchsel, Marrs, and Hysjulien, 2013). The remaining studies focused on programs that targeted prevention of both perpetration and victimization.

The most commonly evaluated strategy was variations of the Prevention and Relationship Enhancement Program (PREP), a curriculum that focuses on improving communication, conflict resolution, and other aspects of a healthy relationship. The flagship PREP curriculum is conducted in person and uses individual and group education and activities intended for premarital or marital couples (Antle et al., 2019; Rhoades, 2015; Williamson et al., 2015), although on-demand electronic content (ePREP) (Braithwaite and Fincham, 2009; Braithwaite and Fincham, 2014; Georgia Salivar et al., 2020; Negash et al., 2016) and content that is flexibly catered to individuals who may not be in a relationship (Within My Reach) are also available (Owen, Antle, and Quirk, 2017). Another program is Strength at Home Couples, a trauma-informed abuse prevention program to help military and veteran couples who report distress in

their relationship without recent violence (Taft et al., 2014; Taft et al., 2016).¹ Like PREP, Strength at Home Couples focuses on communication, conflict resolution, understanding domestic violence and impact of trauma, and other healthy aspects of relationships (such as intimacy).

Other similar approaches to teaching relationship skills included programs oriented around a single large problem in a relationship (OurRelationship) (Georgia Salivar et al., 2020; Nowlan, Georgia, and Doss, 2017; Roddy, Georgia, and Doss, 2018), with a focus on young adults in college (Skills for Health Adults) (Khalifian et al., 2019), youth in disadvantaged areas (Antle et al., 2011; Antle et al., 2020), building empathy and understanding (Williamson et al., 2015), and everyday relationship maintenance (Williamson et al., 2015). Different approaches included an annual marriage checkup to identify marriage issues early (Cigrang et al., 2016), the use of expressive writing about relationship issues, and the use of cognitive reappraisal to revisit relationship issues (Rodriguez, Stewart, and Neighbors, 2021)—a method of recognizing and amending negative patterns in thinking.

Several prevention strategies were targeted toward specific subpopulations and adopted approaches specific to those groups. Prevention strategies targeting low-income couples emphasized flexibility in format (Heyman et al., 2020) and convenience, such as having session sites at many locations across a community (Rhoades, 2015), and some were tailored to individuals at risk of violence and abuse (Georgia Salivar et al., 2020). Programs targeting military or veteran populations designed content that was trauma-informed and sensitive to stressors faced by those population, such as deployment and combat exposure (Cigrang et al., 2016; Taft et al., 2016). One of those approaches specifically drew from models of aggression in military populations that emphasize a damaged threat perception and hostile attribution bias among those who have experienced trauma (Taft et al., 2014; Taft et al., 2016). Several of the more-general relationship skills curriculums (e.g., PREP, OurRelationship) also provided military- and veteran-specific content. Programs catering to specific racial/ethnic groups included bilingual content and culturally specific content, such as familism and a focus on known issues of the community (Fuchsel, Marrs, and Hysjulien, 2013; McCabe et al., 2016).

Measures of Impact and Outcomes

Outcomes to evaluate relationship skills programs included healthy communication, relationship satisfaction, measures of aggression and conflict, and measures of domestic abuse. Observed measures of relationship functioning tended to improve, and these effects tended to endure longer than others. Two studies found evidence that the effectiveness of relationship skills strategies depended on baseline relational risk factors and that effectiveness may be greater among relationships at higher risk of domestic abuse (Nowlan, Georgia, and Doss, 2017;

¹ Trauma-informed programs are sensitive to how traumatic stress can affect relationships and integrates elements of posttraumatic stress disorder interventions.

Williamson et al., 2015). Improvement in relationship satisfaction was split among studies, and, in one study, satisfaction declined relative to a comparison group (despite relative improvements in domestic violence) (Taft et al., 2014).

Other alternatives to direct measurement of domestic abuse included measures of relationship aggression, which one study, using self-reported surveys of self and partner behaviors, found to be reduced through expressive writing exercises paired with cognitive reappraisal (Rodriguez, Stewart, and Neighbors, 2021). Measures of occurrence of some form of domestic abuse was found to be reduced at least one time point in 10 of 11 studies, measured in most studies using CTS; however, in some cases these reductions were not detected across all types of abuse (Owen, Antle, and Quirk, 2017). Studies tended to find that associations with reduced measures of domestic abuse attenuated over time (McCabe et al., 2016; Rhoades, 2015), although with some exceptions (Braithwaite and Fincham, 2014). The two studies of Strength at Home Couples, trauma-informed relationship education that focused on military populations, detected stronger reductions in self-reported domestic abuse than a control group receiving a minimal intervention (Taft et al., 2014; Taft et al., 2016). One study found that improvements in measures of male-to-female domestic abuse were partly accomplished by improved communication about HIV (but not alcohol intoxication) (McCabe et al., 2016). Other strategies, such as the marriage checkup, only measured perceived effectiveness, which showed positive results (Cigrang et al., 2016).

Some relationship skills strategies showed differences in effectiveness by subgroup. A few studies examined gender variation. In one evaluation of the Strength at Home Couples program, results were more pronounced in preventing physical violence perpetrated by female partners compared with violence by male partners among relationships with service members (Taft et al., 2016). Two other studies did not see differences in effectiveness by gender (Braithwaite and Fincham, 2014; Carlson, Wheeler, and Adams, 2018). One study tested the Within My Reach curriculum for differences in relationship outcomes among same-sex couples and found no difference in impact (Negash et al., 2016). Other research found mode variation in some subgroups but not in others.

In an evaluation of the Within My Reach curriculum, researchers found that men self-reported reductions in domestic abuse perpetration when participating in groups that included men and women but showed an *increase* in self-reported domestic abuse perpetration after participating in men-only groups (Antle et al., 2019). Three studies evaluated relationship education programs by baseline risk factors for domestic abuse with conflicting results. One of these studies found that treatment effects across several curricula were lower among couples with greater risk factors (Williamson et al., 2015); however, a second study of the Within My Reach program found more pronounced impacts among higher risk groups (Carlson, Wheeler, and Adams, 2018). A third study found that the OurRelationship program is as effective among couples with low-intensity abuse as those without (Roddy, Georgia, and Doss, 2018).

Skills for Parents

Eleven studies focused on promoting either individual or family skills to prevent a relationship involving children from becoming abusive, including three studies targeting potential victims, one study targeting potential perpetrators, and seven targeting both potential perpetrators and potential victims (Feder et al., 2018; Feinberg et al., 2016; Heyman et al., 2020; Jacobs et al., 2016; Keller, Wilkinson, and Otjen, 2010; McKinley and Theall, 2021; Miller et al., 2011; Miller et al., 2016; Shoultz et al., 2015; Timko et al., 2015). The three victimization-focused programs all involved education interventions by medical professionals or paraprofessionals, including two (Miller et al., 2011; Miller et al., 2016) administered among women seeking family planning services and one (Feder et al., 2018) targeting new mothers through a nurse home visitation program. The one study focusing on perpetration alone focused on Responsible Fatherhood programs, which target fathers at risk for domestic abuse through domestic abuse screening, teaching fathers about the consequences of IPV on their children's welfare, and education about healthy parenting strategies in group settings (Karberg et al., 2020).

Family skills strategies targeting both victimization and perpetration were largely designed around the birth of a first child. Programs targeting new parents are rooted in research that shows that the stresses of parenthood can contribute to relationship deterioration, including increased risk of domestic and other abuse. Four studies evaluated home visitation programs, which integrated domestic abuse prevention within programs that provide broader services through paraprofessionals and nurses, such as parenting skills, well-child visits, health promotion activities for the mother, and family planning services (Heyman et al., 2019; Heyman et al., 2020; Jacobs et al., 2016; Olds et al., 2004). In two of those programs, domestic abuse prevention was also integrated into support for the mother's educational and professional goals (Jacobs et al., 2016; Olds et al., 2004).

One of these studies (Couple CARE for Parents) used a mix of intervention modes, including active electronic education modules and counseling (both physical and electronic) (Heyman et al., 2019). Two other new parenthood programs involved interactive group education outside of the home, one at a community center and one at a health care facility, focusing on coparenting strategies and conflict resolution. One of the family educational and training interventions was not centered around a first child and instead targeted the whole family, who would come together for sessions lasting two and a half hours of a shared meal and then community-facilitated educational instruction in four different developmental age groups (McKinley and Theall, 2021).

Family skills programs were sometimes tailored to particular risk groups, particularly low-income and young, first-time parents. To meet the coexisting needs of these populations, education and trainings would include components focused on job skills and career planning, which can be disrupted with the birth of a child and can be linked with economic stressors that may contribute to domestic abuse (Charles, Jones, and Guo, 2014; Heyman et al., 2020). Other features catering to low-income needs included schedule flexibility, child care, transportation assistance, and a meal (Charles, Jones, and Guo, 2014). In addition, two programs were

specifically designed for racial or ethnic subgroups, which consisted of culturally targeted curricula and matching the race or ethnicity of the class facilitators with that of the group (Charles, Jones, and Guo, 2014). One program designed for Native American families also included content specifically targeting concurrent community issues, including substance use and community violence (McKinley and Theall, 2021).

Measures of Impact and Outcomes

Prevention outcomes measured for family skills strategies included relationship satisfaction and quality, conflict resolution skills, communication skills, and self-reported domestic abuse (e.g., CTS). Studies conducted in a family planning context would also include measures of reproductive coercion (Miller et al., 2011; Miller et al., 2016). The program that worked with potential perpetrators (Responsible Fathers Program) was only evaluated through staff interviews, which noted that teaching fathers about the impact of domestic abuse on children's well-being could be an effective strategy for motivating fathers to further engage in domestic abuse services (Karberg et al., 2020).

Two of the five home visit prevention programs found no overall effect on the reduction of domestic abuse (Heyman et al., 2019; Jacobs et al., 2016). However, one of these programs found reductions in domestic abuse when the visit was conducted by a nurse but not a paraprofessional (Olds et al., 2004). Two home visit prevention programs found that participation in the intervention actually increased self-reported physical domestic abuse among couples with higher levels of domestic abuse risk or couples who were already experiencing domestic abuse (Feder et al., 2018; Heyman et al., 2019). Both new parent programs conducted outside a home setting found reductions in self-reported measures of domestic abuse (Charles, Jones, and Guo, 2014; Feinberg et al., 2016). The Couple CARE for Parents program found that measures of moderate psychological domestic abuse declined after the intervention (Heyman et al., 2020); however, measures of severe physical and psychological domestic abuse stayed the same. Finally, neither educational intervention conducted among women seeking family planning were found to reduce measures of domestic abuse, although one found reductions in measures of reproductive coercion (Miller et al., 2016).

Engage Influential Community Members

We examined 19 studies investigating strategies focused on engaging influential community members in domestic abuse prevention. These strategies targeted individuals in places of social or personal influence for education or training to promote preventative values, such as setting positive relationship expectations and modeling positive beliefs, guiding people to needed resources, and increasing the willingness to intervene when domestic abuse is encountered. We identified 11 references evaluating strategies targeting bystanders and peers, one study evaluating a strategy targeting military leaders, and seven references evaluating strategies

targeting faith leaders. Table C.4 describes the aims, measures, and outcomes for strategies identified in the literature to prevent domestic abuse by each of these approaches.

Table C.4. Domestic Abuse Prevention Strategies Focused on Engaging Influential Community Members

Strategy Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Bystanders or peers	To raise awareness and knowledge of domestic abuse; to decrease acceptance of violence and domestic abuse myths; to increase positive bystander behaviors, efficacy, and intention to act	1. Norms, attitudes, and beliefs regarding domestic abuse (5/9)	1. Alegría-Flores et al., 2017; Amar, Sutherland, and Kesler, 2012; Ames, Glenn, and Simons, 2014; Kim and Muralidharan, 2020; McMahon and Dick, 2011	1. Borsky et al., 2018; Gadomski et al., 2001; Monyihan et al., 2010; Monyihan et al., 2011
		2. Bystander intention (7/9)	2. Alegría-Flores et al., 2017; Amar, Sutherland, and Kesler, 2012; Ames, Glenn, and Simons 2014; Kim and Muralidharan, 2020; McMahon and Dick, 2011; Monyihan et al., 2010; Monyihan et al., 2011	2. Borsky et al., 2018; Gadomski et al., 2001
		3. Bystander behaviors (2/3)	3. Alegría-Flores et al., 2017; Monyihan et al., 2010	3. Borsky et al., 2018
		4. Self-efficacy and confidence (5/6)	4. Alegría-Flores et al., 2017; Amar, Sutherland, and Kesler, 2012; McMahon and Dick, 2011; Monyihan et al., 2010; Monyihan et al., 2011	4. Borsky et al., 2018
		5. No backlash (2/2)	5. Monyihan et al., 2010; Monyihan et al., 2011	5. –
		6. Knowledge of domestic violence (3/3)	6. Ames, Glenn, and Simons, 2014; Pomeroy et al., 2011; McMahon and Dick, 2011	6. –
Military leaders	To provide information and training on family maltreatment, the impact of maltreatment, risk and protective factors, available resources available to families, relevant rules and laws, and leaders' role preventing and responding to maltreatment	1. Attitudes regarding domestic abuse (1/1)	1. Mitnick et al., 2021	1. –
		2. Self-efficacy (1/1)	2. Mitnick et al., 2021	2. –
		3. Knowledge about domestic abuse (1/1)	3. Mitnick et al., 2021	3. –

Strategy Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Faith leaders	To provide information and increase pastors' understanding of domestic abuse and motivations to address proactively; to provide faith leaders with faith-based materials on family violence prevention and interventions that they are willing to use with their congregations	1. Comfort discussing domestic abuse (1/1)	1. Hancock, Ames, and Behnke, 2014	1. –
		2. Self-efficacy (1/2)	2. Jones et al., 2006	2. Choi et al., 2019
		3. Misperceptions regarding domestic abuse (1/1)	3. Drumm et al., 2018	3. –
		4. Knowledge of domestic abuse resources (2/2)	4. Choi et al., 2019; Drumm et al., 2018	4. –
		5. Attitudes regarding domestic abuse (2/2)	5. Choi et al., 2019; Jones et al., 2006	5. –
		6. Prevention behaviors (2/4)	6. Drumm et al., 2018; Hancock, Ames, and Behnke, 2014	6. Choi et al., 2018; Choi et al., 2019

SOURCE: RAND analysis of scoping review data.

NOTES: Objective shows one or more examples that are representative of the types of strategies within the grouping. Measured outcomes present outcomes across the identified literature used to evaluate strategy effectiveness. Qualitative measures or outcomes with no test of impact are not included in this table. Full references for citations are listed in Appendix D.

^a Parentheses contain the number of included studies that reported a positive impact or impacts for that outcome over the total number of studies using the outcome.

Bystanders or Peers

Eleven studies investigated strategies to engage bystanders or peers in preventing and responding to domestic abuse (Alegría-Flores et al., 2017; Amar, Sutherland, and Kesler, 2012; Ames, Glenn, and Simons, 2014; Borsky et al., 2018; Casey and Ohler, 2012; Gadomski et al., 2001; Kim and Muralidharan, 2020; McMahon and Dick, 2011; Moynihan et al., 2010; Moynihan et al., 2011; Pomeroy et al., 2011). While mode and emphasis vary, a common goal of these strategies is to promote positive bystander behaviors and efficacy within a community, so that domestic abuse is recognized and prevented by peers. These strategies mostly incorporated one of two approaches, sometimes in combination: mass awareness campaigns and active education or training sessions. Focusing on the latter approach, one bystander education program, *Bringing in the Bystander*, evaluated in three separate studies (Amar, Sutherland, and Kesler, 2012; Moynihan et al., 2010; Moynihan et al., 2011), used either a single or multisession program with male and female cofacilitators to dispel rape myths, to promote awareness of dating violence as a problem, and to promote positive bystander behaviors to prevent rape and violence among their peers.

Two other bystander education strategies used similar structure and content, with one focused on a college community (Alegría-Flores et al., 2017) and one focused on men in the general community. Four studies used mass awareness campaigns to promote positive bystander behaviors, including television ads (Kim and Muralidharan, 2020) (comparing the effectiveness of narrative and non-narrative public service announcements), an orientation video and social marketing campaign using posters on a college campus (Borsky et al., 2018), a campus-wide presentation and candlelight vigil (Ames, Glenn, and Simons, 2014), and a multimedia public health campaign. One strategy used a different approach—an interactive peer theater intervention. Finally, one study broadly explored the perceptions of bystander opportunities among men involved in antiviolence against women groups (Casey and Ohler, 2012).

Two studies described efforts to appeal to subgroups or populations. In one campus awareness campaign, posters displayed couples from a variety of racial and ethnic groups and sexual and gender minority groups (Borsky et al., 2018). In another study of college students, example scenarios included in the bystander education curriculum were written by students to improve realism and relevance to the target population (Alegría-Flores et al., 2017).

Measures of Impact and Outcomes

Studies used a wide variety of measures and scales to evaluate impacts on bystander intentions and behaviors, including scales to measure intention to intervene, measures for the degree of confidence an individual has to make a difference (self-efficacy), and measures of preventative behaviors that bystanders have engaged in. Studies also use a variety of metrics to measure knowledge and attitudes, including about rape and domestic abuse myths and whether

domestic abuse is a problem in the community. Finally, some studies measured the extent to which prevention measures produced negative reactions (backlash).

Results of mass awareness campaigns were split on whether they affected domestic abuse attitudes and bystander intentions, although all strategies were found to have made a positive impact in at least one measured domain. One study of a successful campaign found a particularly strong effectiveness on bystander intentions using narrative over non-narrative messages (e.g., statistics only) through the elicitation of empathy (Kim and Muralidharan, 2020). Active education or training interventions were mostly successful in increasing bystander intention and self-efficacy, but were less successful in changing norms, attitudes, or beliefs regarding domestic abuse.

Results from the three studies evaluating the intervention Bringing in the Bystander all showed a significant increase in participants' bystander intention and confidence (Amar, Sutherland, and Kesler, 2012; Moynihan et al., 2010; Moynihan et al., 2011), but only one study detected an impact on norms and attitudes (Amar, Sutherland, and Kesler, 2012). In one study, men who previously knew someone who was abused reported significantly *lower* scores related to willingness to intervene as a bystander, indicating that prior experiences possibly cause heightened concerns about failing (McMahon and Dick, 2011). One qualitative study examined bystander responses among male antiviolence allies and found that individuals faced complex choices when presented with bystander situations, with only 26 percent reporting consistently intervening (Casey and Ohler, 2012).

Engage Military Leaders

One study examined a standardized mandatory training (provided by FAP) given to military base leaders and key personnel in the U.S. Air Force to engage them in activities to identify and prevent child and partner maltreatment (Mitnick et al., 2021). The trainings were one-hour, in-person sessions that were intended to improve knowledge and beliefs around family maltreatment, including resources within the military that are available, and to teach participants their roles in responding to and preventing family maltreatment.

Measures of Impact and Outcomes

The study measured participant evaluations and assessments of knowledge, beliefs about when family aggression may be justified, and feelings of self-efficacy (Mitnick et al., 2021). After training, improvements were detected across all outcomes among participants compared with pretraining levels. The broader military prevention system in the Air Force, NORTH STAR, was also centered on training military leadership at the base level (described under “Organizational and Professional Coordination and Capacity Building” in the “Create Protective Environments” subsection that follows).

Faith Leaders

Seven studies focused on the use of faith leaders, especially clergy, to engage in domestic abuse prevention at their places of worship (Choi et al., 2018; Choi et al., 2019; Choi and Cramer, 2016; Drumm et al., 2018; Hancock, Ames, and Behnke, 2014; Jones et al., 2006; Raymond et al., 2016). In each case, the strategies involved providing faith leaders with education and training to improve communication with church membership on domestic abuse (and often also included training on recognizing and responding to domestic abuse). In one study, an additional goal was to build linkages between faith leaders and other domestic abuse service providers and advocates (Jones et al., 2006). Authors describe that the targeted delivery of domestic abuse prevention that is consistent with the cultural and spiritual beliefs of potential victims and perpetrators is a possible advantage of this approach, possibly improving effectiveness. Study interventions included the provision of education and skills training, either online or in person, with total training ranging from less than one hour to 12 hours; content often included education on the types of abuse and the effects abuse can have on families and the community. Better knowledge and attitudes on domestic abuse improves the likelihood of adopting effective prevention behaviors, such as including prevention messaging in sermons.

In two qualitative studies, researchers interviewed faith leaders about the role that places of worship might play in addressing domestic abuse and the appropriateness of these locations for domestic abuse prevention and response interventions (Choi and Cramer, 2016; Raymond et al., 2016). The studies found that faith leaders were receptive to the use of places of worship in domestic abuse prevention, although one study found concerns among members of an African American community in Minnesota that publicly addressing IPV in places of worship might turn away some members (Raymond et al., 2016). One study reported that Korean pastors found a preference for community-wide approaches rather than approaches targeted at victims and abusers (Choi and Cramer, 2016).

In several cases, these strategies included design and content elements that catered to specific racial and ethnic subgroups, including Hispanic, Black, and Korean American. For instance, in one study, educational material for the faith leaders followed a biblically supported approach that took into consideration the traditional role of fathers and husbands in those Hispanic immigrant families (Hancock, Ames, and Behnke, 2014).

Measures of Impact and Outcomes

Prevention-relevant outcomes in this research were survey-based and consisted of knowledge of domestic abuse, self-efficacy (confidence in the ability to intervene), misperceptions regarding domestic abuse, knowledge of domestic abuse resources, attitudes regarding domestic abuse, and prevention behaviors (e.g., intention to incorporate recommended domestic abuse material in sermons). No direct outcomes of effectiveness were studied. All studies of interventions reported positive post-intervention change on at least some domestic abuse prevention-related outcomes. However, the only study that collected longer-term outcomes found that six months after the

intervention, all prevention-related outcomes were no longer significant or had decreased significantly (Jones et al., 2006). One study that used a randomized control trial design of church leader domestic abuse prevention education with short online modules (30–45 minutes) found mixed impact, with statistically significant effects on intervention participants’ knowledge of domestic abuse resources and domestic abuse attitudes, but not on behaviors to prevent domestic abuse (Choi, et al. 2019).

Create Protective Environments

Fourteen studies looked at shaping environments—such as through rules, programs, policies, or institutional capabilities—to foster prevention of domestic abuse. We identified research on four types of approaches in this category, including workplace strategies, public policies, community engagement, and organizational capacity-building. Table C.5 describes the aims, measures, and outcomes for strategies identified in the literature to prevent domestic abuse by each of these approaches.

Workplace Strategies

Three studies evaluated workplace domestic abuse prevention strategies, which targeted both potential victims and perpetrators (Glass et al., 2016; Navarro, Jasinski, and Wick, 2014; Wagner, Yates, and Walcott, 2012). Workplace strategies for preventing domestic abuse were discussed in the context of both the economic costs of abuse that occur because of reduced labor and increased health costs and the risk that workplaces become a site of domestic abuse. One study with a randomized design (an intervention group and a delayed control group) focused on training supervisors in Oregon county governments (Glass et al., 2016). The supervisor training used a combination of behavior change training and knowledge dissemination through active electronic education modules (Glass et al., 2016). These trainings sought to increase supervisor knowledge of domestic abuse; methods for improving workplace climate; and available supports, such as state law providing medical leave benefits for victims of domestic abuse. A different study evaluated an in-person workplace training session designed to inform employees and employers of the impact that intimate partner abuse has in the workplace and approaches for supporting employees (Navarro, Jasinski, and Wick, 2014). Another study looked at a workplace awareness program for communication to union workers to help challenge gender stereotypes and encourage ally peer behavior (Wagner, Yates, and Walcott, 2012).

Table C.5. Summary of Domestic Abuse Prevention Strategies Focused on Creating Protective Environments

Strategy Target	Objective	Measured Outcomes^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Workplace strategies	To improve workplace climate and knowledge of domestic abuse; to significantly improve trainees' knowledge in referring IPV survivors to community resources	1. Workplace climate toward domestic violence (1/1)	1. Glass et al., 2016	1. –
		2. Workplace practices (1/1)	2. Glass et al., 2016	2. –
		3. Adoption of domestic abuse policies (1/1)	3. Glass et al., 2016	3. –
		4. Domestic abuse knowledge (1/2)	4. Navarro, Jasinski, and Wick, 2014	4. Wagner, Yates, and Walcott, 2012
		5. Willingness to respond to domestic abuse (2/2)	5. Navarro, Jasinski, and Wick, 2014; Wagner, Yates, and Walcott, 2012	5. –
Public policy strategies	To reduce intimate partner homicide through public policy; to change perceptions of domestic violence	1. Perceptions of domestic abuse (1/1)	1. Zeoli and Webster, 2010	1. –
		2. Intimate partner homicide (1/1)	2. Zeoli and Webster, 2010	2. –
		3. Firearm intimate partner homicide (1/1)	3. Salazar et al., 2003	3. –
Community engagement	To create a community-owned network of safe support groups; to increase community engagement and ownership; to increase understanding of domestic abuse, healthy relationships, and effects of domestic abuse	1. Perception of the capacity to address domestic abuse (2/2)	1. Magnussen et al., 2019; Shoultz et al., 2015	1. –
		2. Awareness, Knowledge and Confidence Tool (2/2)	2. Magnussen et al., 2019; Shoultz et al, 2015	2. –
		3. Perceptions of the Acceptability of Violence Tool (1/2)	3. Magnussen et al., 2019	3. Shoultz et al, 2015

Strategy Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Organizational and professional coordination and capacity-building	To enhance domestic violence coalitions and build prevention capacity; to provide unit leaders with information, training, and support to implement and evaluate prevention activities within their unit	1. Collaboration (2/2)	1. Estefan et al., 2019; Lia-Hoagberg et al., 2001	1. –
		2. Prevention capacity (2/2)	2. Freire et al., 2015, Lia-Hoagberg et al., 2001	2. –
		3. Planned organizational changes (1/1)	3. Schober and Fawcett, 2015	3. –
		4. Attitudes and beliefs (0/1)	4. –	4. Smith Slep et al., 2020
		5. Prevention behaviors (0/1)	5. –	5. Post et al., 2010
		6. Occurrence of domestic abuse (1/2)	6. Smith Slep et al., 2020	6. Post et al., 2010

SOURCE: RAND analysis of scoping review data.

NOTES: Objective shows one or more examples that are representative of the types of strategies within the grouping. Measured outcomes present outcomes across the identified literature used to evaluate strategy effectiveness. Qualitative measures or outcomes with no test of impact are not included in this table. Full references for citations are listed in Appendix D.

^a Parentheses contain the number of included studies that reported a positive impact or impacts for that outcome over the total number of studies using the outcome.

Measures of Impact and Outcomes

To measure change in workplace climate, studies relied on a mix of surveys and interviews. In the study focused on supervisors, authors developed the workplace climate toward domestic violence (WCTDV) measure, which provides an overall index based on several domains relevant to workplace climate, such as confidentiality, training, and policies (Glass et al., 2016). This study found that the intervention group had a significantly more positive WCTDV six months after receiving the training, was significantly more likely to develop new workplace policies around domestic abuse, and was more likely to provide employees with information on medical leave for domestic abuse. Trainees in the employee-focused intervention completed questionnaires before and after the training to identify their willingness to respond to domestic abuse and knowledge in recognizing and referring possible domestic abuse (Navarro, Jasinski, and Wick, 2014). Participants were more willing to indicate intentions to intervene to prevent domestic abuse after training. Knowledge of domestic abuse was significantly higher as well.

Public Policy Strategies

Two studies evaluated policy prevention strategies designed to limit perpetration of domestic abuse (Salazar et al., 2003; Zeoli and Webster, 2010). One study examined the impact of state policies—including firearm, warrantless arrest, alcohol tax, and police staffing—on intimate partner homicide (Zeoli and Webster, 2010). Another study evaluated whether public *perceptions* of enacted criminal justice policies for domestic violence could affect social norms toward domestic abuse (Salazar et al., 2003).

Measures of Impact and Outcomes

To evaluate the effects of state policy on domestic abuse, researchers used Federal Bureau of Investigation supplementary homicide reports on intimate partner homicide and firearm intimate partner homicide (Zeoli and Webster, 2010). The study found that state statutes restricting the access to firearms by individuals with domestic violence restraining orders, laws that allowed for warrantless arrests of domestic violence restraining order violators, and higher police staffing levels reduced both intimate partner homicide with firearms and intimate partner homicide overall (an effect of alcohol excise taxes on intimate partner homicide was not detected). To evaluate the impact of criminal justice policy perceptions on social norms related to domestic abuse, researchers compared community member victim-blaming attitudes and attitudes toward criminal justice response before and after policy enactment in intervention communities compared with control communities (Salazar et al., 2003). Results from that study revealed that people who perceived criminal justice system policies to be responsive to domestic abuse were more likely to believe that they *should* be involved, which in turn was associated with fewer victim-blaming attitudes. The authors concluded that criminal justice policies should be enacted concurrently with dissemination efforts to educate the public regarding these policies to promote better community attitudes toward domestic abuse.

Community Engagement

Three studies looked at different forms of community engagement to reduce domestic abuse (Burnette and Sanders, 2017; Magnussen et al., 2019; Shoultz et al., 2015). Two of these studies evaluated a prevention strategy among Hawaii residents (Magnussen et al., 2019; Shoultz et al., 2015), while one study interviewed community members and professionals on solutions to prevent domestic abuse among indigenous women (Burnette and Sanders, 2017). The Hawaii intervention emphasized addressing domestic abuse prevention with a community focus, utilizing a series of five informal group discussions led by trained community members meant to spread awareness, change attitudes, and develop leaders in domestic abuse prevention.

All studies of strategies using community engagement principles used or recommended approaches centered on local culture and customs. To achieve this, all studies incorporated a bottom-up approach, with elements of the prevention design and implementation developed in consultation with community members. For instance, the two strategies focused on Hawaiian communities used *talk story*, an informal, relaxed in-person group discussion to share thoughts and ideas that is an important form of communication among Hawaii residents.

Measures of Impact and Outcomes

Evaluations included measures of the perceived acceptability of violence; awareness of, knowledge of, and confidence to address domestic abuse; and perception of the capacity to address domestic abuse in the community. The two studies among Hawaiian residents found an improvement in participant scores for awareness of domestic abuse, confidence to address domestic abuse, and perception of community capacity to address it. Only one of the two studies saw a decrease in the perceived acceptability of violence (Magnussen et al., 2019), partly because of the already low rates of violence acceptance at the start of the other intervention (Shoultz et al., 2015). The study on indigenous women's prevention perspectives used qualitative interviews to gather ideas to address the disproportionate rate of domestic abuse among this population (Burnette and Sanders, 2017). It found that both women and professionals focused on holistic and preventative strategies over individual or psychological interventions, such as raising community engagement, awareness, and family focused interventions.

Organizational and Professional Coordination and Capacity Building

Six studies examined strategies to prevent domestic abuse victimization and perpetration through organizational capacity building (Estefan et al., 2019; Freire et al., 2015; Lia-Hoagberg et al., 2001; Post et al., 2010; Schober and Fawcett, 2015; Smith Slep et al., 2020). Several studies examined the effects of CDC efforts to support domestic abuse prevention. These included CCR and subsequent DELTA efforts. CCR involved the provision of funding to communities over three to six years to develop and provide coordinated domestic abuse interventions across sectors (e.g., education, justice, health care) that spanned ecological levels of risk and protective factors (e.g., individual, social, community). DELTA was a multipronged

state-level project that provided a variety of supports, including grant awards, training events, technical assistance, and action planning resources to facilitate coalition development and implementation across 19 state domestic violence coalitions. A subsequent effort, DELTA PREP, continued these efforts with funding and training sessions to specifically build capacity in *primary* prevention of domestic abuse, including through assistance in the development of action plans (Schober and Fawcett, 2015). A third effort, DELTA FOCUS, funded state domestic violence coalitions to support local coordinated community response teams that involve members of many sectors (e.g., health care, education, criminal justice) to implement domestic abuse prevention strategies.

A second strategy, the NORTH STAR program, conducted and evaluated by the U.S. Air Force, is a prevention system involving a community assessment, planning, and action framework and support to military leaders to reduce secretive problems in military communities, including substance use, domestic abuse, and suicidality. NORTH STAR targeted both active-duty military members and their spouses and included components to train and assist Community Action Teams and base leadership. A third strategy included training of professional and paraprofessionals across sectors (health care, social work, advocacy) in a community in Minnesota in domestic abuse interventions, data collection and interpretation, and professional collaboration (Lia-Hoagberg et al., 2001).

Measures of Impact and Outcomes

Evaluation of these strategies included organizational-level measures, such as organizational and professional prevention capacity and planned organizational changes in domestic abuse policies, and metrics of collaboration like coalition member information and resource sharing. The NORTH STAR program also evaluated measuring the incidence of partner maltreatment on bases with and without the program. The CDCs CCR efforts were evaluated using community attitudes and beliefs, prevention behaviors, and occurrence of domestic abuse in the past year through a modified version of the CTS.

Evaluations of DELTA coalitions found that all 19 improved prevention capacity, developed detailed action plans for organizational change, and worked as catalysts for prevention activities in other states (Freire et al., 2015; Schober and Fawcett, 2015). An evaluation of the subsequent DELTA FOCUS effort found that participant coalitions broadly disseminated their experience and knowledge of domestic abuse to help other organizations with prevention efforts and worked directly with other partner agencies to help effect change (Estefan et al., 2019). In the final report of a randomized trial of the NORTH STAR prevention system (randomized at the base level), researchers found that the system significantly predicted rates of partner maltreatment for three process factors after controlling for partner maltreatment at baseline (Smith Slep et al., 2020).

The impact of the NORTH STAR prevention system was evaluated separately for those who had recently returned from Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn deployment and was also found to be effective for this population. The

evaluation of CDC CCRs did not detect a significant difference in domestic abuse attitudes and beliefs, prevention behaviors (e.g., receiving or providing domestic abuse help, seeking resources or information), or reported occurrence of domestic abuse when comparing CCR communities with a neighboring community without CCR (Post et al., 2010). The community leader training in Minnesota found that participants increased community partnerships and collaborations and use of violence prevention data (Lia-Hoagberg et al., 2001).

Strengthen Economic Supports

We examined five studies investigating strategies focused on the impacts of strengthening economic support on preventing domestic abuse. Table C.6 describes the strategy target and associated aims, measures, and outcomes for strategies identified in the literature to prevent domestic abuse by providing economic and job support.

Table C.6. Summary of Domestic Abuse Prevention Strategies Focused on Strengthening Economic Supports

Strategy Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Economic support	To rapidly transition participants into formal employment and to better prepare participants for jobs to decrease partner abuse; to provide financial incentives and mandatory participation in employment-focused services to reduce partner abuse; to reduce domestic abuse through economic policies targeting women at the intersection of domestic abuse and poverty	1. Incidence of partner abuse (4/4)	1. Gibson-Davis et al., 2005 (for both evaluated reforms); Nou and Timmins, 2005; Spencer et al., 2020	1. –
		2. Change in attitudes and skills toward violence (1/1)	2. Antle et al., 2020	2. –

SOURCE: RAND analysis of scoping review data.

^a Parentheses contain the number of included studies that reported a positive impact or impacts for that outcome over the total number of studies using the outcome.

Three evaluations focused on the impact of welfare reforms encouraging reentry into the workforce on domestic abuse among low-income single mothers (Gibson-Davis et al., 2005; and Nou and Timmins, 2005). In these studies, welfare dependence is hypothesized to be linked with domestic abuse because women may feel forced to stay in abusive relationships because of resource constraints, whereas employment may produce financial independence. Welfare reforms encouraged employment through changes such as time-limited benefits, mandatory participation in employment-focused efforts and services, and financial incentives to make employment relatively more appealing than public assistance. One study looked at the impact on

domestic abuse of anti-poverty measures such as higher minimum wage policies and direct cash assistance through TANF and the Earned Income Tax Credit (Spencer et al., 2020).

Measures of Impact and Outcomes

Welfare reforms promoting a return to work were all associated with reductions in domestic abuse. For two evaluations, these reductions were self-reported through questionnaires (Gibson-Davis et al., 2005) and in one study, the results were determined using an official state law enforcement violence reporting program (Nou and Timmins, 2005). The study on direct financial assistance found that few state-level TANF policies had an impact on domestic abuse outcomes and the same was true for minimum wage policies. The refundable Earned Income Tax Credit, which requires employment but has few other conditions for receipt, did protect against domestic abuse (Spencer et al., 2020). Results for TANF were analyzed by race and ethnicity, and the results showed that African American women in states with less restrictive TANF had increased odds of coercive victimization, indicating a complex relationship between state economic assistance policies and domestic abuse.

Integrate Approaches Across Other Prevention and Risk Reduction Efforts

Seven studies examined prevention strategies that cointegrated domestic abuse prevention with efforts to address other behavioral health issues. Table C.7 describes the strategy target and associated aims, measures, and outcomes for strategies identified in the literature that cointegrate domestic abuse prevention with behavioral health treatments.

Three studies examined domestic abuse prevention strategies that were cointegrated with programs to treat substance use disorders (Fals-Stewart, Birchler, and Kelley, 2006; Lam, Fals-Stewart, and Kelley, 2009; Timko et al., 2015). The first study on substance use disorder programs examined a sample of programs (most involving either individual services, group counseling, continuing care, or case management) that incorporate domestic abuse perpetrator services and staff trained in providing domestic abuse services (Timko et al., 2015). We do not recommend that the remaining two studies be evaluated as part of the literature (Fals-Stewart, Birchler, and Kelley, 2006; Lam, Fals-Stewart, and Kelley, 2009). William Fals-Stewart was investigated for research misconduct; although he died before the investigation could be completed, it included credible claims of data falsification (Golden, Mazzotta, and Zittel-Barr, 2021).

Table C.7. Summary of Prevention Strategies Focused on Integrating Domestic Abuse Prevention in Other Prevention and Risk Reduction Efforts

Strategy Target	Objective	Measured Outcomes ^a	Studies with Positive Outcome Detected	Studies That Did Not Detect a Positive Outcome
Cointegration with substance use disorder	To examine the associations of client, organization, and program linkage factors with end-of-treatment outcomes of program completion, substance use, and domestic abuse perpetration; to lower reported frequency of alcohol use and increase relationship satisfaction and reduction in partner violence	1. Occurrence of domestic abuse (1/1)	1. Timko et al., 2015	1. –
Cointegration with HIV	To provide women with information, skills, and strategies to enhance the quality of their lives and to encourage the adoption of safer-sex behaviors, proper condom use, and knowledge on how to protect themselves from sexually transmitted diseases and relationship abuse	1. Occurrence of domestic abuse (0/1)	1. –	1. Wingood et al., 2004

NOTE: Three studies examined in this category (Edwards et al., 2016; Frye et al., 2012; White, Sienkiewicz, and Smith, 2019) are not included in this table because they had no testable outcomes. Two studies (Fals-Stewart, Birchler, and Kelley, 2006; Lam, Fals-Stewart, and Kelley, 2009) were excluded based on credible claims of data falsification (Golden, Mazzotta, and Zittel-Barr, 2021).

^a Parentheses contain the number of included studies that reported a positive impact or impacts for that outcome over the total number of studies using the outcome.

Another study examined a prevention strategy cointegrated into an HIV risk reduction intervention (Wingood et al., 2004). The program used community leaders to teach women healthy relationship skills in the context of safe sex and provided information about domestic abuse community resources.

Three identified studies used qualitative methods to determine the views of community members, experts, and professionals on domestic abuse prevention strategies covering many strategies across sectors (but were not included in Table C.7 because they had no testable outcomes) (Edwards et al., 2016; Frye et al., 2012; White, Sienkiewicz, and Smith, 2019). One study interviewed leaders in domestic violence advocacy, policy, service, and research to explore their vision as leaders in the field for the future direction of domestic violence prevention (White, Sienkiewicz, and Smith, 2019). A second study used group brainstorming sessions to solicit responses among two low socioeconomic status neighborhoods regarding neighborhood actions

to prevent a woman from experiencing partner violence (Frye et al., 2012). The inputs were used to create a visual map conceptualizing the prevention strategies, a process called concept mapping. The last study interviewed rural adults on their thinking on the causes of domestic abuse and ideas for how to most effectively prevent it (Edwards et al., 2016).

The study that explored low socioeconomic status community perceptions through concept mapping looked at the feasibility and effectiveness of proposed solutions (Frye et al., 2012). Interventions that were victim focused were rated the highest for feasibility, while interventions focused on linking the victim to official systems were identified as the most effective. The study to identify the future direction of domestic violence prevention used group discussions to identify common themes, which included the need to increase cultural competence for victim services and criminal justice responses, develop both community- and state-level partnerships, examine the context of victim and perpetrator experiences, and increase reliance on victims' voices (White, Sienkiewicz, and Smith, 2019). Finally, three themes detected in rural adults' thinking on effective prevention were increasing education and awareness, victim-focused prevention, and job creation (Edwards et al., 2016).

Measures of Impact and Outcomes

Prevention outcomes in these studies included measures of occurrence of domestic violence perpetration as reported by substance use disorder program officers (Timko et al., 2015). In this study, domestic abuse services integrated with substance use disorder treatment were associated with lower rates of recorded abuse. No impact on the occurrence of self-reported domestic abuse was detected from participation in the HIV risk reduction program (Wingood et al., 2004).

Detailed Cataloguing of the Findings on Programming for Those with Risk Factors for Domestic Abuse

From our search, 38 studies investigated prevention strategies that included elements used to reach individuals and couples with risk factors for domestic abuse or directly investigated strategies to reach these populations or measures to evaluate outreach effectiveness.

New Families and Pregnancy

Thirteen studies examined programs targeting pregnant women, women seeking family planning services, or new families (Charles, Jones, and Guo, 2014; Decker et al., 2017; El-Mohandes et al., 2008; Feder et al., 2018; Jack et al., 2019; Jacobs et al., 2016; Krans, Davis, and Schwarz, 2013; Herzig et al., 2006; Heyman et al., 2019; Heyman et al., 2020; Humphreys et al., 2011; Miller et al., 2016; Olds et al., 2004). These strategies often used additional risk factors beyond pregnancy to target outreach that were obtained through a risk assessment or were based on sociodemographic risk factors, including young age, low income, first child, and being unmarried. This population was frequently identified during family planning visits or routine

visits at prenatal clinics where women were approached to participate in an intervention (Krans, Davis, and Schwarz, 2013; Humphreys et al., 2011; Olds et al., 2004). Other outreach efforts occurred at hospitals in maternity wards (Heyman et al., 2019; Heyman et al., 2020). In one study, new parents were recruited through door-to-door visits in the maternity ward by representatives of a home visitation program; eligible parents were shown a promotional video and given informational pamphlets.

Program sites or the referral lines of broader programs aimed at new families also offer opportunities for targeted delivery (Feder et al., 2018; Jack et al., 2019; Jacobs et al., 2016). One example was nurse home visitation program sites where domestic abuse prevention was embedded within standard home visitation functions. Another program recruited participants to a relationship skills and family strengthening intervention through community organizations and the county health department. To attract high-need individuals, the program offered flexible session schedules and the provision of child care, meals, and transportation assistance (Charles, Jones, and Guo, 2014).

Visitors to Emergency Departments

Three studies examined strategies delivered in emergency departments (Edwardsen and Morse, 2006; Ernst et al., 2011; Randell et al., 2012). Each study noted the high rate of victimization and perpetration rates among emergency department patients in some hospitals, which offers opportunity for outreach. One study cited the Joint Commission standard to require domestic abuse screening for all emergency department patients as motivation for evaluating the feasibility of domestic abuse interventions in emergency departments (Ernst et al., 2011).¹ According to the organization's website, "The Joint Commission is the nation's oldest and largest standards-setting and accrediting body in health care." Two studies evaluated conducting outreach through the display or provision of written domestic abuse resources (Edwardsen and Morse, 2006; Randell et al., 2012). In one, educational pamphlets targeting both perpetration and victimization were made available in male and female emergency department bathrooms within patient areas (Edwardsen and Morse, 2006). The other study evaluated a strategy distributing domestic abuse materials in pediatric emergency departments (Randell et al., 2012). Another study evaluated educational materials and a video depicting domestic abuse perpetration and victimization delivered universally among consenting patients in the emergency department (Ernst et al., 2011).

Racial and Ethnic Groups

Seven studies examined strategies to reach specific racial or ethnic groups that have risk factors for domestic abuse or that may lack access to domestic abuse services because of language, immigration, or cultural or other barriers (Ames, Glenn, and Simons, 2014; Behnke,

¹ The Joint Commission is a standards-setting and accreditation body for health care organizations.

Ames, and Hancock, 2012; Burnette and Sanders, 2017; Choi et al., 2018; Choi and Cramer, 2016; Hancock, Ames, and Behnke, 2014; Shoultz et al., 2015). One approach to reaching members of these communities was through recruitment in community health clinics that tend to serve members of a particular racial or ethnic group (Shoultz et al., 2015). Another outreach strategy involved enlisting members from the target community to consult on appropriate outreach techniques or to deliver prevention resources and referrals themselves (Burnette and Sanders, 2017). Places of worship were another vehicle for delivery of domestic abuse prevention to particular racial or ethnic groups, including in Latino and Korean American communities (Fuchsel, Marrs, and Hysjulien, 2013).

Individuals with Substance Use Disorders

Two articles investigated targeting people with risk factors for domestic abuse in conjunction with treatment or programs targeting substance use and or other behavioral issues (Fals-Stewart, Birchler, and Kelley, 2006; Timko et al., 2015). Authors posit that the strong association between substance use and domestic abuse suggests that both problems should be addressed in parallel. One study found that the majority of substance use programs studied ($n = 339$) included domestic abuse counseling, particularly in programs for men only (Timko et al., 2015). Another study examined domestic abuse prevention within behavioral couples therapy for women with alcoholism (Fals-Stewart, Birchler, and Kelley, 2006).

Low-Income and Marginalized Communities

Five studied programs targeted low-income or marginalized communities with risk factors for domestic abuse (Antle et al., 2020; Fuchsel, Marrs, and Hysjulien, 2013; Karberg et al., 2020; Rhoades, 2015; Wenzel et al., 2009), including recently incarcerated fathers (Karberg et al., 2020), homeless women (Wenzel et al., 2009), and at-risk youth who recently experienced violence (Antle et al., 2020). To reach these groups, targeted populations were sometimes recruited through flyers and personal contact within existing social service programs, including homeless shelters, responsible fatherhood programs, and job skills programs. One strategy (Within Our Reach) investigated a more broad-based approach, targeting schools, community-based organizations, military bases, social service agencies, and health care providers within low-income communities. The program targeting at-risk fathers aimed to increase engagement by providing destigmatized, non-shaming spaces to discuss issues of domestic abuse (Rhoades, 2015).

Military

We identified four studies that examined outreach strategies specifically for military or veteran populations (Brown and Joshi, 2014; Creech et al., 2021; Mitnick et al., 2021; Taft et al., 2014). One study examined outreach through passive electronic materials by recording the availability and presentation of domestic abuse resources on the web, including on military and

Veterans Health Administration websites (Brown and Joshi, 2014). A separate study evaluated a broad-based outreach strategy to recruit military and veteran populations to participate in a cognitive-behavioral couples' intervention to prevent domestic abuse. This strategy included clinical referrals at Veterans Health Administration hospitals and veteran's centers, flyers, mailings to veterans, presentations at military events, and promotion through support groups for veterans and nonprofit organizations serving veterans (Taft et al., 2014). These outreach efforts were followed by outreach through a website, a Facebook page, and local news media. A third study used a much more targeted approach to recruit at-risk female veterans in clinic waiting rooms at a Veterans Health Administration hospitals (Creech et al., 2021). The last study evaluated a training for military base leaders and key personnel to improve the identification of soldiers at risk for family maltreatment and to facilitate delivery of services (Mitnick, 2021).

Extending Reach Through Organizational Coordination or Capacity-Building

Two studies sought to reach populations with risk factors through either building organizational capacity or the development of collaborative organizational networks (Ryan, Anastario, and DaCunha, 2006; Whitaker et al., 2007). One study looked at how building collaborative networks of organizations and providers can help bring culturally competent services and prevention (Whitaker et al., 2007). Another study looked at the development of a best practices handbook for journalists as a means of shaping news coverage of domestic abuse (Ryan, Anastario, and DaCunha, 2006).

Reaching Those with Risk Factors Through Innovative Technology

One study explored advocate and survivor perspectives on the use of technology to provide outreach and resources for domestic abuse (including sexual violence) awareness and response among new generations of emerging adults at three universities (Voth Schrag et al., 2021). These technologies included texting and messaging apps, social media, web apps, and more-traditional electronic means such as email and websites. The use of digital media in prevention was described by advocacy professionals as a means to "get the word out" about available campus services.

However, in this study, the use of digital technologies for outreach was more frequently discussed in terms of capacity to improve service and information accessibility. With an active and engaged online presence, social media and digital communication provided an easy means to connect at-risk individuals and survivors with information and services through such capabilities as direct digital portals to advocates and professionals. One study examined the use of longitudinal patient data available in electronic health record systems as a means of predicting a patient's future risk of domestic abuse, potentially providing more-precise information on patients with risk factors to be used for directing interventions in a health care context (Reis, Kohane, and Mandl, 2009).

Outreach Measures and Outcomes

Several studies measured the **views of key informants**—such as potential deliverers of outreach, community leaders, or community members who experienced domestic violence (Burnette and Sanders, 2017)—regarding outreach strategies. In one example, a study polled providers across several health care contexts regarding the appropriateness of pregnancy as a target for risk behavior intervention. Most participants viewed pregnancy to be an opportune time for a woman to change behaviors, given increased motivation and continuity of care, and an appropriate target for outreach (Herzig et al., 2006). Another study interviewed mothers with histories of domestic abuse to solicit their views on the presentation of domestic abuse materials in pediatric emergency departments. These mothers emphasized providing materials in English and Spanish and presenting information in a nonjudgmental manner. They also cautioned that the term *domestic abuse* may be a turn-off to many women who do not believe the term applies to them (Randell et al., 2012).

Participating pastors gave their views on a training program to increase domestic abuse outreach to Latino immigrants in their churches (Behnke, Ames, and Hancock, 2012). These pastors suggested that including clergy in the training team and follow-up from trainers would improve efficacy. In another study, pastors believed that church leaders were trusted and could reach Latino families who would normally not seek domestic abuse services on their own. These pastors also were receptive to partnerships with culturally competent human service professionals to deliver prevention activities (Hancock, Ames, and Behnke, 2014).

The ability of community organizations to deliver outreach tended to be evaluated through staff interviews identifying barriers and facilitators (Karberg et al., 2020; Whitaker et al., 2007). For instance, in one study, staff at a responsible fatherhood program noted stigma, cultural normalization of violence, and a lack of accessible programs as barriers to attracting at-risk fathers (Karberg et al., 2020). Interviews of staff within a collaborative network in one study highlighted the importance of the use of culturally competent staff, such as the use of Latino staff who understand Latino history and culture, to bring cultural competence to outreach efforts aimed at Latino families.

Another way outreach programs can be measured is with metrics that capture **implementation of the preventative strategy**, such as the frequency with which clinicians provided the intervention when appropriate. In one study of the use of a prenatal visit to deliver a preventative intervention, a low-literacy, computerized interview on a touch screen was used to assess risk and stimulate conversation via video with a prenatal health care provider, including the provision of cueing sheets with patient history and suggested risk-reduction statements for the provider (Humphreys et al., 2011). This outreach significantly increased the delivery of the prevention intervention when appropriate. In another study of a universal screening and education intervention among women seeking family planning services, exit surveys were performed to assess whether providers discussed domestic abuse and whether prevention

materials (pamphlets) were delivered. For this study, the prevention information or materials were delivered 65 percent of the time, although authors did not characterize whether this was an acceptable result (Miller et al., 2016). An outreach strategy to use Latino pastors to deliver domestic abuse resources referrals found that slightly less than half intended to use this information (Hancock, Ames, and Behnke, 2014).

Participation in programs, another potential metric to evaluate outreach, was tracked by several studies, but most studies only reflected participation in the research study, not the program overall. Overall participation in research studies tended to be poor, particularly among participants with low levels of education (Feder et al., 2018). In one implementation evaluation of a 12-month program supporting marriage health among low-income families, both program participation and **number of hours of total programing attended** were tracked (Rhoades, 2015). The evaluation noted that high initial participation rates indicated an interest among low-income married couples in receiving marriage education; however, participation dropped dramatically in the following six months. In a study of behavioral couples therapy among military populations, program participation faced many barriers, and most of a broad range of passive outreach strategies were determined to be ineffective, whereas face-to-face informal recruitment targeting wives, girlfriends, and family members were most effective (Taft et al., 2014).

Another study looked at **program completion** as a measure of the impact of including domestic abuse programming within a larger substance use disorder program, indicating whether domestic abuse topics may turn some populations away from treatment (Timko et al., 2015). The study found that completion rates were higher among programs in which violence prevention was integrated than they were for with programs that did not offer violence prevention. We did not observe any evaluation of the effectiveness of specific outreach efforts to boost participation (e.g., monetary incentives).

Another method of evaluating outreach is by **tracking receipt of the outreach itself**, although this was rarely measured or evaluated. We identified one study that measured the percentage of patients and visitors in an emergency department who had seen, read, or taken an educational and resource pamphlet that had been posted in the male and female restrooms of the patient area. In this study, roughly half had noticed the pamphlets, while less than 10 percent had read and retained the material (Edwardsen and Morse, 2006). One evaluation of a public health campaign that incorporated passive educational material on domestic violence in rural health clinics asked respondents whether they saw the material, finding that higher proportions reported seeing the material in intervention compared with non-intervention counties (Gadomski et al., 2001).

One study tracked outreach receipt by surveying domestic abuse survivors to identify which outreach method (e.g., word of mouth, email, text, social media, program website) informed them of available programs (Voth Schrag et al., 2021). This study found that no outreach mode dominated and that survivors learned about domestic abuse services through a variety of sources,

including friends, web searches, information tables, and orientation activities. Organizational websites and social media sites were rarely identified as a source for gaining awareness; however, most survivors said that they used organization social media pages and websites to learn more about services after they become aware of them by other means.

Some studies investigated **reactions to prevention content** among communities with domestic abuse risk factors as a measure of their appeal. In one study, researchers investigated how women who had experienced domestic abuse responded to print and television health communication campaigns in the prior ten years that were aimed at preventing domestic abuse. This study found that nearly all women in the study experienced at least one negative reaction to the material; in particular, women viewed stereotypes and graphic content as unhelpful or counterproductive (West, 2013).

Some studies directly evaluated features of **content of messaging** that may make people more or less likely to seek prevention help (Keller and Honea, 2016). In one study of a best practices handbook for journalists, researchers tracked features of coverage after the delivery of the handbook and observed significant changes in the framing of domestic abuse murders (Ryan, Anastario, and DaCunha, 2006). An evaluation of domestic abuse resource content on military and civilian websites found a wide array of information available but that the material often lacked information about privacy and limitations on privacy that would be valuable for those who seek domestic abuse resources (Brown and Joshi, 2014).

Observations on the Literature

The scoping review found several areas where future research may move our understanding of domestic abuse prevention forward.

- The high number of studies on strategies for improving relationship skills and the common use of standardized outcome measures and study designs indicates that the literature could support a systematic review or meta-analysis to evaluate effectiveness and the quality of the evidence of programs to improve relationship skills. We identified one systematic review that included relationship education programs (Stith, 2021), but it included fewer than half of the studies we identified and no meta-analyses of these programs appeared during our search. Moreover, the results in several studies indicate that the role of relationship satisfaction in domestic abuse should be more closely examined, because programs that are apparently successful in reducing the risk of domestic abuse do not necessarily achieve greater satisfaction in a relationship. Better characterizing the nature of the relationship between satisfaction and domestic abuse could contribute to further improvements in relationship skills efforts.
- We identified little evidence on the design or effectiveness of domestic abuse prevention among Black populations or sexual or gender minorities, despite evidence that risks can be elevated for these populations in part because of the added stress that these relationships are subjected to (Lewis et al., 2012). Since relationships among minority populations may have unique dynamics that are not addressed by generic prevention approaches, targeted approaches that include elements such as culturally sensitive content

are important to effective prevention. It is important that the effectiveness of generic approaches is tested alongside more-targeted approaches that attend to these unique dynamics. Additionally, evaluations of targeted strategies should include considerations of impact on participation and retention, as these strategies may have stronger appeal among target populations.

Appendix D. List of the 104 Studies Included in the Scoping Literature Review

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