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DEPARTMENT OF THE AIR FORCE INSTRUCTION 40-301

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Medical Command

FAMILY ADVOCACY PROGRAM

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This instruction implements Department of Defense Instruction (DoDI) 6400.01, *Family Advocacy Program (FAP)*; DoDI 6400.03, *Family Advocacy Command Assistance Team (FACAT)*; DoDI 6400.05, *New Parent Support Program (NPSP)*; DoDI 6400.06, *Domestic Abuse Involving Department of Defense Military and Certain Affiliated Personnel*; DoDI 1402.05, *Background Checks On Individuals In DoD Child Care Services Program*; Department of Defense Manual (DoDM) 6400.01, Volume 1, *Family Advocacy Program (FAP) FAP Standards*; DoDM 6400.01, Volume 2, *Family Advocacy Program (FAP): Child Abuse and Domestic Abuse Incident Reporting System*; DoDM 6400.01, Volume 3, *Family Advocacy Program (FAP): Clinical Case Staff Meeting (CCSM) and Incident Determination Committee (IDC)*; and DoDM 6400.01, Volume 4, *Family Advocacy Program (FAP): Guidelines for Clinical Intervention for Persons Reported as Domestic Abusers*. This manual requires the collection and maintenance of information protected by the Privacy Act of 1974 authorized by Title 10 United States Code, Section 9013, Secretary of the Air Force. The applicable System of Record Notice (SORN) F044 AF SG Q, Family Advocacy Program Record and F033 AF B, Privacy Act Request File is available at: **http://dpclo.defense.gov/Privacy/SORNs.aspx**. This instruction applies to all civilian employees and uniformed members of the Department of Defense and their dependents. It also applies only to members of the Air Force Reserve and Air National Guard on Title 10 or Title 32 orders. All records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS), or any updated statement provided by the AF Records Management office (SAF/CIO A6P). Refer recommended changes and questions about this publication to the

Headquarters Air Force, Office of the Surgeon General, using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. This publication may be supplemented at any level, but all direct Supplements must be routed to the office of primary responsibility (OPR) of this publication for coordination prior to certification and approval. The authorities to waive wing and unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See DAFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestor's commander for non-tiered compliance items.

SUMMARY OF CHANGES

This document is substantially revised and must be completely reviewed. The intent behind this revision is to address changes in public law, expand the scope of AF FAP's mission to mirror expansions at the DoD level to address Problematic Sexual Behavior in Children and Youth, alter FAP's prevention mission to align with HAF guidance, and make general updates and clarification to the existing instruction. Compliance with **attachments 5** and **7** in this publication is mandatory.

Chapter 1

OVERVIEW AND APPLICABILITY

1.1. The mission of the Air Force Family Advocacy Program (AF FAP). Is to build healthy communities through implementing programs and policies designed for the prevention and treatment of domestic abuse, child abuse and neglect, and Problematic Sexual Behavior in Children and Youth (PSB-CY).

1.1.1. The AF FAP provides program and guidance development, training and resourcing for medical treatment facility (MTF) FAP staff, data collection and reporting activities, and program research and evaluation. AF FAP personnel provide expert training and consultation services to key customers, including active component members, their families, other eligible beneficiaries, unit leaders, and personnel from other helping agencies. AF FAP personnel collect, maintain, analyze, and report data on domestic abuse and child maltreatment. In collaboration with installation and community agencies, AF FAP personnel provide a continuum of services designed to build community health and resilience and promote family, community, and mission readiness by reducing domestic abuse and child maltreatment.

1.1.2. The AF FAP develops and implements FAP initiatives in support of the Major Commands via coordination with the Major Command (MAJCOM) Mental Health Consultants.

1.1.3. This applies to all active component, reservists, and civilian personnel and their dependents entitled to receive medical care in a MTF as specified in AFMAN 41-210.

1.1.4. Collaboration between FAP staff and AF reserve personnel is highly encouraged and may include consultations, one-time emergency evaluations, referrals, prevention, and education. Any duty to warn requirements for families who are not entitled to MTF care based on duty status must result in immediate referral by the FAP provider to the appropriate civilian authority. **(T-0).**

1.2. Air Force Reserve Command (AFRC). The AF Reserve does not maintain a FAP. Efforts to minimize domestic abuse and child maltreatment and their effect on mission readiness of Reserve forces are limited to preventive education, identification, emergency intervention, and referrals, when indicated. Allegations of domestic abuse and child maltreatment involving Reserve Airmen and/or their families (when not eligible for care in a MTF) are routinely managed by civilian agencies in conjunction with civilian law enforcement organizations. Where available, an AFRC installation unit Director of Psychological Health is the point of contact for information and referral.

1.3. Air National Guard (ANG). The AF FAP provides services to ANG members when they are activated in Title 10 or Title 32 status and are not in the dual status Technician Program.

1.3.1. All referrals for suspected domestic abuse and child maltreatment for these ANG members within the catchment area of a MTF will be handled by that MTF's FAP following active component maltreatment referral processes, including presentation to the Central Registry Board (CRB). **(T-1).**

1.3.2. When a member who is suspected of domestic abuse or child maltreatment is in the Technician Program, the case will be coordinated by the ANG installation unit Director of

Psychological Health for information and referral. **(T-1).** When AF FAP assets become involved due to circumstance or geographic proximity, victim(s) may be provided advocacy services to address immediate safety issues and assisted with referrals to community resources for ongoing services. These incidents are not taken to the CRB for disposition; however, involved FAP assets will notify command and provide information or updates regarding any serious safety or fitness for duty concerns. **(T-1).**

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The Headquarters of the USAF (HAF). The Secretary of the Air Force (SecAF) delegates management of the FAP to The Air Force Surgeon General (AF/SG), who implements DoD and AF requirements as described below:

2.2. Air Force Surgeon General (AF/SG). The AF/SG provides guidance, supports personnel requirements and resources needed to implement the FAP, and is involved in strategic planning.

2.2.1. AF/SG assigns a clinical social worker as the Air Force Chief of the Family Advocacy Program (AF Chief, FAP).

2.2.2. AF/SG assigns operational management responsibility of the FAP to the AF Chief, FAP.

2.2.3. AF/SG or designee appoints a forensic pediatrician and an expert medical consultant to participate in the AF FAP Fatality Review process.

2.3. The Air Force Chief, Family Advocacy Program.

2.3.1. Maintains overall operational responsibility for all FAP procedures.

2.3.2. Will develop and implement instruction and guidance, as well as the corresponding Self-Assessment Communicator IAW AFI 90-201, *The Air Force Inspection System,* for use at the installation FAP to monitor the quality of installation FAP services. **(T-1).**

2.3.3. Develops and manages the FAP budget.

2.3.4. Maintains a central registry of all reported domestic abuse and child maltreatment incidents that meet criteria for maltreatment at the installation CRB.

2.3.5. Will provide direction, training, and consultation to personnel involved in the FAP. **(T-0).**

2.3.5.1. Ensures appropriate specialty training for installation staffs: Family Advocacy Officer (FAO), Family Advocacy Treatment Manager (FATM), Family Advocacy Intervention Specialist (FAIS) (and/or Family Advocacy Outreach Manager (FAOM)) where still assigned), Family Advocacy Nurse (FAN), Domestic Abuse Victim Advocate (DAVA), and Family Advocacy Program Assistant (FAPA).

2.3.5.2. Supports the FAP staff in the delivery of required trainings as listed in DoDI 6400.06 paragraph 7.

2.3.6. Serves as subject matter expert consultant on domestic abuse, child maltreatment, and AF FAP procedures to HAF and DoD agencies, Office of the Secretary of Defense (OSD), and other officials.

2.3.7. Provides FAP data to the OSD FAP office as requested or required.

2.3.8. Contributes to the development of DoD FAP guidance.

2.3.9. Convenes annual AF Multidisciplinary Child Maltreatment and Domestic Violence Fatality Review Board IAW DoDI 6400.06. **(T-0).**

2.3.10. Resolves program problems resulting from lack of personnel or material resources in coordination with the MAJCOM/Surgeon General.

2.3.11. Ensures pertinent and timely information is shared with Air Force Integrated Resilience Directorate (AF/A1Z) from Congress, DoD, and other key venues regarding laws, policies, guidance, and other information impacting family violence primary prevention efforts. This includes providing special observance theme month materials developed by OSD FAP to AF/A1Z.

2.4. The AF Chief of Chaplains (AF/HC). Is a consultant to the AF Chief, FAP and appoints a senior chaplain to participate in the annual AF FAP Fatality Review process.

2.5. The AF Judge Advocate General. Will ensure compliance with requirements for legal services outlined in DoDI 6400.06. **(T-0).** The AF Judge Advocate General is a consultant to the Chief, AF FAP and appoints a senior attorney to participate in the annual AF FAP Fatality Review process.

2.6. The Air Force Office of Special Investigation (AFOSI). Will provide information on all domestic abuse and child maltreatment-related deaths to support timely completion of DD Form 2901, IAW DoDI 6400.06, paragraph 6.9.1., upon request of AF Chief, FAP or the AF FAP Clinical Director. **(T-0).** The AFOSI is a consultant to the AF Chief, FAP and appoints a senior investigator to participate in the annual AF FAP Fatality Review process.

2.7. The Deputy Chief of Staff, Manpower, Personnel and Services - Integrated Resilience Directorate (AF/A1Z). Oversees and implements the Air Force's Resilience Program, Violence Prevention Program, and Community Action Board (CAB) and Community Action Team (CAT) as described in AFI 90-5001, *Integrated Resilience*. This includes incorporating and reinforcing the Comprehensive Airman Fitness (CAF) framework as appropriate.

2.7.1. The Violence Prevention Program focuses on non-clinical and primary prevention of interpersonal and self-directed violence; stopping it before it occurs.

2.7.1.1. It is implemented by Major Command Violence Prevention Program Managers (if available) and installation Violence Prevention Integrators (VPIs).

2.7.1.2. It seeks to collaboratively identify, implement, and assess public health-informed and evidence-based prevention guidance, practices, programs, and processes to eliminate interpersonal and self-directed violence.

2.7.2. Secondary prevention and clinical interventions related to family violence (e.g., domestic abuse and child maltreatment) remains solely within the purview of the FAP.

2.8. The AF Director of Security Forces (AF/A4S). Is a consultant to the AF Chief, FAP and appoints a Security Forces Squadron (SFS) member to participate in the annual AF FAP Fatality Review process.

2.9. The Deputy Chief of Staff, Air Force Personnel Center (AFPC). Provides consultation to the AF Chief, FAP and appoints a representative to participate in the annual AF FAP Fatality Review process.

2.10. Major Commands.

2.10.1. Each MAJCOM Commander will ensure each installation in the command establishes and maintains the FAP IAW DoD and AF policies. **(T-1).**

2.10.1.1. Identifies and corrects service delivery and compliance issues.

2.10.1.2. Provides assistance and guidance to base level FAP.

2.10.2. The MAJCOM Behavioral Health Consultant:

2.10.2.1. Consults with the AF Chief, FAP or designee when addressing domestic abuse and child maltreatment issues on behalf of the MAJCOM/Surgeon General.

2.10.2.2. Ensures high interest incidents (e.g., death due to maltreatment, suicide related to maltreatment, unexplained child death, or sexual abuse by a DoD-sanctioned caregiver) of suspected domestic abuse or child maltreatment are reported to the AF Chief, FAP within 24 hours of MTF/MAJCOM notification.

2.11. Installation Commander (CC).

2.11.1. Will retain overall responsibility for the installation FAP. **(T-0).** Will designate the MTF Service Commander to administer and monitor the installation FAP IAW DoD and AF policies. **(T-1).**

2.11.2. Will establish an installation Family Advocacy Committee (FAC). **(T-0).**

2.11.2.1. The Installation CC will appoint the MTF Service Commander as Chair, or may chair the FAC him or herself if desired. **(T-1).**

2.11.2.2. The FAC is typically an independent forum to address installation implementation of the FAP. With approval from the CAB Chair, the FAC may also be accomplished utilizing the CAB or CAT as appropriate and IAW AFI 90-5001.

2.11.2.2.1. The CAB Chair will ensure that all AF FAC requirements are met if the CAB or CAT is utilized. **(T-1).**

2.11.2.2.2. The Community Support Coordinator (CSC), as the CAB Executive Director and CAT Chair, will be informed of FAC activities (e.g., meetings) involving the CAB or CAT and may provide support as appropriate. **(T-1).** This ensures any CAB action items are tracked and monitored for progress, at CAT meetings, and that the CAB Chair is informed on activities. The CAB Executive Director and CAT Chair will not serve as the FAC lead administrative support function. **(T-1).** FAC-specific administrative support is the responsibility of FAP personnel, under the direction of the FAO.

2.11.2.2.3. If a FAC is occurring at the end of a CAB or CAT meeting, CAB or CAT members who are not FAC members will be excused for the FAC portion. **(T-1).**

2.11.2.2.4. The FAC does not fulfill all CAB and CAT requirements outlined in AFI 90-5001.

2.11.3. Shall serve as a member of FAC or delegate responsibility to a key member of the senior staff (e.g., Installation Deputy CC or a Group CC). **(T-0).**

2.11.4. Will ensure the command post, or other similar installation level emergency notification agent, immediately notifies the FAO of any death incidents related to suspected domestic abuse or child maltreatment, including maltreatment-related suicides and unexplained child deaths to allow family safety planning pending autopsy results. **(T-0).**

2.11.5. Will ensure the installation FAO (or identified FAP designee) is authorized to receive law enforcement sensitive information (e.g., the blotter and SFS police reports) that may be related to child abuse or neglect, domestic abuse, or PSB-CY; as well as all alcohol and drug related misconduct that may pose a risk to children or other family members. **(T-1).**

2.11.6. In collaboration with the Child Sexual Maltreatment Response Team (CSMRT), shall consider requesting Family Advocacy Command Assistance Team (FACAT) assistance from OSD IAW DoDI 6400.03, when needed to address allegations of multi-victim child sexual maltreatment in DoD-sanctioned activities or multi-victim PSB-CY allegations involving military children or children on military installations. **(T-0).**

2.11.7. Will receive FAP senior leader training and direct family maltreatment and/or CRB training for installation leadership and key agencies IAW **Chapter 4** of this publication. **(T-0).**

2.11.8. Shall ensure Squadron Commanders (SQ/CCs), First Sergeants (CCFs), and joint-service equivalent senior leaders are aware of the availability of New Parent Support Program (NPSP) in promoting protective factors and reducing risk factors associated with child abuse and neglect. **(T-0).**

2.11.9. In joint-service areas, shall establish a joint FAC with a joint NPSP subcommittee to plan, administer, and evaluate coordination processes. **(T-0).**

2.11.10. Installation CC will ensure FAOMs (where still assigned) and FAIS, are identified to group and squadron senior leaders as the designated staff for secondary or selective prevention services for active component and eligible family members who are known to have early indicators of risk for family maltreatment or in need of family relationship support. **(T-1).** Installation CC will ensure at risk active component and eligible family members are aware of FAP's self-referral process, and referral by CCFs via the FAP CCF Consultation services. **(T-0).**

2.11.11. The Violence Prevention Integrator (VPI) will serve as the installation OPR for the primary prevention of interpersonal and self-directed violence as described in AFI 90-5001. **(T-1).**

2.11.11.1. The VPI will implement primary prevention programs and activities related to family violence (domestic abuse and child maltreatment) as directed by AF/A1Z. **(T-1).**

2.11.11.2. The VPI will have primary responsibility of implementing primary prevention strategies for the special observance theme months (of Domestic Violence Awareness Month, Teen Dating Violence Awareness Month and National Child Abuse Prevention Month) as directed by AF/A1Z to meet DoD requirements. **(T-1).**

2.11.11.2.1. Appropriate FAP personnel (e.g., FAIS or FAOM where still assigned) will support and collaborate with VPIs by providing subject matter expertise, networking support, and at times logistical support as necessary and as appropriate IAW FAP core mission requirements. **(T-1).**

2.11.11.2.2. Awareness raising, while helpful, does not replace or diminish the priority of skills building that support programs and activities related to the primary prevention of violence.

2.11.11.3. Secondary prevention and clinical interventions related to family violence (e.g., domestic abuse and child maltreatment) remain solely within the purview of the FAP.

2.12. Family Advocacy Committee (FAC).

2.12.1. Will monitor the installation FAP to ensure implementation is IAW DoD and AF guidance. **(T-0).** For sites with FAP assets working from a Limited Scope MTF, FAP data and information will be included with an affiliated installation's FAC. **(T-1).** Installations without an established FAP (e.g., unaccompanied remote sites) do not require an independent FAC. In these exceptional cases, components of the FAC described below will be implemented based on the needs of the installation and at the discretion of the installation CC. **(T-3).**

2.12.2. Coordinates local policies, agreements, and procedures with installation agencies and community partners to address safety of victims of domestic abuse and child maltreatment, of alleged offenders, of other family members and of the community at large.

2.12.2.1. Will ensure the installation has Memorandums of Understanding (MOUs) with domestic violence shelters in the local area, and county or state child protective service agencies serving the installation and surrounding area. **(T-0).** When the installation is Outside Continental United States (OCONUS), the host country agencies may or may not agree to participate in the MOU process.

2.12.2.2. Will ensure execution of required MOUs outlining responsibilities required by DoDM 6400.01. **(T-0).** MOUs will require child protective services to inquire on every child maltreatment investigation when any household member is an active component member. **(T-0).** MOUs must be reviewed triennially from the effective date of the signed document. **(T-0).** Example DAVA, legal, and law enforcement MOU provisions are contained in **Attachments 2**, **3**, and **4**.

2.12.3. Will ensure the installation has an established 24-hour emergency response plan to child abuse and domestic abuse incidents IAW DoD and AF guidance. **(T-0).** The 24-hour emergency response plan must include options where adult victims can have direct 24-hour access to FAP, a DAVA, or a MTF Provider telephonically at a minimum, in order to preserve the victim's option for restricted reporting even if no DAVA is assigned to the installation. **(T-0).**

2.12.3.1. If a full-time DAVA is assigned, the installation will publish a local emergency telephone number for 24-hour advocacy response. **(T-1).** DAVAs should answer in a standardized, brief, courteous manner without specifically revealing his or her position and identity upon initial greeting (e.g., "[Installation Name] Medical Group, how may I help you?"). The DAVA should try to establish the caller's identity, if possible, to avoid scenarios where an alleged offender is tracking a victim's outgoing calls and to protect the DAVA's anonymity to the greatest extent possible. DAVA telephone call and response scripts are available through the AF FAP office or the DAVA Program Manager to assist in these situations.

2.12.3.2. If other personnel are assisting with 24-hour advocacy coverage (e.g., a Mental Health on-call provider or FAP staff member), the same precautions should be applied.

2.12.4. The FAC will ensure implementation of a screening process for provision of NPSP services where available. **(T-0).**

2.12.5. The FAC will meet at least semi-annually. **(T-1).** Additional meetings may be held at the call of the Chair.

2.12.6. The FAC will include the following members, two-thirds of whom must be in attendance to form the quorum necessary to convene the meeting: Installation CC (or designee); MTF Service Commander (typically the Chair, unless the Installation CC elects to Chair) or Deputy MTF Service Commander as alternate; FAO; FAIS (or FAOM where still assigned); DAVA, where available; Director, Airman and Family Readiness Center (or joint-service equivalent) (or designee); Staff Judge Advocate (SJA) (or designee); SFS/CC (or designee); AFOSI Detachment/CC (or designee); Wing Chaplain (or designee); Command Chief Master Sergeant (CCC); Department of Defense Education Activity (DoDEA) designated representative (at installations with DoD schools). **(T-1).**

2.12.6.1. The installation VPI (where assigned) may be invited when the FAC is seeking guidance on primary prevention of interpersonal and self-directed violence.

2.12.6.2. The Installation Community Support Coordinator may be invited when the FAC is seeking guidance on resilience or CAB and CAT functions.

2.12.6.3. The FAC may add other members as appropriate, such as Chief Circuit Special Victims' Counsel, representatives from civilian agencies or community service organizations with a direct role in supporting military families at risk of, or experiencing, domestic abuse or child maltreatment.

2.12.7. The FAC will ensure installation support for interagency collaborations and written agreements where needed to ensure prompt and appropriate response to military families at risk of, or experiencing, domestic abuse or child maltreatment. **(T-0).**

2.12.8. The FAC Chair, assisted by the FAO, will ensure all appointed FAC members are trained by the FAP on domestic abuse and child maltreatment and FAC roles prior to serving on the FAC. **(T-0).**

2.12.9. The FAC Chair, assisted by FAP administrative support, maintains minutes of the FAC meetings that reflect attendance, issues discussed, and decisions made. The FAC Chair will ensure timely forwarding of the FAC minutes to the Installation CC for review following each meeting. **(T-0).**

2.13. The Military Treatment Facility Service Commander.

2.13.1. Will assume responsibility for the implementation of the FAP under Installation CC oversight. **(T-1).**

2.13.2. Will chair the installation FAC (unless the installation CC chooses to fulfill this role). **(T-1).**

2.13.3. Shall direct a clinical social worker (active component when available, but can be civil service when assigned to the appropriate position description), privileged in the MTF, to serve as the FAO. **(T-0).** Another mental health (MH) flight provider may fill this position if privileged in the MTF. An additional MH provider should be designated to serve as alternate FAO to ensure continuity and coverage. The MTF Service Commander will ensure that any

designated FAO or alternate FAO participates in AF FAP-sponsored FAO trainings when provided. **(T-0).**

2.13.4. Will ensure that the CRB is the only meeting outside the MTF that the FAO is directed to attend where the FAP client identification or individual case discussions take place, IAW Health Insurance Portability and Accountability Act (HIPAA) requirements, and to protect the privacy of the FAP clients. **(T-0).** The MTF Service Commander will consult with the Installation CC or the FAC members as needed to intervene when the FAO or other FAP provider is asked to participate in any forum where there is potential for a FAP staff member to inappropriately disclose protected health information or sensitive client-specific information. **(T-1).**

2.13.5. With the Chief, Medical Staff, will ensure medical personnel notify the FAP of all suspected incidents of domestic abuse and child maltreatment, and provide timely care for any injuries, with documentation of injuries and allegations in the EHR to inform future assessments of maltreatment. **(T-0).**

2.13.6. Where a FAN is assigned, the MTF Service Commander will ensure policies and procedures are established to offer screening to eligible beneficiaries in the NPSP target population (expectant, and/or with children birth to three years of age), whether they receive medical care at the MTF or in the community. **(T-0).** With the Chief, Medical Staff, will ensure all MTF providers refer eligible Service Member and beneficiary parents to NPSP. **(T-0).**

2.13.7. Will ensure the FAP has facilities to ensure staff and patient safety, including duress system, a secure point of entry and safety for home visitation services. **(T-0).**

2.13.8. Will ensure suspected domestic abuse and child maltreatment victims receive prompt medical and/or dental assessment when requested by the FAO. **(T-0).** With the FAO, will ensure identified victims are not left unattended with potential offenders pending medical assessment, treatment, and safety planning. **(T-1).** Generally, victims of abuse/neglect should be given priority appointments in primary care and not be sent to the emergency department during duty hours unless medically indicated.

2.13.9. Serves as Incident Status Determination Review (ISDR) authority and confirms compliance with all procedures for ISDR.

2.13.10. Supports implementation of FAP prevention programs and services to include NPSP, Family Advocacy Strengths-based Therapy (FAST) and psychoeducation.

2.13.11. Will ensure the MTF supports FAIS (or FAOM where still assigned) in facilitating and coordinating annual training requirement on domestic abuse and child maltreatment for MTF healthcare providers, professional staff, and support staff including administrative and intake support staff, through FAP designated in-person and automated training formats. **(T-1).** (Note: Within DHA facilities, DHA may direct standardized training regarding the identification and reporting of Child Abuse or Neglect and Domestic Abuse.)

2.13.12. Shall participate as the senior Surgeon General (SG) representative on the installation CAB IAW AFI 90-5001. **(T-1).**

2.13.13. Shall direct a FAIS (or FAOM where still assigned) to be the FAP representative to the installation CAT and other interagency collaborative forums to advise on risk and protective factors in addressing domestic abuse and child maltreatment. **(T-1).**

2.14. Family Advocacy Officer.

2.14.1. Will manage the installation FAP IAW DoD and AF FAP guidance. **(T-0).**

2.14.2. Will coordinate the CRB and chair the Clinical Case Staffing (CCS), CSMRT, High Risk for Violence Response Team (HRVRT), and NPSP Case Staffing. **(T-0).**

2.14.3. Shall serve as a member of the FAC. **(T-0).**

2.14.4. Shall serve as consultant on domestic abuse and child maltreatment to installation units and agencies. **(T-0).**

2.14.5. Shall serve as consultant on all suspected child maltreatment in DoD-sanctioned activities. (T-0).

2.14.6. Shall serve as consultant on all allegations of PSB-CY. **(T-0).**

2.14.7. Oversees implementation of the various service delivery components of the installation FAP, to include:

2.14.7.1. NPSP IAW **Chapter 3** of this instruction. In addition:

2.14.7.1.1. Will ensure risk management for NPSP clients, to include support by clinical social workers and NPSP case staffing meetings held monthly at a minimum, with participation by social work and nursing staff members. **(T-1).**

2.14.7.1.2. Will ensure that FAN interventions for families served in the maltreatment program are based on appropriateness of referrals and available FAN resources, balancing the impact on current NPSP caseload, FAN workload priorities, and the need for nursing intervention. **(T-1).**

2.14.7.2. Oversees Secondary Prevention and Client Engagement activities IAW **Chapter 4** of this instruction. In addition, ensures the FAP Prevention Program administrative requirements for program management, measurement, and program evaluation are completed. The FAIS (or FAOM where still assigned) completes planning, documentation, outcome measures, metrics, and program evaluation with administrative support of the FAPA.

2.14.7.3. Oversees victim support and maltreatment response and intervention IAW **Chapter 5** and **Chapter 6** of this instruction. In addition:

2.14.7.3.1. The FAO will ensure appropriate triage, assessment, and management of maltreatment referrals. **(T-0).** The FAO will safeguard the privacy of individuals making maltreatment referrals to FAP. **(T-0).** Disclosing personally identifying information of a caller or of an extra-familial caregiver who is accused of child maltreatment creates the potential for those individuals to be subjected to harassment or other inappropriate behavior.

2.14.7.3.2. Shall ensure all maltreatment referrals are presented at the CCS. **(T-0).**

2.14.7.3.3. Will ensure all adult victims of domestic abuse have 24-hour access to a DAVA on that installation, the DAVA at the nearest AF installation, or information on how to connect with a civilian advocacy agency. **(T-0).**

2.14.7.3.4. Will ensure all allegations that meet reasonable suspicion of maltreatment go to the CRB for determination. **(T-0).** The only allegations meeting reasonable suspicion that are not taken to CRB are restricted reports of domestic abuse (these reports are logged in Family Advocacy System of Records (FASOR) as restricted reports), and domestic abuse allegations where an adult victim refuses to cooperate with a FAP maltreatment assessment, exercising his or her right to self-determination, when there is no imminent risk of serious harm or death, (these reports are logged in FASOR as no assessment warranted (NAW)-uncooperative victim).

2.14.7.3.4.1. If the victim is determined to be at imminent risk of serious harm or death, the FAO will convene an HRVRT, invite the adult victim to attend, and must take the case to CRB even if the victim refuses to cooperate with the FAP assessment. **(T-1).**

2.14.7.3.4.2. Indicators of potential adverse impact on a child (e.g., report that a child witnessed intimate partner maltreatment) should also be considered to determine whether a case should be taken to the CRB for emotional maltreatment of the child or neglect due to exposure to physical hazards.

2.14.7.3.5. Will formalize a process for notifying the MTF Service Commander and AF FAP of all domestic abuse and child maltreatment-associated deaths, including suicides, as well as all unexplained child deaths that occur on or off the installation. **(T-0).**

2.14.7.3.6. Shall attend FAO CRB boot camp prior to, or within six months of, assuming FAO duties. **(T-1).**

2.14.7.3.7. Will ensure immediate notification to active component DoD member's CC, SF, and AFOSI Detachment, (or equivalent DoD entities where appropriate) of all suspected unrestricted reports of domestic abuse. **(T-0).**

2.14.7.3.8. Will ensure immediate notification to active component DoD member's CC, SFS, and AFOSI Detachment (or equivalent DoD entities where appropriate) and the civilian Child Protective Services (CPS) agency(ies) with local jurisdiction of all suspected child maltreatment incidents. **(T-0).**

2.14.7.3.9. In cases of death due to suspected domestic abuse or child maltreatment, to include suicides, or any unexplained child death, the FAO will ensure notification of the AFOSI Detachment and SFS, referral of the family to the FAP for assessment and/or supportive services, and notification to the MAJCOM Mental Health Consultants. **(T-1).** The FAO will provide AF FAP a completed high-interest worksheet within 24 hours of notification of the death. **(T-0).**

2.14.7.3.10. Will ensure a coordinated community response to high risk maltreatment situations by activation of the HRVRT when indicated. **(T-0).**

2.14.7.3.11. For foreign locations, the FAO will formalize an installation-specific Emergency Placement Care (EPC) process to manage child safety in limited

circumstances. **(T-1).** The process accounts for host nation laws, the status of forces agreement, or any other applicable international agreement. FAOs coordinate the EPC process with the installation SJA, support agencies, the MAJCOM Behavioral Health Consultant, AF FAP and AFPC. Guidance for formalizing EPC process is found in **Attachment 5.**

2.14.7.4. Manages allegations of PSB-CY IAW **Chapter 7** of this instruction.

2.14.7.5. Manages other installation FAP administrative requirements IAW **Chapter 8** of this instruction.

2.14.8. Shall ensure all requests for release of information from FAP records includes a consult with Medical Law Consultant in order to reduce risk of harm to victims. **(T-1).**

2.14.9. Shall ensure FAP providers consistently consult CCs regarding fitness for duty and safety of individuals with career-impacting conditions (e.g., offenders of domestic violence, child abuse, or chronic neglect). **(T-1).**

2.15. Group Commanders, Squadron Commanders, Command Chief Master Sergeants and First Sergeants (Group, squadron or similar military department unit; first level of command on G-series orders).

2.15.1. Shall receive training and education from the installation FAP IAW **Chapter 4** of this instruction. **(T-0).**

2.15.2. CCs shall refer any incident of domestic abuse reported or discovered independent of law enforcement to military law enforcement or the appropriate criminal investigative organization for possible investigation IAW DoDI 5505.03, *Initiation of Investigations by Defense Criminal Investigative Organizations*, and report to FAP IAW DoDI 6400.06. **(T-0).** CCs and any individual in the active component service member's chain of command shall report all credible information (which may include a reasonable belief) of suspected child maltreatment immediately to the FAP office responsible for serving the unit. **(T-0).**

2.15.3. Will direct suspected active component domestic abuse or child maltreatment offenders to the FAP for comprehensive assessment and if the CRB determines that the maltreatment incident "met criteria," shall direct the active component alleged offender to complete the treatment plan recommended by the CCS. **(T-0).**

2.15.4. Will complete CRB training annually and participate in the CRB for incidents involving their squadron unit members. **(T-0).**

2.15.5. CC will document, as appropriate, that a service member engaged in conduct that is a dependent-abuse offense when referring such action for court martial and when initiating action to administratively separate the Service member from active duty so family members will be eligible to apply for transitional compensation benefits. (T-0) When applicable, ensure family members are aware of their eligibility for transitional compensation. **(T-1).** Eligibility criteria are explained in AFI 36-3012, *Military Entitlements*.

2.15.6. Will pursue training and consultation with the installation legal office on collateral misconduct (e.g., active component victim underage drinking when physically assaulted by partner) to ensure an appropriate command response striking the proper balance between encouraging reporting and continued cooperation, limiting avenues to unnecessarily attack a

victim's motivation to report, ensuring the victim a voice in the process, and protecting Airmen's perceptions and attitudes of the military justice system. **(T-1).**

2.15.7. Will ensure "no-contact" orders and military protective orders (MPOs) are issued IAW AFI 51-201, *Administration of Military Justice*, Section 16I-No Contact and Military Protective Orders. (T-1). If a "no-contact" order is issued, will collaborate with the FAP Provider to ensure the victim is notified of the provisions of the "no-contact" order so an appropriate safety plan can be created with the family.

2.15.8. Upon consultation with the FAP provider, will consider cases closed as unresolved and multiple cases involving the same active component member in determining the member's suitability for continued service. **(T-1).**

2.15.9. FAIS (or FAOM where still assigned) will function as the FAP consultant to leader or active component member consultation on early signs of risks for potential abuse, maltreatment, or need for service member prevention program intervention; provides leader, squadron, MTF, or agency strategies on FAP prevention, strength-based behavioral health support, fitness and skill, or Resource Finding and Service Linking. **(T-1).**

2.16. Wing Chaplain.

2.16.1. Shall serve as a member of the FAC. **(T-1).**

2.16.2. Will ensure all chapel staff and volunteers receive the FAP training on identification and reporting procedures for suspected domestic abuse and child maltreatment when hired and annually thereafter. **(T-0).**

2.16.3. Will ensure implementation of DoD guidance for installation background checks and screening of applicants seeking chapel employment, contractor or volunteer positions working with children and youth. **(T-0).**

2.17. Installation Staff Judge Advocate (SJA).

2.17.1. Will serve, or designates an attorney to serve, on the installation CRB and FAC. **(T-0).**

2.17.2. Shall appoint an attorney to serve on the CSMRT and HRVRT. **(T-1).**

2.17.3. Will provide consultation to the FAC in the development of MOUs and Inter-Service Support Agreements. **(T-0).**

2.17.4. Will provide consultation services to the FAP in cases of domestic abuse restricted reporting and state reporting requirements for intimate partner abuse. **(T-0).**

2.17.5. Shall train group and SQ/CCs about administrative options for military members involved with domestic abuse and child maltreatment and on AF transitional compensation for victims of domestic abuse and child maltreatment. **(T-0).**

2.17.6. Shall advise CCs on the AFI regarding collateral misconduct (e.g., active component victim underage drinking when physically assaulted by partner), to ensure an appropriate command response striking the proper balance between encouraging reporting and continued cooperation, limiting avenues to unnecessarily attack a victim's motivation to report, ensuring the victim a voice in the process, and protecting Airmen's perceptions and attitudes of the

military justice system when active component victims of domestic abuse report maltreatment, prompting an investigation of the incident. **(T-0).**

2.17.7. Shall assess the need to establish MOUs between the installation legal office and local (state, city, county) district attorney's office applicable to sharing of information regarding domestic abuse and child maltreatment cases involving military personnel assigned to the installation and their family members or unmarried intimate partners. **(T-0).** (Example district attorney MOU provisions are contained in **Attachment 3**).

2.17.8. Will coordinate with the FAO to ensure availability and effectiveness of Victim Witness Assistance Program (VWAP) services for qualifying family members and ensure VWAP personnel responsible for responding to domestic abuse and child maltreatment incidents attend the FAP training on the identification and reporting protocols for suspected abuse or maltreatment. **(T-0).**

2.17.9. Will provide consultation to the FAP on questions of engagement with local organizations, concerns related to serving on community agency boards, and the appropriate management of funds or contributions provided by agencies. **(T-0).**

2.18. Installation Security Forces Squadron Commander.

2.18.1. Will serve or designate a representative (NCO or equivalent and above) to serve on the FAC. **(T-0).**

2.18.2. Will serve or nominates a representative (NCO or equivalent and above) to the CRB and HRVRT. **(T-0).** SFS representative on the CRB will serve as liaison between local law enforcement and the installation, securing civilian and military police reports and other relevant information for the CRB process. **(T-0).** Will ensure preliminary investigative findings related to domestic abuse and child maltreatment cases investigated by SF are provided to the CRB to meet the 60-day deadline from initial referral to CRB incident status determination (ISD). **(T-0).**

2.18.3. Will ensure SFS personnel search the Defense Incident-Based Reporting System and its internal database for historical data pertaining to all reported incidents of domestic abuse and child maltreatment and provides this information to the FAP, and CRB when indicated. **(T-0).**

2.18.4. Will ensure SFS personnel responsible for responding to domestic abuse and child maltreatment incidents attend annual FAP training on the identification and reporting protocols for suspected abuse or maltreatment. **(T-0).**

2.18.5. Will ensure the DAVA's contact information (at installations where a DAVA is assigned) is passed to the victim at the time of an incident to which SFS personnel have responded. **(T-1).**

2.18.6. Will ensure the FAP receives notification within 24 hours of all reports of suspected domestic abuse and child maltreatment received by law enforcement. **(T-0).**

2.18.7. Shall ensure the installation FAO (or identified FAP designee) receives law enforcement sensitive information (e.g., the blotter) that may be related to child abuse or neglect, domestic abuse, or PSB-CY; as well as all alcohol and drug related misconduct that may pose a risk to children or other family members. **(T-1).**

2.18.8. Shall coordinate with investigative agencies and the FAP on domestic abuse and child maltreatment incidents under investigation. **(T-0).**

2.18.9. Will support investigative interviews of alleged offenders in child maltreatment cases occurring in DoD-sanctioned activities and bring findings to the CRB. **(T-0).**

2.18.10. Will work with the local AFOSI Detachment and installation legal office to attempt to establish MOU(s) between installation law enforcement units and local (city, county, state) law enforcement agencies in sharing of information regarding domestic abuse or child maltreatment cases involving military personnel and their family members or unmarried intimate partners. **(T-0).** (Example law enforcement agency MOU provisions are contained in **Attachment 4**).

2.19. Installation AFOSI Detachment Commander.

2.19.1. Will serve or designate a representative (NCO or equivalent and above) to serve on the installation FAC, CSMRT and HRVRT. **(T-0).**

2.19.2. Will serve or designates a representative to serve on the installation CRB as a non-voting member. **(T-0).** The Detachment CC shall ensure preliminary investigative findings related to domestic abuse and child maltreatment cases investigated by AFOSI are provided to the CRB to meet the 60-day deadline from initial referral to CRB ISD. **(T-1).** In the event AFOSI's criminal investigation is ongoing, the AFOSI CRB representative will use judgment to determine the extent to which information may be shared without damaging investigative efforts. **(T-0).**

2.19.3. Will report all allegations of domestic abuse or child maltreatment to the FAP within 24 hours of receipt, unless immediate notification is precluded by specific investigative or operational necessities. **(T-0).** Until the FAP is notified, AFOSI must address safety concerns for all family members or unmarried intimate partners. **(T-0).**

2.19.4. Will ensure the FAP is authorized access to family members or unmarried intimate partners at the earliest opportunity possible in incidents of partner or child maltreatment or of sexual maltreatment of a child by a DoD-sanctioned child care provider, balancing the risks of hindering a criminal investigation with the need to complete risk assessments, safety plans, and the FAP intake interviews in preparation for the CRB and intervention planning with the family. **(T-1).**

2.19.5. Shall search the Defense Clearance Investigations Index and its internal database for historical data pertaining to all reported incidents of domestic abuse and child maltreatment, and provides this information to the FAP and CRB. **(T-0).**

2.19.6. Investigates aggravated assaults involving grievous bodily harm, sexual assaults, and all incidents of child sexual abuse within their jurisdiction.

2.19.7. Shall coordinate and monitor domestic abuse and child maltreatment investigations conducted by civilian agencies, when there is a DoD interest, and provides information to CRB for incident determinations, and to the FAP to support care of family members. **(T-0).**

2.19.8. Will ensure all agents attend annual FAP training on the identification, reporting, and dynamics of domestic abuse and child maltreatment when hired and annually, thereafter. **(T-0).**

2.19.9. Will work with SFS and installation legal office to attempt to establish MOU(s) between installation law enforcement (SFS and AFOSI Detachment) and local (city, county, state) law enforcement agencies to address sharing of information regarding domestic abuse or child maltreatment cases involving military personnel and their family members or unmarried intimate partners. **(T-0).** AFOSI Detachment/CC will coordinate with AFOSI Headquarters and installation AFOSI/SJA prior to entering into MOUs. **(T-1).** Even sample MOUs require coordination prior to implementation. (Example law enforcement agency MOU provisions are contained in **Attachment 4**).

2.20. Installation Force Support Squadron Commander.

2.20.1. Will appoint the Director, Airmen and Family Readiness Center (or joint-service equivalent), or designee, to serve on the FAC. **(T-0).**

2.20.2. Will ensure all Airmen and Family Readiness Center staff, joint-service equivalents, other support agency staff, and volunteers who work directly with children and youth receive training through the FAP to include identification, reporting procedures, and dynamics of domestic abuse and child maltreatment when hired and annually thereafter. **(T-0).**

2.20.3. Shall ensure staff working with prenatal families and families with children ages birth to three years of age are aware of the NPSP to include program services, eligibility, and referral procedures. **(T-0).**

2.20.4. Will ensure reports of suspected incidents of child maltreatment occurring in DoD-sanctioned activities are immediately reported to the FAP (e.g., family child care, child development and youth centers, or recreation programs). **(T-0).**

2.20.5. Will ensure completion of installation background checks and screening of applicants seeking employment, contractor or volunteer positions working with children and youth are completed IAW current DoD guidance. **(T-0).**

2.20.6. Will consult with installation legal office to determine proper jurisdiction and course of action for investigating and resolving situations where a child care provider or youth program staff member is suspected of child abuse or neglect in a DoD-sanctioned activity. **(T-0).**

2.20.7. Will ensure installation agency (e.g., Child Development Center, Youth Center, Medical Treatment Facility, etc.) staff working with children age 3 to 17 years, and active component members, couples, or parents with indicators of risk for domestic abuse or child maltreatment are aware of secondary prevention services, and resource finding and service linking through FAP Prevention and Outreach Program Services. **(T-0).**

2.21. Installation Public Affairs Office.

2.21.1. Distributes FAP news releases to installation newspapers and other news media.

2.21.2. Will serve as the point of contact for the FAP's response to press inquiries. **(T-1).**

2.21.3. Provides consultation to the FAP staff on public affairs, articles, and media releases.

2.22. Air Force Reserve Command's (AFRC) Director of Psychological Health and Psychological Health Advocates. Where available, the AFRC's Director of Psychological Health and Psychological Health Advocacy Program may coordinate services between reserve personnel, the FAP staff, and civilian authorities.

2.23. Air National Guard Wing Director of Psychological Health. The ANG's Wing Director of Psychological Health may coordinate services between ANG personnel, the FAP staff, and civilian authorities.

Chapter 3

NEW PARENT SUPPORT PROGRAM

3.1. New Parent Support Program (NPSP). The NPSP is a secondary prevention program that utilizes an intensive, voluntary on and off-installation home visitation model to provide education and supportive services to expectant families and families with children from birth to three years of age IAW DoDI 6400.05. The FAN, with support from the FAP team and the FAC, delivers NPSP services to community members eligible for care in the MTF, under the oversight of the FAO.

3.2. Eligibility for New Parent Support Program.

3.2.1. A parent must be eligible for military medical care. **(T-0).**

3.2.1.1. For families where only one parent is eligible for military medical care, NPSP services will only be provided to the eligible parent. **(T-0).**

3.2.1.2. The eligible parent must complete NPSP paperwork, and only his or her information will be entered into the Family Advocacy Program Network (FAPNet) NPSP documentation system by FAP staff. **(T-0).**

3.2.1.3. The eligible parent must be present at all contacts with the family. **(T-0).**

3.2.2. The individual must be expectant, have expectant partner, and/or have or be anticipating adoption of a child under the age of 3 years. **(T-0).**

3.2.3. The individual, couple, or family must have no open "met criteria" maltreatment incident, or pending maltreatment allegation. **(T-1).**

3.2.3.1. Maltreatment cases will not be closed by the FAP team as long as there is more than minimal risk for maltreatment, unless the client is refusing services. **(T-1).** It is not appropriate to close a maltreatment record and immediately open a NPSP record.

3.2.3.2. Decisions related to opening a NPSP case following maltreatment case closure will be made on a case by case basis by the FAP team, taking into account safety assessment and risk management, to ensure the appropriate level of care for the family. **(T-1).**

3.2.3.3. NPSP case opening following maltreatment case closure will be considered by the FAP team only if the maltreatment case was closed as resolved. **(T-1).**

3.3. New Parent Support Program Services for Families with an infant or young child with Failure to Thrive.

3.3.1. The FAO, in collaboration with the referring medical provider, may consider an initial referral for failure to thrive (FTT) as a prevention referral to NPSP if the condition is new and the following interventions have not yet been provided to the family:

3.3.1.1. Increased frequency of pediatric appointments and weight checks.

3.3.1.2. Referral to a nutritionist.

3.3.1.3. Referral to NPSP.

3.3.2. The FAO can assign such referrals to the FAN for supportive services in NPSP and should also consider assigning a social worker to augment the Family Service Plan. Due to

the fragile nature of children diagnosed as FTT, it is important to manage FTT clients as priority clients on a prevention caseload. FAP staff must initiate and sustain close communication with the child's pediatric healthcare provider. **(T-1).** The FAO must ensure the case is regularly staffed. **(T-1).** The NPSP case manager must notify the FAO immediately if the clients do not keep NPSP appointments or do not adhere to the Family Service Plan. **(T-1).** A maltreatment referral will be made by the pediatric healthcare provider or FAP staff should the pediatric healthcare provider and/or FAP staff suspect that the child has become or is at risk of becoming malnourished due to parental or caregiver neglect. **(T-1).**

3.4. Acceptance of New Parent Support Program Services. Is always voluntary for the client or prospective client. Services are provided using a strengths-based, family centered developmental approach that promotes protective factors associated with the reduction of risk for child abuse and neglect (nurturing and attachment, knowledge of parenting and child development, concrete supports in times of need, social connections and parental resilience). Services are provided in a manner sensitive to cultural differences. Involvement of both parents in NPSP services is promoted, when applicable.

3.5. Key components of the New Parent Support Program.

3.5.1. Marketing and outreach to the NPSP target population and referral sources.

3.5.2. Establishment of an effective screening process based on empirically determined protective and risk factors associated with child abuse and neglect and risk factors for domestic abuse, using the Air Force Family Needs Screener (FNS) to identify expectant and new parents whose life circumstances may place them at risk for family maltreatment.

3.5.2.1. The screening process must be established and maintained by FAP staff in coordination with other MTF personnel, with screening offered to all members of the NPSP target population (prenatal families and families with 0-3 year old children), and home visitation offered to families at risk for maltreatment. **(T-0).**

3.5.2.2. The FNS will be scored by a FAP staff member within 3 duty days of completion by the client. **(T-0).** Mother completed FNSs are entered directly into the FAPNet automated system for scoring. Father completed FNSs (optional) are hand scored and documented in a Contact Note or SF600.

3.5.2.3. FNSs with High Need scores and FNSs with Low Need scores identified as having areas of potential concern (completed by a single active component member, written comments on the FNS, 10 or more items not completed, or referral information indicating family members are at risk) will be reviewed by the FAN/FATM/FAIS/FAO the same day the FNS is scored, to determine intervention. **(T-1).**

3.5.3. The FAN/FATM/FAIS will contact prospective NPSP participants with High Need FNS scores or other areas of potential concern and offer services within 45 calendar days of FNS completion, or sooner if indicated by screener or referral information. **(T-1).**

3.5.4. Low Need NPSP families may receive up to 2 home visits. The FAN/FATM/FAIS will conduct an assessment of these families, to include assessment for child and partner maltreatment risk factors, protective factors and abuse dynamics within the family. **(T-1).** Education related to Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) and SBS/AHT prevention, Sudden Unexpected Infant Death and safe sleeping environments for

newborns, infants and young children will be provided to participating parents at the home visits by the FAN/FATM/FAIS. **(T-1).**

3.5.5. The cases of all families who screen as High Need on the FNS or receive home visits will be staffed by the FAP team within 45 days of the first home visit at the NPSP team Case Staffing meeting, chaired by the FAO and occurring at least monthly. **(T-1).** NPSP Case Staffing Attendees:

3.5.5.1. FAO (or Alternate FAO).

3.5.5.2. All FANs.

3.5.5.3. All FATMs, FAISs (or FAOMs where still assigned), and FAPAs.

3.5.5.4. Medical personnel who may add value to the case discussion may be invited, at the FAO's discretion.

3.5.5.5. The DAVA will attend and participate only in those portions of the NPSP Case Staffing in which supportive services and safety for the clients they serve are discussed, only sharing information that the client has authorized the DAVA to share. **(T-1).**

3.5.6. Clients to be presented at NPSP Case Staffing:

3.5.6.1. High Need families (after the first home or office visit, within 45 days of the first home or office visit)

3.5.6.1.1. At least annually for review (12 months from the last case staffing)

3.5.6.1.2. With occurrence of special circumstances, stressors impacting the family, change in risk and/or protective factors for maltreatment

3.5.6.1.3. High Need Enrolled families proposed for closure.

3.5.6.1.4. Families who are screened as High Need and do not accept home visitation services (High Need Pending, High Need Refused), to inform the FAP team of family status and risk factors and seek input related to strategies for engaging the family in home visitation services if appropriate.

3.5.6.2. Low Need families.

3.5.6.2.1. Low Need families that receive a home visit (after the first home visits, within 45 days of the first home visit)

3.5.6.2.2. With status changes (Low to High Need)

3.5.7. Discussion related to clients presented at the NPSP Case Staffing:

3.5.7.1. Will include reason for referral to NPSP. **(T-1).**

3.5.7.2. Will include FNS score and results of other inventories if completed. **(T-1).**

3.5.7.3. Will include the following clinical assessment: presence of child and partner maltreatment risk factors, factors that are protective against child maltreatment (nurturing and attachment, knowledge of parenting and child growth and development, parental resilience, social connections and concrete supports for parents), and the balance of risk and protective factors. **(T-0).**

3.5.7.4. Will include assignment of a NPSP case manager (FAN, FATM, FAIS, FAO). **(T-1).**

3.5.7.5. Will include a plan of care for the family and referrals made. **(T-1).**

3.5.8. Documentation of NPSP Case Staffing meetings:

3.5.8.1. Will include the Case Staffing Agenda generated by the FAPNet automated system. **(T-1).** Each attending FAP team member will sign the agenda, and the FAO will initial each case discussed on the agenda. **(T-1).** The Master copy of the agenda will be maintained for 2 years. **(T-1).** No meeting minutes are produced for the NPSP Case Staffing meeting.

3.5.8.2. Will include Case Staffing SF600s, documented by the NPSP case manager in each individual family's NPSP record in the FAPNet NPSP automated system. **(T-1).**

3.6. Medical Electronic Health Record (EHR) Review. If review of the EHR or interview with a NPSP client reveals the client is currently receiving services in ADAPT or the Mental Health Clinic (MHC), the NPSP provider will discuss with the client the need to consult with other provider(s) and make contact with them for the purpose of continuity of care. **(T-1).** All open NPSP cases for clients who are also being seen by another MH provider (in ADAPT or the MHC) will be staffed at the Multidisciplinary Clinical Case Conference. **(T-1).** The NPSP provider will protect the confidentiality of other family members during Multidisciplinary Clinical Case Conference discussions. **(T-1).**

3.7. High Need Family Home Visitation. All families assessed as High Need will be offered intensive home visitation services by the FAN/FATM/FAIS. **(T-0).**

3.7.1. Home visits will be conducted at least twice monthly by the FAN/FATM/FAIS. **(T-0).**

3.7.2. Home visitation services will include an Initial Family Assessment (completed within 60 days of High Need Enrollment home visit by the FAN/FATM/FAIS providing services to the family). **(T-1).**

3.7.3. Home visitation services will include a Family Service Plan (completed within 60 days of High Need Enrollment home visit by the FAN/FATM/FAIS providing services to the family). **(T-1).**

3.7.4. The NPSP home visitor will provide initial and ongoing assessment regarding the presence and balance of child and partner maltreatment risk and protective factors, and abuse dynamics within the family. **(T-0).**

3.7.5. The NPSP home visitor will make referrals, as appropriate, for community services. **(T-0).**

3.7.6. Home visitation services will include provision of prevention education by the FAN/FATM/FAIS to all clients enrolled in the program in the following areas: SBS/AHT and SBS/AHT prevention, sudden unexpected infant death, and safe sleeping environments for newborns, infants and young children. **(T-1).** The education will be provided to both parents when possible. **(T-1).**

3.7.6.1. SBS/AHT and SBS/AHT prevention education will be provided by the FAN/FATM/FAIS as follows: At least prenatally, as soon as possible following birth, when infant is 2 months old, and 4 months old. **(T-1).** For parents who enter the program

with children older than 4 months, SBS/AHT education will be provided a by the FAN/FATM/FAIS at least twice: initially upon program entry and a reinforcement. **(T-1).** SBS/AHT education will be provided by the FAN/FATM/FAIS more frequently than noted above, if clinically indicated. **(T-1).**

3.7.6.2. Education on Sudden Unexpected Infant Death and safe sleeping environments for newborns, infants, and young children will be provided by the FAN/FATM/FAIS at least prenatally, as soon after birth as possible and periodically as clinically indicated. **(T-1).**

3.7.7. All High Need NPSP families receiving home visits will be asked to complete assessment measures to assess and evaluate clinical interventions (mandatory assessments: FNS, Ages and Stages Questionnaires), and additional measures will be used when needs are identified on the FNS or via clinical assessment. **(T-1).** Significant scores on measurement tools will be addressed by the administering clinician via discussion with the client(s), consultation with the FAP team or other medical providers involved in the client's care, adjustment of the Family Service Plan, and/or referrals for additional services. **(T-1).**

3.8. High Need Enrolled New Parent Support Program Case Closure. Cases are closed when one or more of the following occur:

3.8.1. Participant(s) have met agreed upon Family Service Plan goals.

3.8.2. Youngest child in the family reaches their 3rd birthday.

3.8.3. Participant(s) are no longer eligible for military medical care.

3.8.4. Participant(s) decline further services.

3.8.5. Participant(s) Permanent Change of Station (PCS) to another installation.

3.8.6. NPSP staff is unable to contact participant(s) after multiple attempts.

3.8.7. No face-to-face contact with the participant(s) has occurred in more than 60 days.

3.8.8. Participant(s) are involved in a "Met Criteria" maltreatment case. If a maltreatment allegation is received while a family is receiving NPSP services, the NPSP record will remain open until a determination is made by the CRB, and the NPSP case will be closed by the NPSP case manager if the incident "Meets Criteria." **(T-1).** If the incident "Does Not Meet Criteria," NPSP services may continue.

3.9. Installations Without an Assigned Family Advocacy Nurse Position. The NPSP team consists of the FAO, FAN, FATM, FAIS, FAOM (where still assigned), FAPA and/or MH Technician, where available. At some small locations, less than a full FAP team is authorized. If a FAN position is not assigned to the FAP, full implementation of the NPSP Model is not required; NPSP target population needs will be addressed by existing FAP services, or referrals off base to receive services. **(T-1).**

3.10. New Parent Support Program Documentation. NPSP services will be documented by Family Advocacy Program staff in the FAPNet NPSP automated documentation system in a manner that ensures continuity and quality of care and facilitates compliance with DoD metric outcome reporting requirements. **(T-0).**

3.10.1. The quality of NPSP documentation will be sufficient to allow NPSP staff to evaluate the range, depth, and outcomes of NPSP intervention services; provide services to NPSP participants that are based on specific client assessment, data collection and integration of the assessment data into the Family Service Plan; and facilitate continuity of care for participating families. **(T-1).**

3.10.2. Documentation of NPSP services for High Need Enrolled families by the FAP staff will include ongoing assessments, family progress toward intervention goals, and effectiveness of interventions. **(T-0).**

3.10.3. A NPSP record will be established by FAP staff for each eligible adult receiving home visits. **(T-1).**

3.10.4. The NPSP record for High Need Enrolled NPSP clients includes, at a minimum:

3.10.4.1. Privacy Act (DD Form 2005) and FAP Informed Consent Prevention (AF Form 4402), signed by each eligible adult receiving home visits.

3.10.4.2. NPSP Family Information Form (AF Form 4403), How Can We Help Form - Mother (AF Form 4401), How Can We Help Form - Father (AF Form 4400) and assessment instruments administered.

3.10.4.3. Automated NPSP Initial Assessment Form, Case Staffing Form and Family Service Plan.

3.10.4.4. Summary of prevention and intervention services documented on a SF600, completed by the FAP staff member providing services for each home visit or contact with family members. Documentation will include any significant change in clinical assessment for the Family Service Plan. **(T-1).**

3.10.4.5. Discharge summary.

3.10.4.6. Other relevant significant documentation.

3.10.5. NPSP interventions will not be documented in participant's medical EHR. **(T-1).** The following exceptions apply:

3.10.5.1. NPSP staff will follow specific MTF policies and guidelines for referring significant clinical observations to the appropriate service provider for medical treatment, and for communicating relevant information to referring MTF providers. **(T-1).** Significant clinical observations will be communicated by the FAP team member providing services through direct contact to the client's primary care manager as soon as feasible based upon level of risk assessed, and such observations and communications will be documented by the FAP team member providing services via the medical EHR. **(T-1).**

3.10.5.1.1. Significant clinical observations include indicators of possible physical or psychological conditions requiring medical assessment, treatment, or follow-up, and/or high risk for harm indicators, to include Suicidal Ideation or Homicidal Ideation.

3.10.5.1.2. NPSP staff will also document actions taken to refer or communicate significant clinical observations to the appropriate service provider in the NPSP record. **(T-1).**

3.10.5.2. NPSP services for active component members on Sensitive Duty Program status will be recorded by the FAP team member providing services IAW DoDM5210.42_AFMAN 13-501, AFI 31-117, *Arming and Use of Force by Air Force Personnel* and MTF guidance (this applies only to the active component member). **(T-1).**

3.10.6. If a NPSP client requests a restricted report of domestic abuse, or if a client with a restricted report of domestic abuse is eligible for NPSP services (expectant, and/or with a child under three years of age) and amenable to receiving NPSP services, two records will be opened for the client in the FAP office. **(T-1).**

3.10.6.1. The NPSP record will be maintained by the NPSP case manager until a CRB determination of "Met Criteria" is made, or the NPSP record closes for another reason. **(T-1).**

3.10.6.2. A FAP provider will establish a restricted report maltreatment record upon the adult victim's request when the client is determined to be eligible for services under a restricted report. **(T-0).** See **Chapter 6** regarding restricted reporting maltreatment cases.

3.10.6.3. The NPSP record and the maltreatment record will each annotate the existence of the other record, and the case will be staffed by both the NPSP case manager and the maltreatment case manager at least monthly. **(T-1).** If the client was receiving NPSP services prior to the restricted report request, the first staffing will occur at the NPSP Case Staffing, where the request will be discussed by the FAP team. **(T-1).** If a restricted report is in place prior to NPSP services, the initial staffing will occur at the CCS, and the case will then be staffed a by the FAP team at the CCS every month. **(T-1).** Documentation of the monthly staffing will be placed in both records by the FAP provider and the FAN. **(T-1).**

3.10.6.4. The safety of the home environment for home visitors will be regularly assessed, and if safety cannot be reasonably assured, office visits will be provided. **(T-1).**

3.10.7. NPSP records will be maintained under a double lock system for 2 years after case closure and then shredded. **(T-1).**

3.10.8. Closed NPSP records will only be transferred by FAP staff to another FAP upon receipt of a written request that includes a release of information consent from each participating adult family member. **(T-1).**

3.10.9. If a maltreatment allegation occurs while a family is receiving NPSP services, the NPSP record will remain open until a determination is made by the CRB. **(T-1).**

3.10.9.1. If the FAN is the NPSP case manager and there is an allegation of maltreatment, the FAN will use a SF600 note in FAPNet NPSP to document that a maltreatment allegation has been made, and specifics related to the allegations are available in FASOR, and continue to document client contacts in FAPNet NPSP. **(T-1).**

3.10.9.2. If the FATM/FAIS is the NPSP case manager, and there is an allegation of maltreatment, the FATM/FAIS will use a SF600 note in FAPNet NPSP to document that a maltreatment allegation has been made and specifics relating to the allegations are available in FASOR. **(T-1).** Further contacts solely for the purposes of NPSP will continue to be documented by the FATM/FAIS in FAPNet NPSP prior to CRB determination. **(T-1).**

3.10.9.3. The NPSP case will be closed by the NPSP case manager if the maltreatment incident "Meets Criteria." **(T-1).** If the maltreatment incident "Does Not Meet Criteria," NPSP services may continue with documentation in the NPSP record.

3.11. New Parent Support Program Peer Review. A review process will be established by the FAO and FAP clinical staff to ensure quality of clinical services and documentation in the NPSP record, IAW AFI 44-119, *Medical Quality Operations*. **(T-1).**

3.11.1. The FAO and FAN will consult with the MTF Chief Nurse regarding standards of nursing practice, FAN/NPSP integration into the MTF, and establishment of a process to assess the quality of clinical nursing intervention and documentation within NPSP. **(T-1).** FAN peer review is facilitated within the FAPNet system. The FAPNet FAN peer review checklist will be used by FANs conducting peer review. **(T-1).**

3.11.2. Social workers engaged in NPSP clinical activities will also be subject to standardized NPSP peer review. **(T-1).**

3.11.3. NPSP records will be maintained by FAP staff IAW DoD guidance. **(T-0).**

3.12. New Parent Support Program Staff Training. The Air Force NPSP Director and AF FAP Chief will ensure DoD personnel and contractors in the NPSP receive required training. **(T-0).** Training includes:

3.12.1. Identifying and reporting suspected child maltreatment and domestic abuse.

3.12.2. Shaken Baby Syndrome/Abusive Head Trauma.

3.12.3. Sudden Unexpected Infant Death.

3.12.4. Safe sleeping environments.

3.12.5. Postpartum depression and other mental health issues impacting maternal child health.

3.12.6. Promoting appropriate parenting skills and disciplinary techniques and parent-child communication skills.

3.12.7. Strategies to engage and support the active component member's parenting role, especially during separations due to deployment and other military operations.

3.12.8. Methods for screening for, assessing and addressing protective and risk factors associated with child abuse and neglect using a strengths-based family centered developmental approach.

3.12.9. The role of attachment in the social emotional development of children and strategies for enhancing bonding and attachment.

3.12.10. Assessing and strengthening adaptation to parenthood.

3.12.11. Assessing and strengthening parental capacity for problem-solving, building and sustaining trusting relationships, and seeking help when necessary.

3.12.12. Facilitating informal and formal community networks to build positive relationships and reduce social isolation.

3.12.13. Utilizing community-based services and formal and informal community networks to provide concrete support for families who may be in crisis.

3.12.14. Assessing developmental milestones and referral procedures for indicators of special needs or developmental delays.

3.13. Team Roles in New Parent Support Program.

3.13.1. FAO: Team leader and supervisor; ensures NPSP implementation IAW DoD and AF instruction and guidance. May provide direct NPSP clinical intervention or support as needed.

3.13.2. FAN: Manages installation NPSP, to include establishment and maintenance of effective screening processes and engagement of families at risk for maltreatment in home visitation services.

3.13.2.1. Provides home-based nursing intervention services including education, support and anticipatory guidance re: growth and development, nutrition, parenting, attachment and bonding, individual and family health related issues, family violence dynamics, problem solving, family communication skills and bereavement.

3.13.2.2. FAN Workload Priorities.

3.13.2.2.1. Home visits to NPSP High Need clients.

3.13.2.2.2. Home visits and other contacts with NPSP Low Need clients.

3.13.2.2.3. Nursing intervention support to FAP maltreatment clients who are expectant and/or have children birth to three years of age.

3.13.2.2.4. Teaching classes or facilitating groups is not a FAN workload priority but may be considered if time allows.

3.13.3. FAIS: Provides social work support to NPSP clients as requested or as directed by the FAO.

3.13.3.1. Utilizes home visitation as the key NPSP service modality. Provides strengths-based clinical social work services to NPSP clients, geared toward prevention of family maltreatment. Interventions include individual, couple and family counseling to address family needs including: relationship concerns, communication concerns, single parenting issues, behavior management, anger management, stress management, anxiety reduction, alleviating depression, conflict resolution.

3.13.3.2. See **Chapter 4** for FAIS secondary prevention priorities. Training and support to NPSP are priority services delivered by the FAIS.

3.13.4. FATM: Provides space available social work support to NPSP clients as requested or as directed by the FAO.

3.13.4.1. Utilizes home visitation as the key NPSP service modality. Provides strengths-based clinical social work services to NPSP clients, geared toward prevention of family maltreatment. Interventions include individual, couple and family counseling to address family needs including: relationship concerns, communication concerns, single parenting issues, behavior management, anger management, stress management, anxiety reduction, alleviating depression, conflict resolution.

3.13.4.2. Delivery of NPSP services will be documented by FAP staff in the FAPNet NPSP module. **(T-1).** FAST services and documentation will not be used if the client is eligible for NPSP services. **(T-1).**

3.13.5. FAPA: Provides administrative and computer support to the NPSP, including: assisting with the screening process, building and maintaining NPSP records, entering NPSP FNSs, inventories and cases, compiling statistical data, preparing Case Staffing agendas, processing NPSP pre- and post- outcome measures.

3.13.5.1. In accordance with their skill level, may provide supportive services to NPSP clients under the oversight of the NPSP case manager.

3.13.5.2. Participates and assists in NPSP briefings and marketing.

3.13.6. DAVA: Provides victim advocacy services, to include education related to the dynamics and effects of domestic violence, to NPSP clients when indicated (e.g., NPSP clients with a restricted report of domestic violence or NPSP clients with a history of domestic violence).

Chapter 4

SECONDARY PREVENTION AND CLIENT ENGAGEMENT

4.1. Secondary Prevention and Client Engagement (SPaCE). Is a strength-based support program that provides secondary prevention services to clients with indicators of risk associated with partner violence, child maltreatment, or PSB-CY. It includes engagement services (e.g., targeted training for leadership and base agencies), support to the NPSP, FAST, and adjunct psychoeducational services and classes.

4.1.1. The FAIS (or FAOM where still assigned) manages SPaCE services for the installation FAP and practices within the parameters and scope of prevention. The FAO will have final approval for secondary prevention services. **(T-1).**

4.1.1.1. The FAIS will be credentialed and privileged within the MTF to conduct FAP clinical services (e.g., marital counseling through NPSP or FAST, or maltreatment intake assessments). **(T-1).**

4.1.1.2. FAOMs, where still assigned, will only participate in those SPaCE services that do not require credentialing and privileging (e.g., leader and agency training or psychoeducational classes). **(T-1).** Those FAOMs who are minimally qualified and actively transitioning to the FAIS position must practice IAW restrictions set by credentialing and privileging guidance (e.g., supervision or peer review requirements). **(T-1).**

4.1.1.3. Where no FAIS or FAOM is assigned, the FAO will prioritize services to meet the SPaCE mission utilizing other installation FAP assets, to include the FAO him or herself. **(T-1).**

4.1.1.3.1. The DAVA, the FAN, or the FATM may support prevention services as time permits and with the FAO's guidance.

4.1.1.3.2. The FAPA may support primary prevention activities at the FAO's direction.

4.1.2. SPaCE program functions and priorities**.**

4.1.2.1. The installation FAP (the FAIS/FAOM where still assigned) is the OPR for Family Violence Education and Prevention Training. This targeted training, intended specifically for installation leadership and agencies, must be accomplished as the top priority of the FAP SPaCE program. **(T-1).**

4.1.2.1.1. FAP will ensure training includes: DoD definitions and the dynamics of domestic abuse and child maltreatment; identification and referral procedures (to include restricted reporting options); an overview of the coordinated community response model and other key military and community resources; maltreatment secondary prevention strategies; and availability of NPSP in promoting protective factors and reducing risk factors associated with child abuse and neglect. **(T-0).** This training will also include a discussion of FAP's purpose (e.g., prevention and clinical intervention of family maltreatment) as contrasted with the purpose of other entities engaged in activities to investigate, hold accountable, and/or discipline (e.g., command, law enforcement, or the legal community.) **(T-1).**

4.1.2.1.2. Senior Leader Training.

4.1.2.1.2.1. The Installation CC, Deputy CC, Group CCs, SQ/CCs, and joint-service equivalent leaders will receive in-person, individualized New Leader Orientation on family maltreatment, protocols, prevention, and victim advocacy, from the FAIS (or FAOM where still assigned) within 90 days of the leader's assumed command date. **(T-0).** A FAP programmatic training will be required annually (once per fiscal year) thereafter. **(T-1).**

4.1.2.1.2.2. Senior Enlisted Advisors, defined for AF purposes as the CCC, CCFs, and joint-service equivalents, will receive in-person, individualized New Leader Orientation on family maltreatment, protocols, prevention, and victim advocacy, from the FAIS (or FAOM where still assigned) within 90 days of assumption of the position. **(T-1).** A FAP programmatic training will be required annually (once per fiscal year) thereafter. **(T-0).**

4.1.2.1.2.3. Training will be made available to tenant unit CCs, CCFs, or other leadership (e.g., Directors) upon request. **(T-1).**

4.1.2.1.2.4. Leadership training metrics are tracked by OSD FAP per fiscal year.

4.1.2.1.2.4.1. Installation FAP staff will work with local leadership to determine and project the most appropriate timing and forum for annual training based on mission, leader availability, and the fiscal year timeframe to ensure training requirements are met. **(T-1).**

4.1.2.1.2.4.2. Given occasional extenuating circumstances that hinder the ability to provide training in a timely manner, the goal is to train at least 80 percent of identified leaders within the prescribed timeframes.

4.1.2.1.2.5. When feasible, initial training for some senior leaders may be combined with other required FAP-specific training (e.g., CRB training referenced in **Chapter 6** of this publication) to minimize mission impact.

4.1.2.1.3. Key Agency Training.

4.1.2.1.3.1. IAW DoDI 6400.06, mandatory annual training (at least once per fiscal year) to key agencies will be provided by the FAIS (or FAOM where still assigned). **(T-0).** Additional training will be available upon agency request and provided as installation FAP resources allow. (T-1).

4.1.2.1.3.2. Key agencies include: SJA, SFS, AFOSI, Airmen and Family Readiness Center personnel, Child Development Center personnel, Family Child Care Providers, Youth Center personnel and volunteers, DoDEA school personnel, Sexual Assault Prevention and Response (SAPR) personnel, and Chaplains.

4.1.2.1.3.2.1. MTF healthcare professional and support staff (as defined by DoD) require training as well. However, FAP prevention staff will coordinate this training with the Defense Health Agency (DHA). **(T-0).**

4.1.2.1.3.2.2. Service members are required to receive training on the FAP. This may be accomplished through participation in installation Newcomers Orientation programs.

4.1.2.1.3.2.3. FAP training will be available to the installation CSC, VPI, CAB and CAT. **(T-1).**

4.1.2.1.4. The DAVA, when available, is encouraged to support the FAIS (or FAOM where still assigned) when training installation leadership and base agencies on domestic abuse and victim advocacy services. System advocacy, education, training, and public awareness are important DAVA functions. However, these functions should not occur at the expense of providing direct services and support to victims.

4.1.2.1.5. FAP staff will document and maintain Family Violence Education and Prevention Training for installation leaders and agencies in the Outreach Prevention Automated Log (OPAL). **(T-1).**

4.1.2.2. Support to the NPSP is the second priority of the FAP SPaCE services.

4.1.2.2.1. Refer to **Chapter 3** for details on the NPSP and the types of support that may be requested.

4.1.2.2.2. Documentation of NPSP support will be placed in the NPSP module of the FAP information system (i.e., FAPNet) by the FAP provider. **(T-1).**

4.1.2.3. Provision of FAST will be the third priority for SPaCE services. **(T-1).**

4.1.2.3.1. Only FAP clinicians appropriately credentialed and privileged within the MTF (e.g., FAIS, FATM or FAO) will provide FAST services. (**T-1).**

4.1.2.3.2. FAST services provide psychosocial assessments and short-term therapy to families at risk for domestic abuse or child maltreatment where there is no open maltreatment record and the family is not eligible for NPSP.

4.1.2.3.3. FAST services to eligible families will include psychosocial assessment of identified clients. **(T-1).**

4.1.2.3.4. Assessment will include risk factors or dynamics indicative of maltreatment. **(T-1).**

4.1.2.3.5. An intervention plan will be developed by the FAP provider in collaboration with the family members receiving FAST services. **(T-1).**

4.1.2.3.6. The FAST program will provide information and referral services, crisis intervention, short-term therapy, and/or supportive interventions focused on agreed upon goals and objectives and evaluation of FAST effectiveness. **(T-1).**

4.1.2.3.7. Clinical consultation for the FAP providers of open FAST cases will occur as needed at the CCS or one-on-one with the FAO. **(T-1).**

4.1.2.3.8. The FAP providers open and close FAST cases upon agreement with the client. There is no requirement to staff a FAST case at the CCS. However, it is strongly recommended that FAST cases remaining open six-months or longer be staffed at the CCS to ensure FAST services are the most appropriate for the particular client.

4.1.2.3.9. FAST services will be provided in the office setting as the primary intervention locale. **(T-1).** However, FAST services may be provided in the client's home in special circumstances and depending on client needs (e.g., provision of in vivo

parent training). The FAP staff will consider safety issues when making home visits and do so with the approval of the FAO. **(T-1).**

4.1.2.3.10. FAST interventions will not be documented in participant's outpatient medical record (i.e., medical EHR). **(T-1).** The following exceptions may apply:

4.1.2.3.11. FAP treatment providers will follow specific MTF policies and guidelines for referring significant clinical observations to the appropriate service provider for medical treatment, and for communicating relevant information to MTF providers. **(T-1).** Significant clinical observations will be communicated through direct contact with the client's primary care manager as soon as feasible based upon level of risk assessed. **(T-1).** FAP providers will document actions taken to refer or communicate significant clinical observations to the appropriate service provider in the medical EHR and FAST records. **(T-1).** See the definition for significant clinical observation in **Attachment 1.**

4.1.2.3.12. Documentation of FAST services (e.g., intake, follow-up sessions, telephone contacts, or administrative notes) will be placed in the FAST module of the FAP information system (i.e., FAPNet) by the FAP provider. **(T-1).**

4.1.2.4. The FAIS (or FAOM where still assigned) is the lead for psychoeducational classes delivered on behalf of the installation FAP. The FAO will assign SPaCE functions as necessary in the absence of a FAIS/FAOM. **(T-1).**

4.1.2.4.1. Psychoeducational classes are not ranked as a priority service of the FAP Prevention Program, as they offer an adjunct to all other services provided by the installation FAP, from prevention to response.

4.1.2.4.2. Each installation FAP must offer the Skills, Strengths, Techniques, and Resources (SSTaR) program. **(T-1).**

4.1.2.4.3. Any other psychoeducation services will be to be delivered using AF FAP-approved evidence-based or evidence-informed programs and measures. **(T-1).**

4.1.2.4.3.1. Prescribed standardized pre and post-tests will be utilized by all prevention program providers in the evaluation of services outcomes. **(T-1).**

4.1.2.4.3.2. The FAIS (or FAOM where still assigned) will work with the FAO to determine which psychoeducational classes will be offered at a given location. **(T-1).** Such decisions will be based on such factors as client need at a particular installation and FAIS/FAOM capacity versus mission needs. **(T-1).**

4.1.2.4.4. Documentation of client participation in psychoeducational services will be entered and maintained in OPAL. When participants are referred by another clinician (e.g., Maltreatment Intervention Services), it will be the responsibility of the referring provider to document the referral and follow-up in the clinical notes. **(T-1).**

4.1.2.5. In the absence of an assigned FAIS/FAOM, the FAO will assign SPaCE functions as necessary. **(T-1).**

4.1.3. Secondary prevention services focus on early intervention to deter or mitigate risk. All SPaCE program interventions, including consultation and counseling, training, and skill development for individuals, couples, and identified groups, will be provided using evidence-

informed programs and approaches for supporting protective factors as determined by AF FAP. **(T-0).**

4.1.4. The FAIS (or FAOM where still assigned) will support self-referral, agency, squadron, and provider referral of active component and family member beneficiaries with risk factors for domestic abuse or child maltreatment. **(T-1).** Clients should have no open met criteria maltreatment case, except those specifically referred by their treatment manager or intervention specialist for adjunct psychoeducation.

4.1.4.1. CCs will support active component members with indicators of risk through early identification and intervention and by recommending active component member participation in SPaCE services. **(T-1).** The rules of confidentiality will be observed in concert with the FAP protocol as appropriate. **(T-1).**

4.1.4.2. Any FAP staff member may initiate tracking, initial planning, and referral of a client presenting for SPaCE services. FAP staff will use the Information and Referral module within FAPNet to document the initial contact and plan. **(T-1).** This initial contact is not intended to be a clinical encounter.

4.1.4.3. Adult clients reported for alleged domestic abuse or child maltreatment will be referred to the SSTaR program, or its equivalent program, after the intake assessment and before CRB determinations. **(T-1).** After completion of SSTaR, the client may be referred to components of SPaCE services (e.g., psychoeducational classes) to augment treatment, but not in lieu of treatment. Clients that recidivate within the first year after attending SSTaR, may be re-referred to SSTaR, or its equivalent, for additional support toward readiness for change. FAP clinical and secondary prevention staff will screen and coordinate these maltreatment clients to identify levels of hostility, levels of risk, and for the appropriateness and safety of the clients for SPaCE services. **(T-1).** SSTaR attendance will be tracked in OPAL and reported to referring providers. **(T-1).**

4.1.5. During the course of any SPaCE services, any indication of domestic abuse, child maltreatment, or imminent danger to self or others will be reported and referred by the FAIS (or FAOM where still assigned) to the FAO, and other FAP team members involved in the client family's care. **(T-1).**

4.1.6. The Prevention Planning and Management Council (PPMC). The PPMC is the forum for an installation's FAP to plan for prevention and engagement activities, share updates and allow cross-talk regarding SPaCE services, and prioritize interventions (e.g., psychoeducation) most appropriate to the needs of the particular population served.

4.1.6.1. The FAO will chair the PPMC, ensure it meets at least quarterly, and ensure all available FAP staff attend. **(T-1).**

4.1.6.2. The FAIS (or FAOM where still assigned) will lead the PPMC discussion and track and document action items as needed. **(T-1).**

4.1.6.3. At the request of the FAIS (or FAOM where still assigned) and the discretion of the FAO, other installation personnel may be invited to attend the PPMC (e.g., Chaplain, VPI, CCF representative).

4.1.6.4. The PPMC may be held as a stand-alone meeting, or it may be combined with another standing FAP meeting (e.g., recurring FAP staff meeting or CCS). If the PPMC is

held in conjunction with a meeting that discusses personally identifiable information or protected health information, the PPMC portion should be conducted first to allow for the departure of invited guests or others without authorization or need-to-know.

4.2. Family Advocacy Program Secondary Prevention and Client Engagement Services Integration with Installation Functions. The FAP collaborates and coordinates with the CAT on resilience, violence prevention, and other related initiatives.

4.2.1. The FAIS (or FAOM where still assigned) will serve as the official FAP representative to the CAT. **(T-1).** This includes supporting the VPI and CSC with subject matter expertise and consultation and sharing pertinent FAP data and metrics to analyze for installation trends and implications. Shared data will not contain protected health information or unit level information that can be reasonably used to identify individuals. **(T-1).** FAP data requests or reports will be released only after review and expressed approval of the FAO. **(T-1).**

4.2.2. AF FAP leadership will support installation SPaCE personnel with training. **(T-1).** Such training topics include: coaching fundamentals; Motivational Interviewing; adult learning; associated risk and protective factors; social work intervention services for child maltreatment and partner violence prevention; Shaken Baby Syndrome/Abusive Head Trauma; couple relationship enhancement; parenting skills; self-regulation with emphasis on anger management; and prevention science targeting optimal family functioning.

Chapter 5

DOMESTIC ABUSE VICTIM ADVOCATE SERVICES

5.1. Family Advocacy Program Domestic Abuse Victim Advocate (DAVA). The FAP DAVA provides 24-hour telephone and face-to-face non-clinical crisis response and support to adult victims of domestic abuse and intimate partner sexual assault.

5.1.1. All adult victims referred to the FAP will have access to immediate and ongoing FAP DAVA support services, including crisis intervention, safety planning, court or medical accompaniment, and information and referrals. **(T-0).** Where no DAVA is assigned or available within the installation FAP, victims will be referred to DAVA services within the local, civilian community. **(T-1).**

5.1.2. DAVAs work closely with the FAP providers to maintain effective safety plans and empower domestic abuse victims. At the discretion of the FAO or the alternate FAO, the DAVA may also provide emotional support and information and referral services to the non-offending caregiver in a child maltreatment or youth sexual assault case, as well as to non-offending parents of impacted child(ren) in a PSB-CY referral.

5.1.3. If the FAP DAVA is notified of a non-intimate partner sexual assault, the DAVA will immediately notify the installation Sexual Assault Prevention and Response (SAPR) program. **(T-1).** In the event a DAVA inadvertently responds to a non-intimate partner sexual assault victim:

5.1.3.1. The DAVA will immediately notify the installation Sexual Assault Response Coordinator (SARC) and provide initial support until a warm hand-off to the SAPR program can be achieved, **(T-1).**

5.1.3.2. The DAVA will not discuss reporting options or complete any FAP documentation with the victim, referring questions about reporting options to the responding SARC, Sexual Assault Prevention and Response Victim Advocate (SAPR VA), or Volunteer Victim Advocate. **(T-1).**

5.2. Domestic Abuse Victim Advocate Initial Crisis Response. The DAVA is a vital member of the coordinated community response team and is considered a crisis first responder when FAP receives an initial allegation of adult partner maltreatment.

5.2.1. The DAVA will ensure the availability of 24-hour DAVA services either through in-person or telephonic contact. **(T-0).** When only one DAVA is assigned to an installation and is ill, on leave, or TDY, the FAO or Mental Health on-call provider is the best suited to cover the DAVA after-hours hotline. The minimum response required for an FAO or MH on-call provider in lieu of a DAVA is a telephonic response to conduct a risk assessment, safety plan, provide information and resources, and get the victim in touch with FAP the next duty day.

5.2.2. Upon notification of a domestic abuse incident, the DAVA will make initial contact with the adult victim as soon as possible. **(T-1).**

5.2.3. During initial contact, the DAVA will:

5.2.3.1. Advise each victim that services provided by the DAVA are voluntary. **(T-0).** If at any time during the initial contact the victim declines services or is unwilling to divulge

identifying information, the victim will be referred to a local or national domestic violence resource for confidential ongoing advocacy services. **(T-0).**

5.2.3.2. Advise each victim that DAVAs are mandated reporters IAW applicable state, federal, and military reporting requirements (i.e., domestic violence, child abuse, and duty to warn situations). **(T-0).** Communications between a DAVA and the victim of a sexual or violent offense are covered under Military Rule of Evidence (MRE) 514.

5.2.3.3. Inform the victim of both restricted and unrestricted reporting options. **(T-0).** If the victim is interested in requesting a restricted report with FAP, the DAVA will secure the victim's request by having them sign the Domestic Abuse Victim Reporting Option Statement, DD Form 2967. **(T-0).** The form is then given to the FAO and FAP case manager for inclusion in the maltreatment restricted reporting record. The victim does not technically have a restricted report of maltreatment until the FAO or FAP case manager has received the signed Victim Reporting Option Statement, assessed the victim, had the victim complete the FAP paperwork and opened the FAP Restricted Reporting Maltreatment Record.

5.2.3.4. Ensure each victim is aware of the DAVA's requirement to refer all cases to FAP to determine eligibility for clinical maltreatment intervention services. **(T-0).**

5.2.4. The DAVA will ascertain the victim's immediate needs and assess safety by completing the DAVA Risk of Imminent Harm Assessment Form, and will immediately notify the appropriate authorities and the FAO or alternate FAO when imminent danger or life-threatening harm is identified. **(T-0).**

5.2.5. The DAVA shall offer victim information regarding identified needs (e.g., emergency shelter, housing, childcare, legal services, clinical resources, medical services, transitional compensation, etc.) and ensure all victims of sexually related offenses or their non-offending caregiver receive information on Special Victims' Counsel (SVC) services. **(T-0).**

5.2.6. The DAVA will develop an initial written safety plan based on the victim's immediate needs and identified risk factors. **(T-0).** The initial safety plan must be retained in the DAVA client file and a copy provided to the FAP provider to include in the FAP maltreatment record. **(T-1).** The DAVA must provide all victims with a copy of the safety plan. (T-0) The DAVA will instruct the victim to keep this document in a safe and secure location where the abuser will not have access to it. **(T-1).** The AF FAP Individual Safety Plan and Child(ren) Safety Plan can be used as a template when developing a safety plan with the victim. The DAVA will only develop a child safety plan in the presence of the parent receiving DAVA services. **(T-1).** The safety plan should be tailored to the victim's identified needs and risk factors and should include practical and actionable steps that address items such as:

5.2.6.1. Safety if further abuse or violence occurs.

5.2.6.2. Safety if preparing to leave or if victim already left.

5.2.6.3. Safety with a potential protection order.

5.2.6.4. Safety during court or legal appointments.

5.2.6.5. Safety on the job and in public.

5.2.6.6. Safety and technology social media.

5.2.6.7. Safety and drug or alcohol use.

5.2.6.8. Financial safety.

5.2.6.9. Emotional safety.

5.2.6.10. Safety for children involved.

5.2.6.11. Identification of support systems and emergency housing options.

5.2.6.12. List of emergency contacts (i.e., 911, DAVA hotline, local and national DV hotlines).

5.2.7. After initial contact, the DAVA must provide the FAO with victim's contact information, basic information regarding the crisis incident that initiated the referral (i.e., date of incident, type of incident, military status and unit the alleged victim is associated with, and the referral source), and any safety concerns identified. **(T-1).** If needed, DAVAs can provide a copy of the "DAVA Initial Contact Form" to FAP which includes basic information collected about the victim and the reported incident. If the DAVA fills out AF Form 4404, FAP Referral Form, the DAVA will not collect SSNs for either victim or offender or any protected health information/personally identifiable information on the alleged offender. **(T-1).**

5.2.8. Referrals involving a child maltreatment, child sexual assault or PSB-CY allegation must be reviewed by a FAO or FAP provider to determine the best timeframe for when the DAVA should contact the non-offending protective parent or the parent of the impacted child involved in a PSB-CY case to assess safety and offer support. **(T-1).** If the DAVA receives a referral after normal duty hours, the DAVA will collect as much information as possible and make an immediate notification to the FAO or the MH on-call provider to develop an appropriate plan of action for responding. **(T-1).**

5.2.9. If a child sexual assault victim is at the hospital or law enforcement agency, the DAVA can physically respond on behalf of FAP. However, the DAVA will not provide direct services to the child victim (i.e., safety plan directly with the child, accompany the child to get a SAFE exam, etc.). **(T-1).** The DAVA is there to provide support to the non-offending parent and act as a consultant to the first responders and other agencies to ensure the child is connected to appropriate resources.

5.3. Ongoing Domestic Abuse Victim Advocate Support Services. The DAVA will:

5.3.1. With the adult victim’s consent, collaborate with the FAP Provider to ensure law enforcement and command are aware of the victim’s safety plan. **(T-0).**

5.3.2. Maintain follow-up contact with the victim as appropriate. **(T-0).**

5.3.3. Develop an initial safety plan with the victim, if one has not already been completed, and review it during every contact with the victim. **(T-0).**

5.3.4. Support the victim in decision making by providing relevant information and discussing available options. **(T-0).**

5.3.5. Assist the victim with prioritizing actions, establishing short- and long-term goals, and advocating on her or his own behalf. **(T-0).**

5.3.6. Provide the victim with comprehensive information and referrals on relevant local military and civilian resources and assist the victim in gaining access to requested services. **(T-0).**

5.3.7. Assist the victim in contacting appropriate military and civilian legal offices for personal legal advice and assistance specific to the victim's circumstances or case, including the filing for protection orders. **(T-0).** DAVAs do not provide legal advice.

5.3.8. In collaboration with the FAO and FAP Provider, ensure command and SF are made aware of every civilian and military protective order related to domestic violence. **(T-0).**

5.3.9. Refer victims eligible for transitional compensation to the VWAP for information and assistance in processing transitional compensation applications. **(T-0).**

5.3.10. Advise the victim of the impact of domestic abuse on children and offer referrals for assessments of the physical and mental health of involved children. **(T-0).**

5.3.11. Accompany the victim to medical appointments and civilian and military court proceedings, as appropriate and when requested by the victim. **(T-0).**

5.3.12. Inform the victim of basic information and eligibility requirements regarding reassignment or relocation options. **(T-0).**

5.3.13. Attend and participate in those portions of FAP meetings in which safety and supportive services for the domestic abuse victim, and for any children living in the victim's home, are discussed. **(T-0).** The DAVA does not attend those portions of the FAP meetings in which clinical assessment and treatment for the alleged abuser are discussed.

5.4. Domestic Abuse Victim Advocate Documentation. The DAVA will establish an administrative client file for any client receiving initial and ongoing DAVA services. **(T-1).** The primary purpose of the DAVA contact file is to maintain client's name, contact information, and a log of contacts and services provided by the DAVA. The DAVA file will contain extremely limited information so as not to be vulnerable to subpoena by the courts. **(T-1).**

5.4.1. At a minimum, the DAVA file must contain the following: initial contact form indicating referral source, victim contact information, and type of incident; Risk of Imminent Harm Assessment Form signed by DAVA and FAO; contact log to track date, time, and type of contact and service provided by the DAVA; safety plan (initial and revised version); Consent to Release Information Form (if applicable); and Case Closure Form signed by DAVA and FAO (if applicable). **(T-1).**

5.4.2. The DAVA file will be maintained under a double lock system. **(T-0).**

5.4.3. The DAVA will ensure the FAO has access to all DAVA files when needed and to review periodically. **(T-1).**

5.4.4. The DAVA will shred the DAVA file two years from the DAVA's last contact with the victim. **(T-1).**

5.4.5. The DAVA will submit de-identifying data on a monthly basis via FAPNet with information regarding the total referrals received, total number of victims and non-offending caregivers served, and the total number of direct services provided. **(T-1).**

5.5. Domestic Abuse Victim Advocate Systems Advocacy Support. As a systems advocate, the DAVA will support the FAIS (or FAOM where still assigned) in promoting a coordinated community response for the prevention of domestic abuse and for intervention when domestic abuse occurs. **(T-0).** However, these functions should not occur at the expense of providing direct service and support to victims. The DAVA will also:

5.5.1. Continually evaluate the quality of the installation's coordinated community responses and collaborate with installation agencies to improve the system response to victims. **(T-0).**

5.5.2. Advocate for victim services that involve the victim in the decision-making process. **(T-0).**

5.5.3. Collaborate with SFS, AFOSI, and civilian law enforcement and criminal investigative units in the establishment of protocols and procedures to ensure: (1) notification of the DAVA when such units are notified of a domestic abuse incident; (2) collaboration on safety planning and safety measures; and (3) ongoing training of military and civilian law enforcement personnel on the DAVA's role. **(T-0).**

5.5.4. Collaborate with the MTF to establish notification protocols for all incidents of suspected or reported domestic abuse, and the provision of ongoing training of MTF personnel on the DAVA role. **(T-0).**

5.5.5. With direction and approval from the FAO, establish liaisons with civilian victim resources. **(T-0).**

5.5.6. Actively participate as a member of the installation FAC in the development, implementation, and evaluation of installation domestic abuse policies and procedures, including MOUs, victim services contracts, and Inter-Service Support Agreements. **(T-0).**

5.5.7. Actively participate as a member of the VWAP council. **(T-0).**

5.5.8. Collaborate with the SARC and SAPR VA to establish protocols and procedures for the appropriate notification of sexual assault cases IAW AFI 90-6001 and this instruction. **(T-1).**

5.6. Family Advocacy Program Domestic Abuse Victim Advocate Prevention Support. With direction from the FAO, the DAVA will support the FAIS (or FAOM where still assigned) with education, training, and public awareness activities IAW **Chapter 4** of this AFI. **(T-1).** However, these functions should not occur at the expense of providing direct service and support to victims. In support of FAP SPaCE services referenced in **Chapter 4**, the DAVA will:

5.6.1. Assist the FAIS (or FAOM where still assigned) in educating command and pertinent installation personnel on domestic abuse and victim advocacy services. **(T-0).**

5.6.2. Assist the FAIS (or FAOM where still assigned) in training military first responders, including law enforcement and MTF personnel, command personnel, and chaplains. **(T-0).**

5.6.3. Assist the FAIS (or FAOM where still assigned) in training civilian service providers about military victim issues, resources, and services. **(T-0).**

5.6.4. Participate in private sector domestic abuse councils as directed and authorized by the FAO. **(T-0).**

Chapter 6

MALTREATMENT INTERVENTION SERVICES

6.1. Operational Overview.

6.1.1. The FAP clinical providers offer comprehensive family assessments, safety and intervention planning, and case management to all eligible beneficiaries where there is an alleged incident of domestic abuse or child maltreatment.

6.1.2. The FAP providers recommend and offer clinical treatment to eligible beneficiaries where a referral meets standardized criteria for maltreatment.

6.1.3. The FAP providers coordinate with command, law enforcement agencies, victim advocates, local child protective services, and other helping agencies to deter recurrence of domestic abuse or child maltreatment in families served.

6.1.4. The FAP Providers will inform child sexual assault or other sexually related offense victims and non-offending parents of the availability of a SVC as soon as the member or dependent seeks assistance. **(T-1).**

6.1.5. The FAP providers collaborate with other medical and MH professionals, community service providers, and the following FAP management teams to provide optimal care and service coordination to their clients.

6.2. Family Advocacy Program Multidisciplinary Incident Management Teams.

6.2.1. CRB. The CRB is the Incident Determination Committee (IDC) for the FAP, and consists of a multidisciplinary team. The CRB will make administrative determinations for suspected domestic abuse and child maltreatment meeting DoD definitions, determinations which require entry into the AF Central Registry database. **(T-0).** These decisions are known as ISDs.

6.2.1.1. The Installation Deputy CC will serve as the CRB Chair and the Mission Support Group (MSG) CC as the alternate. **(T-1).** At installations that do not have a MSG CC, the Wing CC will appoint an A Team Director as the alternate CRB Chairperson.

6.2.1.2. The chairmanship of the CRB will not be delegated to lower than group level CC. **(T-0).** The MTF Service Commander shall be excluded from chairing CRB due to their role as ISDR authority. **(T-1).**

6.2.1.3. The FAC will approve the other members and alternates of the CRB, who are submitted by their CC and appointed in writing by the CRB Chair. **(T-0).** In addition to the CRB Chair, the other members will include: a SJA representative, CCC, a SFS representative, the FAO, and an AFOSI representative. **(T-0).** The Chair, SJA representative, CCC, SFS representative, and the FAO will be core voting members. The AFOSI representative is a non-voting member, attending when investigative information is available that can inform the determination process. SQ/CCs (or equivalents) will be voting members for incidents involving members of their squadron. **(T-0).** Active component members SQ/CCs (or equivalents), or his or her alternate, will only attend the CRB for his or her squadron's incidents (i.e., the alleged offender, victim, or sponsor is from his or her squadron). **(T-0).** Alternates may be a section CC or a CCF. The CCF is

also welcome as a non-voting member when accompanying the SQ/CC (or equivalent) to the CRB. If both victim and alleged offender are military members, and in different squadrons, both SQ/CCs (or equivalents) will be invited to the CRB, and each squadron gets a vote. **(T-0).** CRB training certificates, obtained upon completion of CRB web training, will serve as verification of training and, for squadron representatives, verification of their appointment. **(T-1).**

6.2.1.4. If additional information is required, the CRB Chair may allow a guest to attend. Guests who have information pertaining to a specific incident may be invited to share their information and participate in the discussion of that incident but they do not vote (e.g., Child Protective Services, Civilian Law Enforcement, or victim's primary care provider or primary case manager). The FAP treatment managers and intervention specialists may observe the CRB during orientation to their job but will not attend the CRB to participate in case discussions. **(T-1).** Clients, family members, and attorneys representing alleged offenders are not allowed to attend the CRB or the ISDR. **(T-0).** Attendance is limited to individuals with an authorized "need to know." Individuals who present information to the CRB shall be excused after they present any relevant information and prior to any discussion by the CRB. **(T-0).**

6.2.1.5. A two-thirds quorum of voting members is required for the CRB to convene. **(T-0)** The AFOSI Detachment representative will attend the CRB only when preliminary investigative findings are available on an incident being presented to the CRB. **(T-0)** AFOSI will not be counted in the CRB quorum. **(T-0)** AFOSI representatives must accomplish the initial (and annual) CRB computer-based training prior to attending the CRB. **(T-0).**

6.2.1.6. All core members will accomplish initial and annual CRB training prior to serving on the CRB. **(T-0).** SQ/CCs and/or CCFs will accomplish initial and annual CRB training prior to participating as a voting member. **(T-0).**

6.2.1.6.1. To ensure training standardization and for the convenience of CRB members, the CRB web-based training found in FAPNet is the preferred training curriculum.

6.2.1.6.2. Upon request, and with the consent of the CRB Chairperson, a standardized face-to-face training curriculum can be made available.

6.2.1.6.3. Please refer to **Chapter 4** of this instruction for further information regarding leader training as it relates to CRB.

6.2.1.7. The CRB makes an ISD on each allegation of maltreatment within 60-days of referral, using the incident and victim impact information and the FASOR automated decision tree algorithm.

6.2.1.7.1. The CRB members will only discuss information related and pertinent to maltreatment issues such as the current allegation(s), and the elements each definition requires (e.g., the act and impact information). **(T-0).**

6.2.1.7.2. The CRB will not wait for a case to be adjudicated in order to make a determination. **(T-0).** However, the CRB may need to wait until the FAP assessment

and/or at least the police or AFOSI investigation is complete in order to have those results available.

6.2.1.7.3. Should new information become available after the CRB has made a determination that could potentially change that determination, the FAO has discretion to place the incident back on the CRB agenda. Prior to placing an incident back on the CRB agenda, the FAO should consult with the CRB Chair to take into account the following:

6.2.1.7.3.1. Acquittal in a criminal case will not, on its own, be justification for an ISDR. **(T-1).**

6.2.1.7.3.2. The level of proof for criminal prosecution is beyond reasonable doubt, while the level of proof required for a met criteria CRB determination is preponderance of available information.

6.2.1.8. The FAO will ensure alleged abuser, victim or parent of a victim receives notification of CRB ISDs. **(T-0).** The FAP generates a letter with the CRB determination that is signed by the Chair at the CRB and given to the unit CC to present to the service member. A copy of the letter marked //Original Signed// is mailed to the alleged abuser, victim or parent of a victim by the FAP. Verbal notification of the ISD to the alleged abuser, victim or parent of a victim may suffice if documented in FASOR.

6.2.1.9. Biological or adoptive parents are authorized to receive information on ISDs in which their child is a victim regardless of custodial arrangements. Disclosure will not be permitted to biological or adoptive parents whose parental rights have been legally terminated. **(T-0).**

6.2.1.10. The CRB should be held in the installation Headquarters conference room. If the installation Headquarters conference room is not available, it can be held in a conference room not affiliated with the MTF or FAP office. The CRB will not be held in the MTF or the FAP office. **(T-1).** The CRB will meet at the call of the Chair, normally monthly, unless there are no new referrals requiring determination. **(T-1).** If there are only one or two new referrals, the CRB Chair may defer the CRB meeting to the following month.

6.2.1.11. CRB discussions are confidential. The only information routinely released from CRB proceedings are ISDs per this instruction. CRB members and guests must be directed not to disclose CRB discussions, deliberations or votes. Information from a CRB cannot be disclosed unless such disclosure is determined to be required under HIPAA, the Privacy Act or other valid legal authority. Only the MTF commander can authorize such disclosure, in consultation with legal counsel." **(T-1).**

6.2.1.12. Minimal information will be on the CRB agenda and agendas will be protected as sensitive information. **(T-1).**

6.2.1.12.1. The CRB agenda will include the date and time the incident is to be presented, the incident number, sponsor and victim names, type of victim, squadron and the type of maltreatment. **(T-1).**

6.2.1.12.2. The agenda will not include the rank of the active component member and that information will not be presented to the CRB. **(T-1).**

6.2.1.12.3. Information about each incident is presented verbally by each CRB member; no written summaries of incidents or read-a-heads will be utilized by the CRB. **(T-0).**

6.2.1.12.4. Only evidence observed during the FAP assessment (e.g., injuries) or collected in the course of a criminal investigation will be presented to the CRB. **(T-0).** Pictures or recordings made independently by victims, alleged offenders or other involved parties will only be submitted to the CRB when there is no disagreement between the alleged offender and the victim (or legal parental representative) that the evidence accurately depicts the incident or the impact of the incident. **(T-0).**

6.2.1.12.5. In making a determination, recantation by the victim will not, in and of itself, be used to conclude that maltreatment did not occur. **(T-1).** Members should consider all the evidence in evaluating the credibility of a recantation.

6.2.1.13. The FAO introduces the incident by identifying the type of victim, type of maltreatment alleged, ages and military status of both victim and alleged offender. The unit CC opens the initial incident presentation by sharing what he or she knows about the incident. After all other CRB members have presented any relevant information, the FAO presents information collected in the FAP assessment that is different from or in addition to what has already been presented. Each CRB member will present relevant information on each incident to facilitate the ISD decision. **(T-0).** The discussion will focus on the current incident. **(T-0).** Past history is not presented unless there is an issue of credibility due to diverging accounts of the incident or in the case of emotional maltreatment or neglect where a pattern of acts must be established. CRB members make decisions based on the totality of the available information, and CRB member votes are recorded by a show of hands by voting members.

6.2.1.13.1. CRB members should discuss the criterion and the information presented until each member feels confident about voting on the criterion. In each member's opinion, does the information presented meet the identified criterion? A vote to support the criterion is cast even if the supporting information only allows the CRB member to be 51% sure. Cases are decided on a "preponderance of the available information" criterion, not "beyond a reasonable doubt." Thus, obtaining as much descriptive information as possible is critical to both a fair and a focused discussion of the incident.

6.2.1.13.2. Once all relevant information has been presented, each member will vote "meets criteria" or "does not meet criteria" as to whether the incident meets each criterion for each type of maltreatment. **(T-0).** ISD are made by majority vote of the voting members in attendance. The CRB Chair votes last, and in the case of a tie, the CRB Chair votes twice. **(T-0).** It is recommended that the chair ask CRB members to share with the team their rationale for voting a particular way to minimize any potential confusion prior to casting the tie-breaking vote. Votes are recorded in the automated decision tree. Re-voting on an incident will not occur simply because one or more members do not agree with the determination. **(T-0).** However, if during the voting process there is confusion on one criterion the FAPA can go back one screen to allow a re-vote on that criterion.

6.2.1.14. When a CRB member has a conflict of interest, the CRB member will request permission from the CRB Chair to abstain from voting on that particular case. **(T-0).** If

granted, the CRB member would vote on neither A nor B criteria. When the CRB Chair has a conflict of interest in voting on an incident, it is recommended that the alternate Chair oversee the meeting and vote on that particular incident. This is because the Chair must be available to break a tie.

6.2.1.15. CRB members do not have discretion to disregard the criteria in the maltreatment definitions. Accurate ISDs are critical to assessing trends, preventing future violence, safeguarding children in DoD programs, and budgeting in support of maltreatment prevention and response activities. Voting by CRB members that is inconsistent with the criteria in the decision tree will be addressed immediately by the CRB Chair. **(T-0).** Recurring problems of this nature that are not resolved by the Chair must be reported by the FAO to the Family Advocacy Clinical Director at AF FAP. **(T-1).**

6.2.1.16. Minutes will be generated within 30-days and reflect the CRB ISDs, and signed by the CRB Chair. **(T-0).** The format of minutes is standardized across the AF by the FASOR system and will not be modified. **(T-1).** Minutes will be maintained at the FAP for five years, then shredded. **(T-1).** Minutes will refer to clients by incident number, not by name; and votes will not be printed in minutes. **(T-0).** It is not necessary for the MTF Service Commander or pertinent medical SQ/CC to review or sign CRB minutes. Clients do not have access to minutes.

6.2.1.17. MTF Service Commander is the ISD reviewer and therefore will not serve as an alternate CRB Chair. **(T-0).** The MTF Service Commander will complete the initial web-based CRB training prior to observing an ISDR. **(T-0).**

6.2.1.18. Appropriate authorities (e.g., SQ/CC, CCF, FAO or the FAP Case Manager) will ensure that family members understand the options and requirements for ISDR. **(T-0).**

6.2.1.18.1. An alleged offender or victim may submit an ISDR request to the FAO if at least one of two criteria is met: 1) the CRB determination was made in error because new information that could affect the determination was not available to the CRB at the time of the original determination; or 2) there are concerns about CRB non-compliance with published protocols and requirements (e.g., the automated decision tree). Only one ISDR will be approved per incident number. **(T-1).**

6.2.1.18.2. The ISDR must be submitted in writing within 30 days of notification of the CRB case status determination. **(T-1).** A copy of the CRB ISD letter should be attached to the request.

6.2.1.18.3. A client's refusal to cooperate with the initial FAP assessment (i.e., not provide information that could be relevant to CRB proceedings) will not be used as the sole reason to authorize an ISDR. **(T-1).** The ISDR request must still meet one of the two criteria to grant an ISDR. **(T-1).**

6.2.1.18.4. When the victim is a child, a parent or legally authorized representative, acting on behalf of the child and in the child's best interest, may request an ISDR.

6.2.1.18.5. The FAO and MTF Service Commander will review the request and make their recommendations to the CRB Chair as to whether the request meets criteria for an ISDR. **(T-1).**

6.2.1.18.6. The Chair will decide whether to grant the review and has discretion about whether to review the request if submitted outside 30 days. **(T-1).** The ISDR Process Reviewer will observe the CRB for each ISDR. **(T-1).**

6.2.1.18.7. Neither the ISDR Process Reviewer nor the CRB Chair is subject to interview by the FAP client.

6.2.1.18.8. The client must submit the ISDR request to the FAO at the installation where the original case status determination was made. **(T-1).** A CRB at one installation cannot conduct an ISDR of a case determination made by a CRB at another installation.

6.2.1.18.9. Changes in the ISD as a result of the ISDR will be noted on the AF Form 2486 in the FAP record. **(T-1).** The new determination must be uploaded into the AF Central Registry. **(T-0).**

6.2.1.19. Any CRB member who is an alleged offender of child maltreatment or an alleged offender or victim of partner maltreatment must be removed from serving on the CRB until the allegation either: (1) does not meet criteria; or (2) the met criteria case where the CRB member is the alleged offender, is closed as resolved. **(T-1).**

6.2.1.20. In cases of death due to suspected family maltreatment or suicides that are related to domestic violence or child maltreatment, the CRB is required to review the available information about the alleged maltreatment incident and its impact on the victim(s) and vote on each criterion. In spite of how difficult it is to discuss such tragic outcomes, homicide is the most extreme form of family maltreatment and must be counted as such in the Central Registry database. **(T-0).**

6.2.2. The Clinical Case Staffing (CCS). The CCS is the forum for clinical management of domestic abuse and child maltreatment cases via multidisciplinary review of the current status, plan and recommendation for each new or open domestic abuse or child maltreatment case.

6.2.2.1. The FAO will chair the CCS. **(T-0).** Attendees of the CCS include the FAO and all Family Advocacy Treatment Managers (FATMs), FAIS (or FAOM where still assigned), FANs, and Family Advocacy Program Assistants (FAPAs). These staff members shall be present unless on leave, or TDY. **(T-1).** The DAVA will attend and participate in the CCS IAW **paragraph 5.3.13** of this publication. **(T-1).** A MH Flight provider, ADAPT provider, or other medical providers who may add value to the clinical case discussions may be invited to the CCS at the FAO's discretion. CPS representatives will be invited to participate for child maltreatment incidents. **(T-1).** No less than two privileged providers will be in attendance at each CCS. **(T-1).** At installations where there is an FAO but no FATM or FAIS, a MH provider will attend CCS in order to meet the requirement for two privileged providers. **(T-1).** In the absence of the FAO, the Alternate FAO or a FATM/FAIS will chair the CCS. **(T-1).** Whoever chairs the CCS must sign the CCS notes in the FAP record and the medical EHR. **(T-0).**

6.2.2.2. Details of client treatment plans, progress, coordination of care with other MTF services, and other HIPAA-protected information are discussed in CCS, not in CRB. Treatment recommendations of the CCS will be conveyed to each adult client. **(T-1).** Care must be taken to protect individuals' personal health information. Therefore, treatment recommendations for the alleged offender cannot be shared with the partner and vice versa,

without client consent. The case manager will document in the FAP record how and when the recommendations were given to the client(s). **(T-1).** The case manager will follow up with the active component member's CC after the CCS to advise him or her of the family's level of risk for further maltreatment, level of motivation or interest in services, any prevention or treatment recommendations for the active component member, and will document the consult in the FAP record. **(T-0).**

6.2.2.2.1. The CCS will recommend all adult males who are the alleged offender in a met criteria partner maltreatment incident be referred to Change Step intervention, which is a domestic abuse group treatment curriculum for adult males provided by FAP providers. **(T-1).** If the alleged offender is not deemed appropriate for Change Step, justification will be well documented and a different treatment course will be included in the treatment plan. **(T-1).** Change Step training for FAP social workers is provided by AF FAP annually.

6.2.2.2.2. The CCS will recommend all adult females who are the alleged offender in a met criteria partner or child maltreatment incident be referred to Vista intervention, which is a group treatment curriculum for adult females provided by FAP providers. **(T-1).** If the alleged offender is not deemed appropriate for Vista, justification will be well documented and a different treatment course will be included in the treatment plan. **(T-1).** Vista training for FAP social workers is provided by AF FAP annually.

6.2.2.3. The CCS will review each open record at least quarterly (child sexual maltreatment incidents, children in foster care, and high risk FAP cases will be reviewed monthly). **(T-0).** The case manager will report the client's progress toward established goals, and current level of risk. **(T-0).** The members of the CCS will provide clinical consultation as needed in support of the most effective intervention course. **(T-0).** Once the ISD is made at the CRB, the case manager will rate the incident severity using the automated Incident Severity Scale and document the severity rating in FASOR. **(T-0).** The incident will be reviewed at the CCS within 30 days of the CRB determination. **(T-1).**

6.2.2.4. CCS documentation in the FAP record: Incidents pending CRB determination will be documented as initial incidents at all CCS, including the first CCS after the CRB determination. **(T-1).** The documentation of the CCS discussion will include: attendance at the CCS, allegation, identified risk and protective factors, level of risk, victim and alleged offender's motivation for change, and interest in services, issues identified in the assessment, CC notification plan (phone call or meeting), incident status ("Record Opened," "Record Closed-resolved" or "Record Closed-unresolved"), and recommendations. **(T-1).** If no recommendation for services is indicated, the CCS note will state "incident closed, no services recommended." **(T-1).** The case manager and FAO will sign the CCS Note for placement in the FAP record. **(T-1).** When the incident is reviewed at the CCS, FASOR will produce a CCS note for the FAP record. **(T-1).**

6.2.2.5. CCS Documentation in the medical EHR: When the referral is received and the incident is entered into FASOR, the CCS template will be generated for documentation of the CCS in the medical EHR. **(T-1).** The FAPA will enter the agenda items into FASOR and will indicate whether the assessed referrals will close or remain open for services. **(T-1).** Those incidents determined to be No Reasonable Suspicion (NRS) and NAW will not

require documentation in the medical EHR. **(T-1).** FASOR will generate a CCS SF600 for the medical record of the alleged offender, victim and sponsor. **(T-1).** A CCS note will be entered in the medical EHR by the FAPA and signed by the FAO for the initial CCS after the CRB determination and the Case Closure CCS. **(T-1).** The FAPA will use the "Add Note" feature to "copy and paste" the initial CCS note into the medical EHR. **(T-1).** The Medical Record CCS note will include the date of CCS and incident number, action: "Record Opened," "Record Closed-resolved" or "Record Closed-unresolved," services recommended for family members (e.g., Return to the FAP for intervention, referred to prevention services, or no services recommended), and risk level. **(T-1).** The FAO (or CCS Chair) will electronically sign the CCS note in the medical EHR. **(T-1).**

6.2.2.6. Case Closure or transfer: When the incident is closed or transferred to another installation, the FAPA will enter the closed or transferred status into FASOR and the closure or transferred note for the medical EHR will be populated by the case manager and generated for the alleged offender, victim, and sponsor and any other family member who received treatment. **(T-1).** The case manager will use the "Add Note" feature in the medical EHR to "copy and paste" the closure or transfer notes into the medical EHR. **(T-1).** This note will contain: date of CCS and incident number, summary of services received, progress toward goals, action: "Record Opened," "Record Closed-resolved" or "Record Closed-unresolved," current risk level, recommendations. **(T-1).** If the CCS recommended secondary prevention services such as NPSP or FAST, the closure note should state "prevention services recommended." The ISD made by the CRB will not be placed in the medical EHR of any FAP client. **(T-1).**

6.2.2.7. All documentation of clinical contact must be placed in FASOR or FAPNet and printed for the FAP, FAST or NPSP record. **(T-1).** Maltreatment face-to-face contacts must have corresponding medical EHR records and those notes will be coded IAW DHA coding guidance. **(T-1).**

6.2.3. The CSMRT.

6.2.3.1. CSMRT members are appointed in writing by their CC and approved by the FAC. **(T-1).** Membership includes the FAO, who serves as the Chair, and representatives from AFOSI and SJA. The FAO will activate the CSMRT immediately upon receipt of a child sexual abuse allegation and manages the initial response to the allegations. **(T-1).** The CSMRT may also be activated in cases of extra-familial or non-caregiver sexual assault of a minor to ensure AFOSI and SJA are aware of the allegation and that victim safety is assessed.

6.2.3.2. The goal of this CSMRT is to minimize risk and trauma to the victim and family and ensure coordinated decision making and case management.

6.2.3.3. The FAO will train members prior to serving on the CSMRT. **(T-0).** Team activation must be reported to the FAC and documented in the FAC minutes. **(T-0).**

6.2.3.4. Under the leadership of the FAO, the CSMRT reviews the allegation(s) and coordinates a course of action. This team determines how organizations will proceed in making required notifications, conducting interviews, scheduling medical exams, arranging for the safety of the victim and all family members, and conducting the FAP psychosocial assessments.

6.2.3.5. The FAO will ensure documentation of the CSMRT is placed in the victim's FAP record. **(T-0).**

6.2.4. The HRVRT.

6.2.4.1. The HRVRT will be activated when there is a threat of immediate and serious harm to family members, unmarried intimate partners, the FAP staff, or Command staff in relation to FAP incidents. **(T-0).**

6.2.4.2. The HRVRT is activated at the discretion of the FAO. Membership may include the FAO, the FAP clinician working with the family, member's SQ/CC, SJA, SFS, MH provider, AFOSI, DAVA, and representatives from other agencies having legal, investigative, or protective responsibilities, as appropriate. If the victim has a SVC assigned, the SVC will be invited to attend, if available. **(T-1).** Due to the urgent nature of the HRVRT, the meeting will not be delayed simply because a specific member is not available. **(T-0).**

6.2.4.3. The FAO will train members prior to serving on the HRVRT, and an HRVRT note will be placed in the alleged offender's FASOR record. **(T-0).** Team activation must be reported to the FAC and documented in the FAC minutes. **(T-0).**

6.2.4.4. The HRVRT addresses safety issues and risk factors.

6.2.4.5. The HRVRT develops a coordinated plan for immediate implementation to manage risk to the individual presenting the potential threat, the suspected or intended victims and the community at large.

6.3. Maltreatment Intervention Process.

6.3.1. Logging Maltreatment Referrals in FASOR**:** Each maltreatment referral or allegation must be entered into FASOR as a new incident. **(T-1).** Each victim is assigned an incident number, and all referrals appear in FASOR's referral log in chronological order. FASOR creates the CCS agenda using incident numbers assigned to each referral. Therefore, each maltreatment allegation is presented to the CCS. FASOR also creates the CRB agenda using all incident numbers except NRS, NAW, and Restricted Report referrals.

6.3.2. The FAPA or other FAP staff will receive a maltreatment referral and document on the FAP Referral Form. **(T-1).** Because the immediacy of the response is based on the imminence of risk, the adult victim or non-offending caregiver must be contacted as soon as possible to evaluate victim safety, safety plan, and immediate needs. **(T-0).** For adult partner maltreatment referrals, if a DAVA is available, the victim advocate must contact the adult victim immediately. (**T-1).** For child maltreatment referrals, DAVAs do not contact child victims directly and may need to wait until after the child victim is interviewed to contact the non-offending caregiver. If a victim advocate is not available, the referral will be given to a FAP provider as soon as possible, but NLT two hours after receipt. **(T-1).** Referrals indicating an emergent response is needed will be immediately referred to law enforcement. **(T-0).** The provider will evaluate the referral for whether or not it meets the FAP's reasonable suspicion for maltreatment threshold, whether the victim(s) or the alleged offender are living in the active component member's household, and initial assessment of risk and safety and the urgency of the situation (e.g., immediate need for clinical, medical, law enforcement, legal or command

intervention). **(T-1).** The FAP does not accept maltreatment referrals on alleged maltreatment of a fetus; the alleged maltreatment must have occurred after the child's birth. **(T-0).**

6.3.2.1. If the alleged offender in a child or partner maltreatment allegation is a member of the FAP staff, that staff member will be removed from direct patient contact until a CRB determination of "did not meet criteria" is received or the case is closed as resolved. **(T-1).**

6.3.2.2. If the victim in a partner maltreatment allegation is a member of the FAP staff, the FAO will assess the victim's ability to fulfill all the duties of that position. **(T-1).**

6.3.3. The FAO, or designee, will open a FAP maltreatment record when the referral indicates there is reasonable suspicion that domestic abuse or child maltreatment has occurred in the home of an active component member, or among members of the active component member's household. **(T-0).** When domestic abuse or child maltreatment occurs among members of the household of an active component member and an intimate partner where one or both is active component, a FAP provider will assess the active component member, assess the intimate partner and all children, provide safety planning, and refer non-beneficiaries to local resources for any needed services. **(T-0).** Intimate partner is defined as: A current or former spouse. A person with whom the alleged abuser shares a child in common. Current or former intimate partner with whom the alleged abuser shares or has shared a common domicile. A person who is or has been in a social relationship of a romantic or intimate nature with the accused, as determined by the length of the relationship, the type of relationship, and the frequency of interaction between the person and the accused. An intimate partner is informed by, but not limited to these factors: (a) Consensual intimate or sexual behaviors. (b) History of ongoing dating or expressed interest in continued dating or the potential for an ongoing relationship (e.g. history of repeated break-ups and reconciliations). (c) Self-identify by the victim or alleged abuser as intimate partners or identified by others as a couple. (d) Emotional connectedness (e.g. relationship is a priority, partners may have had discussed a future together). (e) Familiarity and knowledge of each other's lives. **(T-0).**

6.3.4. Upon receipt of a maltreatment referral the FAO (or provider responsible for triage) will utilize all available information to make a reasonable suspicion determination that maltreatment may have occurred (e.g., Central Registry background check, medical records of each family member, review of police reports or medical exams, discussions with CCFs or DAVA, etc.). **(T-1).** Each allegation of domestic abuse or child maltreatment will be reviewed by a FAP provider within two hours of receipt to determine if it meets the reasonable suspicion of maltreatment threshold. **(T-1).** If the referral meets reasonable suspicion and a FAP maltreatment record is opened, the provider will document review of the medical record, the Central Registry check, and any relevant findings in FASOR. **(T-1).** There is no requirement to document medical record reviews in the medical EHR. Referrals that meet reasonable suspicion receive an immediate risk assessment followed by individual psychosocial assessments with each family member, or unmarried intimate partner. Where available, the DAVA will make initial contact with all adult victims to assess safety, determine the urgency of the situation, and offer information and support. **(T-1).**

6.3.5. Each allegation of domestic abuse or child maltreatment determined by a FAP provider to meet reasonable suspicion will receive an immediate risk assessment, followed by individual psychosocial assessments with each family member, or unmarried intimate partner, conducted

by a FAP provider. **(T-0).** Intake assessments will be initiated by a FAP provider within three duty days, or sooner as level of risk requires. **(T-1).** Initiating an intake assessment within three duty days requires key family members (victim and alleged offender) have been interviewed and a substantive portion of the assessment has been accomplished. Family members will be evaluated for all types of maltreatment witnessed or experienced as well as any service needs. **(T-0).** Each family member will be interviewed separately, at least initially. **(T-1).** In child maltreatment incidents, all parental figures in the home will receive an adult intake interview regardless of which of them is identified as the alleged offender. **(T-1).** The assessment process involves interviewing family members and collecting information from records, background checks, and collateral contacts with other involved agencies. The FAP client will be asked to complete AF Form 2522, *Family Advocacy Program Intake,* and other associated intake paperwork. **(T-1).** The FAP clinician will collect information listed on the FASOR Adult and Child Intake Assessment. **(T-1).** These automated SF600s will be filed in the FAP record. **(T-1).** All intake assessments and any notes for clinical treatment will be documented in FASOR and the medical EHR within 3 duty days of the contact with the client. **(T-1).** The Intimate Partner Physical Injury Risk Assessment Tool will be completed and scored for each allegation of adult partner maltreatment and filed in the FAP record. **(T-0).** A young child will be assessed for his or her developmental ability to give a valid interview. **(T-1).** The child will be interviewed using the National Institute of Child Health and Development (NICHD) Research Based Structured Child Interview, if the case manager has been trained under those guidelines. **(T-1).** If civilian family members refuse to participate in the FAP assessment or if parents refuse to allow their children to participate, the FAP provider will document the refusal and all efforts to obtain these interviews in the FAP record. **(T-0).**

6.3.6. Where there is indication of injury or the potential for injury due to domestic abuse, child abuse or neglect, the FAO or FAP provider will consult with the treating MTF medical provider to ensure appropriate description of the injury (or potential) is captured and documented for the CRB. **(T-1).** IAW AFI 40-301 **paragraph 6.2.1.4**., the treating provider may be invited to present such description to the CRB due to the complexity or unique circumstances of a given case. For complex child maltreatment cases, consultation with the AF Child Abuse Pediatrician for her or his recommendation should also be considered.

6.3.7. Any injury to an infant or young toddler, age birth to 24 months, will be considered serious. **(T-1).** When parents refuse to have an infant or young toddler with injuries medically evaluated, the FAP provider will notify CPS, the active component member's CC, and the FAP provider's chain of command. **(T-1).** A skeletal survey is recommended for any child under the age of 2 years when there is a suspicion of abuse. A head CT is recommended if there is evidence of a head injury or as screening for head injury under 6 months of age. The FAP provider will coordinate with the healthcare provider to ensure recommendations are followed. **(T-1).** It is important to note the military clinic may not be the appropriate place for these studies and the child may need a civilian referral. A consultation with the AF Child Abuse Pediatrician for her or his recommendation should also be considered. Siblings of a child with injuries suspicious for abuse should undergo a physical exam to assess for injuries concerning for non-accidental trauma. Further work-up should follow guidelines as above.

6.3.8. When maltreatment allegations, either child or partner, involve a family with a child under age 1 year in the home, a home visit by a FAP case manager is required. The case manager will arrange the home visit by advising the parents of the home visit requirement and

securing an invitation to the residence. **(T-1).** The assessment of the home environment will include at least, assessment for safe infant sleep environment, adequate infant formula, food and diapers, presence of child safety issues, and assessment of the child's physical condition (any sign of failure to thrive). **(T-1).** The case manager will also verify the infant is receiving well child care pediatric visits and immunizations. **(T-1).** In addition, weekly contact with the infant will be accomplished by the FAP provider until a case status determination is made. **(T-1).** If CPS visits the home, the child is seen by a doctor, or the child attends DoD-sponsored day care, the case manager may contact the CPS worker, doctor, or daycare provider to verify the condition of the child in lieu of a contact that week. This will be documented in the FAP record. **(T-1).** If the child is injured, it is appropriate for continuity of care to contact the child's Primary Care Manager (PCM) or pediatrician to inform him or her of the injury and inquire about any past injuries. **(T-1).**

6.3.9. The FAP accepts referrals of suspected child neglect that are related to a condition called FTT. Typically, FTT referrals are received from the pediatric medical provider. FTT is a physical sign that a child is not receiving adequate nutrition for optimal growth and development. An infant or child becoming malnourished as the result of parental or caregiver neglect creates concern for child maltreatment.

6.3.10. Regardless of incident status, clinical recommendations and appropriate referrals will be made by the FAP provider to address any needs identified in the assessment process. **(T-0).** Moderate to high risk families in OCONUS locations who refuse to participate in the FAP assessments (to include PSB-CY) and treatment recommended by the Clinical Case Staffing team or the CSMRT-Plus should be strongly considered for command-directed humanitarian relocation to promote victim safety and to establish an effective FAP intervention plan, with collaboration with state child protective services for child cases.

6.3.11. The FAP provider will assign a risk level (low, moderate or high) to each victim and offender of family maltreatment based on all available information about the incident and the family. **(T-0).** The FAO will consider activating the HRVRT in high risk situations. **(T-0).** Law enforcement, emergency personnel, and CC/CCF are responsible for managing acute situations where there is risk to the safety of a military member, family member, or unmarried intimate partner. Unit CC/CCF, SF, SJA, and other authoritative agencies will be consulted, as required, in making necessary protective interventions. **(T-0).**

6.3.12. The FAP staff will not accompany command or emergency personnel to unsecured home environments in emergent situations. **(T-1).**

6.3.13. Intervention and safety plans will be developed by the FAP provider and DAVA to ensure the safety of victims or potential victims, alleged offenders, and other family members. **(T-0).** In developing the intervention plan, primary and secondary prevention programs will not be used in lieu of treatment. **(T-1).** However, when needs for education and/or skill building are identified the provider will refer clients to the appropriate groups, classes, etc. **(T-1).** Application of the new information or skills will be integrated into the required treatment sessions (weekly to monthly) with the FAP provider. **(T-1).**

6.3.14. All the FAP maltreatment clients who are receiving treatment from a FAP provider must have a FASOR-generated intervention plan developed with the FAP provider and placed in the FAP maltreatment record within 30 days of the first follow-up session after intake. **(T-1).** The FAP Intervention Plan for maltreatment or the FAST Services Intervention Plan must

include at least the following: statement for each identified problem and specific goal statement for each identified problem. **(T-1).** The intervention statement will include type of intervention, when it will occur, who will be involved and length of intervention, measurable outcome(s), documentation regarding the participation of the FAP provider and client(s) with the development of the plan(s), signatures of client(s) and the FAP provider on original and updated plans and criteria for completion of plan. **(T-1).**

6.3.15. The FAP provider will contact the active component member's command weekly for all high risk clients, and will contact high risk alleged offenders and victims at least once per week. **(T-1).** Ongoing contact with the command of the sponsor is needed to ensure there is a coordinated community response to the risk in the case. When lowering the level of risk the FAP provider will consult with his or her clinical supervisor on the decision to lower the risk, and document the consult and the basis for that decision in the FAP record. **(T-0).** Levels of risk employed and documented by FAP providers and their corresponding definitions are found within the FAPNet FASOR system.

6.3.16. Suicide Risk Assessment, Management, and Treatment for the FAP clients (includes all maltreatment, NPSP and FAST clients seen by a clinical provider):

6.3.16.1. The FAP providers will monitor the FAP client's well-being at each visit using the Outcome Rating Scale and Columbia-Suicide Severity Rating Scale (C-SSRS) screening tool. **(T-1).** When the outcome rating scale scores are low and collateral information indicates the client's possible risk for suicide or C-SSRS screening results indicate, the provider will conduct a comprehensive suicide risk assessment. **(T-1).**

6.3.16.2. Comprehensive suicide risk assessments will include administration of the complete C-SSRS assessment. **(T-1).** The C-SSRS assessment will indicate levels of risk and the FAP clinic provider will respond accordingly to the risk level indicated through consultation with a MHC provider and safety planning commensurate with the level of risk. **(T-1).**

6.3.16.3. In cases requiring higher-level care to maintain safety, the FAP clinical provider will work with MHC personnel for assistance in securing transport and evaluation for possible admission. **(T-1).**

6.3.17. Clinical assessment and treatment for family members identified as at risk for, or referred for suspected domestic abuse or child maltreatment, will be provided solely by licensed, privileged MH Flight providers, including OSD-funded FAP treatment staff. **(T-1).** If more than one MH Flight provider is serving a client, the client's case will be staffed at the Multidisciplinary Clinical Case Conference. **(T-1).**

6.3.17.1. Master's or doctoral-level providers not yet independently licensed and working toward privileged status may treat the FAP clients under the direct supervision of a trained, privileged FAP provider.

6.3.17.2. FAP clinical social workers will self-nominate to attend AF FAP sponsored and funded training in Structured Child (forensic) Interviewing, Change Step group treatment for adult male domestic abuse offenders, and Vista group treatment for adult women who use violence in their familial relationships, within their first year of employment with FAP. **(T-1).** Attendance at these basic skills courses and the annual FAP-sponsored advanced

clinical skills conferences is mandatory. These basic and advanced skills courses are essential to effectively treating clients perpetrating or experiencing family maltreatment.

6.3.17.3. Where the MTF does not have suitable providers in place to treat a FAP client, the client may be referred to a TRICARE network provider so long as there is case management by the FAP provider and the client signs authorization to release treatment progress updates to the FAP provider overseeing the case.

6.3.18. The FAP provider will have at least monthly face-to-face contact with alleged maltreatment offenders who have open maltreatment cases. **(T-1).** If the required contact is not possible, the FAP provider must document all efforts to make contact with the alleged offender. **(T-1).** As risk increases, the FAP provider will have increased communication with clients and Command for continued safety planning. **(T-1).** When maltreatment victims are not engaged in services in the FAP office, the FAP providers will establish a way to monitor whether re-abuse is occurring as part of the victim's safety plan. **(T-1).** This may include face-to-face, telephonic, or other means of monitoring victim safety (e.g., talking with the non-offending protective parent of a child victim). Victims should be interviewed separately from their alleged offenders when ongoing contact with victims is for the purpose of determining whether the maltreatment is continuing, decreasing, or increasing. The FAP provider will have regular contact with the CC or CCF who has an active component member with an open maltreatment case. **(T-1).** When alleged offenders and victims are fully participating in intervention plans and abuse is not re-occurring, quarterly updates from the FAP provider to the CC/CCF are appropriate. As risk increases, so should contact between the FAP provider and the CC/CCF.

6.3.19. When active component alleged offenders are non-compliant with treatment recommendations, the FAP provider will promptly notify the member's CC to request assistance. **(T-1).** CC/CCF refusal to support the FAP treatment recommendations should be well documented in the FAP record. When such problems arise the CCS will review the case. **(T-0).** If safety is deemed to be a concern, the FAO may request assistance from the FAC Chair.

6.3.20. FAP maltreatment records will remain open as long as a military beneficiary child is in foster care unless the parental rights have been removed by the courts. **(T-1).** When the child is in the parent's care, FAP will monitor the child's safety until state CPS closes their record. **(T-1).** Reasons for variance from this guidance must be documented in CCS minutes. **(T-1).**

6.3.21. When unsanitary living conditions are discovered in a military family home, whether on or off installation, a minimum of six months of monthly no-notice home inspections will be conducted by CCF and/or by CPS/FAP to ensure sanitary conditions are maintained. **(T-1).** Successful completion of the FAP intervention plan requires compliance with no-notice inspections.

6.3.22. Information and referral to the VWAP is provided to victims IAW AFI 51-201 and local installation SJA guidance.

6.3.23. Domestic Abuse Reporting Options. Adult victims of domestic abuse have two reporting options: unrestricted reporting (UR) and restricted reporting (RR). All reports of maltreatment are considered unrestricted unless they meet criteria for RR and the victim

requests RR after options are presented by a qualified authority (e.g., medical provider, DAVA). Regardless of whether the victim elects restricted or unrestricted reporting, confidentiality of medical information will be maintained IAW provisions of HIPAA. **(T-0).**

6.3.23.1. Unrestricted Reporting for Domestic Abuse. UR is a process allowing a victim of domestic abuse to report an incident using chain of command, law enforcement or AFOSI and the FAP for clinical intervention. Victims of domestic abuse who choose to pursue an official command or criminal investigation of an incident should use these reporting channels.

6.3.23.1.1. At the victim's request, the medical provider, in coordination with criminal investigators, will conduct a forensic medical examination. **(T-0).** Details regarding the incident will be limited to only those personnel who have a legitimate need to know. **(T-0).**

6.3.23.1.2. All assessment and treatment services for an UR of domestic abuse will be managed IAW DoDI 6400.06 and this instruction, using command and law enforcement resources as needed to enforce safety plans and monitor family well-being until the case is closed. **(T-0).**

6.3.23.2. Restricted Reporting for Domestic Abuse. RR is a process allowing an adult victim of domestic abuse, who is eligible to receive military medical treatment the option of reporting an incident of domestic abuse to specified individuals for the purpose of receiving medical care, supportive services, and advocacy and information without initiating the investigative process or notification to the victim's or alleged offender's CC.

6.3.23.2.1. When an adult victim elects RR, and discloses an abuse allegation to a DAVA, the FAP staff member or any MTF healthcare provider, the domestic abuse allegation will not be disclosed to command or civilian or military investigative or law enforcement agencies except as provided in the exceptions to the DoD Restricted Reporting For Incidents of Domestic Abuse guidance or mandated by state law. **(T-0).** See DoDI 6400.06, Enclosure 3.

6.3.23.2.2. In cases of sexual assault, RR may not be available in a jurisdiction that requires mandatory reporting if a victim first reports to a civilian facility or civilian authority. This may vary by state, territory, or overseas agreements. Section 536 of the Fiscal Year 2016 National Defense Authorization Act, however, preempts mandatory reporting laws if the victim first reports to a MTF in a jurisdiction requiring mandatory reporting. In such a case, RR can therefore be preserved. See DoDI 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures*, Enclosure 4.

6.3.23.2.3. The FAP staff will consult with the appropriate legal office as needed, to ensure appropriate offering and management of restricted reports. **(T-0).**

6.3.23.2.4. For purposes of command responsibility and in the interest of gathering accurate data, information concerning RRs of domestic abuse, without personal identifiers, will be reported by the FAO at the next FAC meeting. **(T-0).** This will inform installation leadership as to the number and type of domestic abuse incidents within the command and enhance the CC's ability to provide a safe environment. If

the installation leadership wants to be notified sooner than the next FAC, the FAO will supply the required information as requested. **(T-1).**

6.3.24. The medical provider will initiate appropriate care and treatment and will report the domestic abuse only to a DAVA or the FAP. **(T-1).** At the victim's request, the medical provider will conduct or arrange any forensic medical examination deemed appropriate. **(T-1).** The forensic component includes gathering information from the victim for the medical forensic history, an examination, documentation of biological and physical findings, collection of evidence from the victim, and follow-up, as needed, to document additional evidence. The medical provider will transfer the forensic evidence, via proper evidence chain of custody procedures, to an AFOSI agent using a control number in lieu of personal identifying information. **(T-1).**

6.3.25. All RRs that have physical evidence associated with them will be assigned a Restricted Report Control Number by a FAP provider or DAVA, which will be developed using a two-digit year, two-digit month, the first four letters of the installation name, a three-digit numerical sequence, and followed by "R-FAP." **(T-1).** For example, "0709RAND001R FAP" represents the incidence occurred in 2007, during September, at Joint Base San Antonio Randolph, is the first report of this sequence, and is a restricted report. The FAP provider must enter the Restricted Report Control Number into the allegation tab of FASOR in order to give the victim access to their evidence after the hardcopy maltreatment record has been retired or destroyed. **(T-1).**

6.3.26. If prior to the ten-year anniversary date a victim changes the reporting preference to an unrestricted report, the FAP shall notify the AFOSI, who shall then process the evidence IAW AFOSI procedures. **(T-1).**

6.3.27. The FAP will notify the victim 30 days prior to the expiration of the ten-year evidence storage period. **(T-1).** The FAP will appropriately document the efforts to obtain a decision from the victim or efforts to locate the victim. **(T-1).** The FAP is authorized to complete any documentation required from AFOSI for the destruction of evidence on behalf of the victim. The evidence may be destroyed at the ten-year anniversary date unless:

6.3.27.1. The victim decides to make an unrestricted report.

6.3.27.2. The victim does not request the return of any personal effects or clothing maintained as part of the collection of evidence.

6.3.27.3. The victim does not advise the FAP of his or her decision after being notified of the upcoming anniversary.

6.3.27.4. The victim cannot be located.

6.3.27.5. In the event a domestic violence case includes a Sexual Assault Forensic Examination, the installation FAP office will consult with the servicing SJA regarding the disposition of such evidence. **(T-1).** Refer to **paragraph 6.6** for further details related to sexual assault in the FAP context.

6.3.28. Due to prohibitions on clinical intervention of pedophiles, the FAP providers (active component, civil service, or contract) will not provide clinical intervention to sexual offenders to modify deviant sexual arousal patterns. **(T-1).** These clients will be referred for such clinical

intervention to specialists in the community. **(T-1).** The FAP and MTF personnel may provide other services to sex offenders as long as services do not focus on deviant arousal patterns.

6.3.29. Protective order notifications.

6.3.29.1. Upon notification of a Civilian Protective Order (CPO), the FAO (or designee) will provide notification of the CPO via encrypted email to the Air Force Indexing Cell (AF-CJIC) at **AF.CJIC@us.af.mil** and the AFOSI Global Watch Center at **hqafosi.watch@us.af.mil**. **(T-1).** The notification must be accompanied by a copy of the signed CPO to facilitate any necessary law enforcement coordination and follow-up with the issuing agency. **(T-1).** FAO (or designee) will ensure the member's CC is aware of all CPOs. **(T-1).**

6.3.29.2. Upon notification of a military protective order (MPO) issued for the protection of persons alleged or known to be at risk of harm from another person, the FAO (or designee) will provide notification of the MPO via encrypted email to the AF-CJIC at **AF.CJIC@us.af.mil** and to the AFOSI Global Watch Center at **hqafosi.watch@us.af.mil**. **(T-1).** The notification must be accompanied by a copy of the signed order or DD Form 2873, *Military Protective Order (MPO)* for entry into the National Crime Information Center. **(T-1).**

6.3.29.3. If the FAP becomes aware of a violation of a CPO or MPO, the FAO (or designee) will immediately notify the chain of command and installation investigative and law enforcement agencies. **(T-0).**

6.4. Department of Defense-Sanctioned Activities and Caretakers.

6.4.1. The FAP providers will open a maltreatment case when there is an allegation of sexual maltreatment of a child by a caretaker in a DoD-sanctioned activity or sexual maltreatment of a child by a member of the active component member's household who is a caretaker of the child. **(T-0).** The FAP providers do not conduct investigative interviews with extra-familial alleged offenders (e.g., Child and Youth Programs paid, contract, and volunteer workers, Youth Center Coach, neighbor). SF or AFOSI conducts investigative interviews. FAP will advise the mandatory reporter if the allegation meets reasonable suspicion of child maltreatment and will also advise them to call the local child protection agency directly to make the report, in addition to the CPS report made by FAP. **(T-0).**

6.4.2. When an incident of physical or emotional child maltreatment or neglect occurs in a DoD-sanctioned activity, including DoDEA schools, the FAP provider will notify Child Protective Services, SFS, and AFOSI, to conduct the investigation. **(T-0).** FAP will advise the mandatory reporter if the allegation meets reasonable suspicion of child maltreatment and will also advise them to call the local child protection agency directly to make the report, in addition to the CPS report made by FAP. (T-0).

6.4.3. The FAP will open a maltreatment record when DoD-sanctioned caregivers, including DoDEA personnel, are accused of child maltreatment and will take the allegation to the CRB. **(T-0).** The FAP provider will notify the family of the maltreatment allegation, and of the notifications made by the FAP, and will offer to assess the victim and conduct non-offending parent intake interviews with the parents. **(T-0).** FAP services will be offered to the victim and family members who are eligible beneficiaries, upon their request. **(T-0).**

6.4.4. The FAP provider will serve as consultant to the DoD/DoDEA personnel involved and attempt to secure updates for them regarding the status of any CPS or military law enforcement investigations. **(T-0).** When CPS, SFS or OSI refuse to investigate DOD/DODEA, personnel who are alleged offenders of child maltreatment, Child and Youth or DODEA leadership will advise the alleged offender of the allegations and what type of maltreatment will be presented to the CRB for determination, and will obtain the alleged offender's side of the story and present that information to the CRB.

6.4.5. When employees are performing DoD-sanctioned childcare activities, or teaching in DoDEA, they must comply with DoD positive child guidance and supervision policies. **(T-0).** For example, physical discipline is an infraction of AF Child Development and Youth Center and DoDEA positive guidance policy.

6.4.6. However, a referral to the FAP is only necessary if there is a suspicion of abuse or neglect. If reasonable suspicion of maltreatment is established by the FAP provider, the FAP will initiate the notification protocols and take the allegation to the CRB. **(T-0).** The DoDEA principal will attend CRB as a non-voting member when an incident involving a DoDEA employee is being presented. **(T-0).** If reasonable suspicion is not established, the FAP provider will serve as a consultant to the Child Development Center and Youth Center Director or DoDEA principal to help him or her identify what incidents should be handled administratively as a breach of policy. **(T-0).**

6.4.7. The FAP providers will advocate for law enforcement investigation of child maltreatment allegations and serve as liaison between military law enforcement and DoD/DoDEA personnel. **(T-0).**

6.4.8. The FAP provider will consult the installation SJA prior to opening a maltreatment case on a GS or Contract employee in an OCONUS location, not to include Alaska and Hawaii (who have state CPS offices). **(T-0).** When risk for maltreatment is high, the FAP provider will notify installation leaders to address safety concerns with non-active component OCONUS families. **(T-0).** The FAP will offer voluntary services to these families. **(T-0).**

6.4.9. If a military beneficiary child is assaulted or endangered by someone outside the family or household (non-DoD-sanctioned), a maltreatment record will not be opened. **(T-0).** However, MH or the FAP providers will offer crisis intervention counseling and if the child or military beneficiary parent is requesting ongoing counseling services, the FAP provider will open a FAST Services record to serve the victim and family and will engage the DAVA when appropriate to support the non-offending parents. **(T-1).** All sexual assaults involving children 17 and younger and all sexual assaults involving spouses or unmarried intimate partners are reported directly to the FAP for risk assessment and safety planning. If a child sexual assault victim is at the hospital or law enforcement agency after duty hours, the DAVA, where available, should respond IAW **paragraph 5.2.9** of this publication. All other sexual assaults are reported to the installation SARC, SAPR VA or Volunteer Victim Advocate as described in AFI 90-6001.

6.5. Family Advocacy Nurse Support to Maltreatment Intervention Services.

6.5.1. When the FAN provides nursing intervention services for families served in the maltreatment program, the FAN will not take an investigative role, or act as a case manager or primary provider in the maltreatment case. **(T-1).**

6.5.2. Family Advocacy nursing intervention services are provided for families in the maltreatment program only when safety can be reasonably assured.

6.5.3. For maltreatment families receiving Family Advocacy nursing intervention services, FAN interventions will be clearly identified in the maltreatment intervention plan, with specific desired outcomes. **(T-1).**

6.5.4. When Family Advocacy nursing intervention services are provided for families in the maltreatment program, the maltreatment case will not be closed as resolved until all goals are met, to include Family Advocacy nursing intervention goals. **(T-1).**

6.5.5. The FAN documents nursing interventions in the FAP maltreatment record using FASOR. This documentation does not require a co-signature by the case manager, and nursing service documentation in the maltreatment record does not require a corresponding Electronic Health Record note.

6.6. Sexual Assault in the Context of Domestic Abuse.

6.6.1. Sexual assault between spouses or unmarried intimate partners is domestic abuse and will be managed by the FAP. **(T-0).** Once the FAP assumes case management of domestic abuse sexual assault cases, no information about the case is shared with the SARC or at the Case Management Group. **(T-0).**

6.6.2. The FAP manages sexual assault allegations when the alleged offender is a partner in the context of a spousal relationship, same sex domestic partnership, unmarried intimate partner relationship, or a military dependent 17 years of age or younger. Intimate partner is defined as: A current or former spouse. A person with whom the alleged abuser shares a child in common. A current or former intimate partner with whom the alleged abuser shares or has shared a common domicile. A person who is or has been in a romantic, intimate, or sexual relationship with the alleged abuser as agreed upon by the victim and with the consideration of the length and recency of the relationship, frequency of the interaction, the victim's previous acknowledgment of the relationship, and the exclusive nature of the relationship.

6.6.3. The installation SARC and FAP provider will collaborate to identify established protocols and procedures for ensuring proper referral and notification of sexual assaults. **(T-1).** In the event there is confusion regarding a specific case and which program should manage that case, the SARC and FAP provider will discuss immediately to assess the potential for ongoing violence. **(T-1).**

6.6.4. In the event the SAPR Program responded to a victim requiring a referral to FAP due to the ongoing risk of violence, the SARC will ensure a warm hand-off to FAP immediately. **(T-1).** In the event FAP responded to a victim requiring referral to SAPR, FAP will ensure a warm hand-off to SAPR immediately. **(T-1).** For cases passed to SAPR, the SARC will manage that case IAW AFI 90-6001, and FAP will not open a maltreatment case in FASOR. **(T-1).**

6.6.5. The FAP will log the case as an unmarried intimate partner case, child abuse case, or sexual assault of a minor, and assess the client, offer safety planning, and when indicated take the incident to the CRB. **(T-1).**

6.6.6. Higher level reporting requirements.

6.6.6.1. Standard Eight-Day Reporting Requirement. IAW the 2014 National Defense Authorization Act, Section 1743, the FAO will ensure encrypted email notification to the Installation CC, to the active component DoD alleged offender's CC and the active component DoD victim's CC of all unrestricted adult partner sexual abuse allegations. **(T-0).** The unit CC must forward the encrypted email notification to the first officer in the grade of 0-6 and the first general officer or flag officer in the victim's and alleged offender's chain of command not later than eight duty days after the unrestricted partner sexual abuse allegation has been made. **(T-0).** The following is included in the notification email:

6.6.6.1.1. Date/Time/Location of alleged incident.

6.6.6.1.2. Type of offense alleged.

6.6.6.1.3. Service affiliation assigned unit and location of the victim.

6.6.6.1.4. Service affiliation assigned unit and location of the alleged offender including whether the alleged offender has been temporarily transferred or removed from an assigned billet, ordered to pretrial confinement, or otherwise restricted, if applicable.

6.6.6.1.5. The notifications will not include the victim's personally identifiable information, the victim's photographs, or additional incident information that could reasonably lead to personal identification of the victim or the alleged offender for both Unrestricted Reports and independent investigations. **(T-0).**

6.6.6.1.6. Post incident actions taken: Date referred to FAP, AFOSI or equivalent Military Criminal Investigation Organization and SF. Receipt and processing status of a request for expedited victim transfer, if applicable. Issuance of any military protective orders in connection with the incident.

6.6.6.1.7. A copy of the encrypted email notification to the CC, with instructions to forward, will be printed and placed in the FAP maltreatment record. **(T-1).**

6.6.6.2. The FAO will ensure immediate notification to the active component DoD member's CC and SF of every civilian and MPO (due to family maltreatment). **(T-0).**

6.6.6.3. Commander's Critical Information Requirement (CCIR).

6.6.6.3.1. The Installation CC or host wing CC will ensure the CCIR is completed for any adult sexual assault incidents involving the following: An O-6 CC (or equivalent) and above, SARC, SAPR VA, Volunteer Victim Advocate, or any SAPR staff member; circumstances that warrant higher level command awareness; an overturned conviction of a sexually based crime; media attention; or Congressional involvement. **(T-1).**

6.6.6.3.2. The CCIR provides timely information to the Secretary of the Air Force, Under Secretary of the Air Force, Chief of Staff of the Air Force, Vice Chief of Staff of the Air Force, AF/CVs, and if necessary the Chairman of the Joint Chiefs of Staff when a sexually based, alleged, or confirmed crime meets specific criteria. This is a separate report from the Eight-day Report listed above and may be accomplished at the same time as Eight-day Report if the criteria required for a CCIR is known, or later, as the criteria becomes apparent. A CCIR must be provided to the installation Command Post for submission as an OPREP-3 IAW AFMAN 10-206, *Operational Reporting*

(OPREP), and the current CSAF OPREP-3 Reporting Matrix, Rule 3D. **(T-1).** The installation or host wing CC will not complete CCIRs for restricted reports. **(T-1).**

6.6.6.3.3. The FAO will manage the CCIR on behalf of the Installation CC or host Wing CC. **(T-1).**

6.6.6.3.4. The FAO will utilize the CCIR template provided at **Attachment 7**, CCIR Template for Sexual Assault **(T-1).** The installation or host wing CC will ensure the CCIR does not deviate from the information required in the template. **(T-1).**

6.6.6.3.5. The Installation CC will provide the CCIR, via an unclassified, yet encrypted, email, to the installation command post for submission as an OPREP-3 IAW AFMAN 10-206, and the current CSAF OPREP-3 Reporting Matrix. **(T-1).**

6.6.7. Notification of Official Unrestricted Reports of Adult Sexual Abuse for Entry into the DSAID. Information of official unrestricted reports of adult sexual abuse will be entered into the DSAID and data will be compiled aggregately for submission to Congress. **(T-0)**

6.6.7.1. The FAP clinical provider will:

6.6.7.1.1. Inform all adult sexual abuse victims of the requirement to provide information of all official unrestricted sexual abuse reports to the installation lead SARC to be entered into the DSAID.

6.6.7.1.2. Have the victim sign the informed consent indicating that they have been informed of this sharing requirement.

6.6.7.1.3. Assist the victim in contacting the LEA to report the sexual abuse, if the victim has not already initiated contact.

6.6.7.2. The MCIO will:

6.6.7.2.1. Consider the sexual abuse report as an official report when and if the victim has signed the DD Form 2967, or other documentation that indicates that the victim has made an unrestricted report of sexual abuse; or

6.6.7.2.2. Provide, upon initiating an investigation of sexual abuse, the FAP clinician, within 48 hours of the start of an investigation, the MCIO case number required for sex abuse cases to be entered into the DSAID.

6.6.7.3. Upon receipt of the MCIO case number, the FAP clinical provider will:

6.6.7.3.1. Notify the installation lead SARC of all domestic abuse cases with an official unrestricted report of adult sexual abuse. Notification will be made when an allegation involves:

6.6.7.3.1.1. A Service member as either victim or alleged abuser; or

6.6.7.3.1.2. Command-sponsored civilians living OCONUS:

6.6.7.3.1.2.1. Identified as either victim; or

6.6.7.3.1.2.2. Alleged abuser and defined as intimate partners.

6.6.7.3.1.3. Notify the lead SARC, by phone:

6.6.7.3.1.3.1. Within 48 hours of an official unrestricted report option being

filed.

6.6.7.3.1.3.2. After collecting the MCIO case number.

6.6.7.3.1.4. Provide the lead SARC the victim's name, MCIO case file number, DoD identification number (if applicable), and rank and unit. If there is no DoD ID number, provide the victim's social security number and date of birth. The subject's information will be provided by the MCIO.

6.6.7.3.1.5. Document the DSAID case number received from the SARC in the victim's case record.

6.6.7.3.1.6. Use the DSAID number as the common identifier for official unrestricted sexual abuse cases when collaborating with sexual assault prevention response or the MCIO.

6.6.7.3.1.7. Notify the lead SARC of the victim's report of retaliation, when appropriate, whether the complaint is made at the initial allegation of sexual abuse or received at a later time.

6.6.7.3.1.8. The FAP clinical provider retains responsibility for all case management.

6.6.7.4. The lead SARC will:

6.6.7.4.1. Initiate an "Open with Limited Information" DSAID case for all official unrestricted sexual abuse reports from the FAP.

6.6.7.4.2. Provide the FAP clinical provider the DSAID case number.

6.6.7.4.3. Indicate in the DSAID that the report is an FAP case.

Chapter 7

PROBLEMATIC SEXUAL BEHAVIOR IN CHILDREN AND YOUTH

7.1. Problematic Sexual Behavior in Children and Youth (PSB-CY) Overview.

7.1.1. PSB-CY is generally defined as behaviors initiated by children and youth under the age of 18 that involve sexual body parts (genitals, anus, buttocks, or breasts) in a manner that deviates from normative or typical sexual behavior and are developmentally inappropriate or potentially harmful to the individual exhibiting the behavior, the individual(s) impacted by the behavior or others.

7.1.2. Full definition with differential characteristics can be found at **Attachment 1**. A basic guide to understanding normative versus cautionary or problematic sexual behaviors can be found at **Attachment 6**.

7.1.3. The FAP's mission scope has been expanded to allow formal education and intervention services to be provided by the FAP.

7.2. Referral and Initial Response.

7.2.1. Referral sources include any of the following:

7.2.1.1. Direct report from sponsors or family members to the FAP.

7.2.1.2. Anonymous or confidential report.

7.2.1.3. Referral agencies and entities:

7.2.1.3.1. Unit CCs will refer all allegations of PSB-CY to FAP. **(T-1).**

7.2.1.3.2. Law Enforcement or AFOSI will refer all allegations of PSB-CY to FAP. **(T-0).**

7.2.1.3.3. Non-medical counselors (e.g., Military Family Life Counselors) will refer all allegations of PSB-CY to FAP. **(T-1).**

7.2.1.3.4. Child and Youth Programs staff will refer all allegations of PSB-CY to FAP. **(T-0).**

7.2.1.3.5. DoDEA personnel will refer all allegations of PSB-CY to FAP. **(T-0).**

7.2.1.3.6. Medical providers and/or other medical staff will refer all allegations of PSB-CY to FAP. **(T-0).**

7.2.1.3.7. Chapel staff (to include volunteers) will refer all allegations of PSB-CY to FAP. **(T-0).** The Chaplain may be the reporting authority on behalf of volunteers.

7.2.2. Initially, referrals for potential PSB-CY will be logged in FASOR under the NAW category for tracking purposes. **(T-1).** Once FAP automation has been developed/modified, PSB-CY cases will be logged as an independent category. **(T-1).**

7.2.3. The installation FAP team, under the direction of the FAO, will review and discuss the referral and compare details to the full definition of PSB-CY to determine if the situation warrants follow-up as a potential PSB-CY incident, utilizing PSB-specific screening tools as available. **(T-0).**

7.2.4. If the referral is determined to meet the definition, a multi-disciplinary team is required to respond to and address referrals for PSB-CY. The CSMRT will serve this purpose for the Air Force. **(T-1).** Standard CSMRT membership applies for initial response, with the addition of a representative from the referral source, as applicable and available and as long as the source is from an identified installation agency as listed under **paragraph 7.2.1.3** The installation School Liaison Officer may be invited if the referral came from a non-DoD school.

7.2.5. The purpose of the initial CSMRT in cases of PSB-CY:

7.2.5.1. Review available information regarding the report and determine by consensus if the behavior is normative, cautionary or problematic.

7.2.5.2. Initially determine if there is information suggesting the need for an investigation or the potential for criminal proceedings (i.e., presence of a criminal act).

7.2.5.3. If there is the need for further investigation, AFOSI will take the lead and the team will discuss the supportive roles team members will take initially. **(T-1).**

7.2.5.4. If not determined to be a matter for further investigation, then the FAP will take the lead and follow steps for further assessment, support, and processing as described below. **(T-1).**

7.2.5.5. Following the initial meeting, a PSB-CY CSMRT may be called by the FAO for a given case any time there is a change in status (e.g., an investigation ends), team members feel there is a need for update, or there are decisions to be made requiring the support of the multidisciplinary team.

7.2.5.6. Safety planning will always be a primary component of the CSMRT. **(T-1).**

7.2.5.7. The discussion will also include whether the parents or legally authorized representative of the identified children involved have been notified and, if not, coordinate how to proceed with such notifications. **(T-1).**

7.2.6. If a case clearly does not meet the definition for PSB-CY based on initial review and there is no need identified for criminal investigation, then supportive services (e.g., parent engagement) will be offered to any involved parties through either information and referral to local agencies (on or off the installation) or FAST services. . **(T-1).**

7.2.7. If a case initially appears to meet the definition of PSB-CY and is under investigation, the installation FAP will provide as much support as possible within the bounds outlined by investigative authorities and legal consultation. **(T-1).**

7.2.7.1. Supportive services received by either the exhibiting child (and parents or legally authorized representative) or the impacted child(ren) (and parents or legally authorized representative) are voluntary.

7.2.7.2. When requested, DAVAs may provide parent-focused advocacy support to the parents (or legally authorized representative) of the impacted child(ren) to augment services provided by the clinical staff. Parent-focused advocacy will include services such as crisis response, court accompaniment, providing information and resources, and safety planning. DAVAs will only provide support to the parent (or legally authorized representative) of the impacted child. **(T-1).** The DAVA will not provide direct services to the impacted child, and the DAVA will not provide services to the parents (or legally

authorized representative) of a child impacted by a sibling or another child in the same home. **(T-1).** Support for parents (or legally authorized representative) of the exhibiting child, impacted siblings, or other impacted children living in the same home as the exhibiting child will be provided through FAP clinical services, Children's Advocacy Centers, private providers, or other collateral services. **(T-1).**

7.2.7.3. As soon as feasible (e.g., once investigative and legal authorities have completed their necessary interviews and initial requirements), the case will be turned over to the FAP for further assessment and processing. **(T-1).**

7.3. Family Advocacy Program Assessment and Processing.

7.3.1. If a case meets the definition screening for PSB-CY, and there is no open investigation (or investigative and legal authorities have communicated that FAP processing may proceed), then the FAP proceeds as follows:

7.3.2. Voluntary supportive services, referrals, etc. will continue for the impacted child and/or family as desired. **(T-0).**

7.3.3. The installation FAP will notify CPS. **(T-0).**

7.3.4. Further assessment will be offered for the exhibiting child. **(T-0).**

7.3.4.1. At the direction of the FAO, the FATM or FAIS (or FAO him or herself) may take lead as case manager for a given PSB-CY case.

7.3.4.2. All documentation of screening, assessment, and referrals will be documented one family per FAST record in the name of each sponsor. **(T-1).** Age categories that would normally separate NPSP case documentation processes from FAST case documentation processes will not apply when the definition for PSB-CY is met. **(T-1).**

7.3.4.3. PSB-CY incidents are generally not taken to the CRB for ISD.

7.3.4.4. Family and client engagement with PSB-CY assessment is voluntary.

7.3.4.5. A trauma-informed assessment approach will be taken using standardized tools. **(T-0).** If the assessment confirms PSB-CY as an area of clinical interest:

7.3.4.5.1. The FAP provider will engage with the parents or legally authorized representative regarding recommendations and possible avenues for support, education, and/or referral for treatment. **(T-1).**

7.3.4.5.2. A multi-disciplinary team will again be activated to ensure a comprehensive community response for intervention planning, safety planning, and monitoring. **(T-0).** The primary objective is to balance the need for safety of the installation community with supporting the parents or legally authorized representative as they navigate the resources available to address the PSB.

7.3.4.5.2.1. The CSMRT construct will again be utilized. **(T-1).**

7.3.4.5.2.2. The following additional participants will be invited: referring agency representative if applicable; other installation agencies as appropriate based on the child's age and enrollment or usage (e.g., a child who attends a DoDEA school and is involved in afterschool activities through the Youth Center would likely drive the attendance of a representative from at least the DoDEA school and Child and

Youth Programs); community or local area agencies involved in the monitoring or care of the child, as applicable (e.g., CPS); a representative from the sponsor's command (i.e., SQ/CC or CCF); parent or legally authorized representative of the exhibiting child; and the identified FAP provider responsible for case management. **(T-1).**

7.3.4.5.2.3. DAVAs who have had contact with the parent(s) or legally authorized representative of the impacted child may attend the CSMRT to provide information on specific needs and concerns that have been identified.

7.3.4.5.3. If based on further assessment, PSB-CY is ruled out as a concern of clinical interest:

7.3.4.5.3.1. The FAP staff will engage the parents or legally authorized representative and discuss options for support most appropriate for the family's situation. **(T-1).**

7.3.4.5.3.2. The FAP staff will update the initial PSB-CY CSMRT and the referring agency, as applicable. **(T-1).**

7.3.4.5.4. If during the course of the PSB-CY assessment, reasonable suspicion arises that child abuse or neglect or domestic abuse (CAN/DA) is a concern, with or without the presence of PSB-CY, the FAP provider will inform the FAO and proceed with a maltreatment case, logging the case as appropriate and collecting the necessary information to prepare a case presentation for CRB IAW the CRB process outlined in **Chapter 6** of this publication. **(T-1).**

7.3.4.5.4.1. If the case does not meet criteria for CAN/DA, voluntary supportive services, referrals, etc. (i.e., intervention plan) may continue for the identified PSB exhibitor and/or family as needed.

7.3.4.5.4.2. If the case does meet criteria for CAN/DA at the CRB, then the FAP staff will proceed with CCS and other standard procedures IAW **Chapter 6**. **(T-1).** These processes will run concurrent with and in parallel to interventions, support, activities, etc. in place to specifically address PSB-CY. **(T-0).**

7.3.5. Parent or legally authorized representative training regarding normative, developmentally appropriate, sexual behavior is an essential concept to address PSB-CY.

7.3.5.1. This will be considered when the FAP conducts agency training IAW **Chapter 4**. **(T-1).**

7.3.5.2. This will likely be a focus of supportive services and PSB-CY intervention. **(T-1).**

7.3.6. The FAP providers (active component, civil service, or contract) will not provide clinical intervention to modify deviant sexual arousal patterns. **(T-1).**

7.3.6.1. These clients will be referred for such clinical intervention to specialists in the community as available. **(T-1).**

7.3.6.2. The FAP and MTF personnel may provide other services (e.g., support, education, or behavior modification) as long as services do not focus on deviant arousal patterns.

7.3.6.3. At OCONUS locations, appropriate intervention may require FAP recommendation and requests for command involvement to return the family member(s) to a CONUS location where appropriate assessment, diagnosis, and treatment can be obtained. Family members requiring specialty treatment should be referred to the Exceptional Family Member Program-Medical office for consultation regarding reassignment options. Similarly, at CONUS locations without access to commensurate treatment, appropriate intervention may require coordination with the family, command, and Exceptional Family Member Program (EFMP) assets to pursue options for family relocation (e.g., EFMP reassignment).

Chapter 8

ADMINISTRATIVE REQUIREMENTS

8.1. Disposition of Personnel.

8.1.1. Special Duty**.** FAP involvement alone does not require any duty restriction. For information about how to assign personnel receiving FAP assistance while performing duties requiring either the Sensitive Duty Programs, security clearance, access to classified information, or unescorted entry into restricted areas refer to DoDM5210.42_AFMAN 13-501 and DoDM5200.02_AFMAN 16-1405.

8.1.2. Review of Duty Assignment. SQ/CCs must review the duty assignment status of all military members whose current duties may make it difficult for them to receive FAP intervention. **(T-1).** Military members considered fit for duty may continue in their primary or control Air Force Specialty Code while involved in FAP intervention, unless precluded under AFI 36-2101. If precluded, the CC may assign members under their secondary or tertiary Air Force Specialty Code during the FAP intervention process.

8.1.3. Promotion and Retention of Personnel. A member's involvement in the FAP will not be the sole basis for denying or withholding promotion, retention, or special duty assignments. **(T-0).**

8.1.4. Assignment Availability. Active component members receiving intervention services for domestic abuse or child maltreatment who are sufficiently emotionally, psychologically, and physiologically stable may be assigned to any location that offers appropriate services.

8.1.4.1. Where the local community does not have sufficient resources to provide appropriate services for families as recommended by the Clinical Case Staffing, the CC may initiate a Humanitarian Reassignment IAW AFI 36-2110, *Total Force Assignments*.

8.1.4.2. If maltreatment occurs in a family pending relocation, who have PCS orders, the unit CC will suspend the assignment until evaluations are completed to ensure availability of services at the gaining installation prior to relocation of the member or family. **(T-0).**

8.1.4.3. Active component members with an open maltreatment record at the time they receive PCS orders for an overseas assignment will participate in the Family Member Relocation Clearance process IAW AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP)*, to assess available services at the gaining MTF. **(T-1).**

8.1.4.4. The installation FAP staff, at the direction of the FAO, will work through the Mental Health Flight to receive periodic lists of active component members scheduled for PCS per the Military Personnel Section. **(T-1).** All FAP records (open and closed) on members projected to PCS will be reviewed to assess risk of adverse mission impact. **(T-1).**

8.1.4.4.1. If the sponsor and family are proceeding on a PCS with an open FAP case, installation FAP staff will coordinate transfer of the FAP record to the gaining installation’s FAP office to ensure continuity of care. **(T-1).**

8.1.4.4.2. Any closed case ("resolved" or "unresolved") a FAP provider deems to present an exceptional concern for adverse mission impact may be transferred to the gaining FAP office to facilitate future care if needed.

8.1.4.5. Profiles. Though not a typical component of FAP operations, there are times a profile may be beneficial to support clients, families, and/or the military unit. If a FAP provider assesses that an active component client should not deploy given concerns regarding safety (to self, or others within the household, or to the mission), the provider should first consult the member's CC.

8.1.4.5.1. If a profile is deemed appropriate and helpful to remove an active member from deployment availability in order to afford time for the appropriate intervention, the FAP provider will work with an Aeromedical Services Information Management System point of contact within the Mental Health Flight (or equivalent) for support in entering deployment availability restrictions for a specified time period (typically 90 days for an initial profile). **(T-1).** The Aeromedical Services Information Management System POC is typically an active component FAO or an active component provider within the MHC. If the POC concurs with the request and justification, he or she will enter the restrictions on behalf of the FAP provider. **(T-1).**

8.1.4.5.2. If circumstances drive a profile, the reason for the profile will be documented by the FAP provider in FASOR and on the corresponding medical EHR note. **(T-1).**

8.1.4.5.3. Such cases will be reviewed at the monthly CCS, and updates will be coordinated with the Aeromedical Services Information Management System POC as needed. **(T-1).**

8.2. Central Registry Background Checks. The FAP staff will conduct background checks when a maltreatment referral is received, to determine if the family has a history of family maltreatment. **(T-1).** The FAP staff will conduct background checks IAW DoDI 1402.05 for any position (paid, contract, or volunteer) that has regular recurring contact with children to determine if the applicant is an alleged offender in a past child or partner maltreatment met-criteria case. **(T-0).** This includes appropriated, non-appropriated, contractors, family child care providers and volunteers working child and youth programs, chapel and medical fields. Central Registry background checks for any other purpose are not authorized and will not be conducted. **(T-0).**

8.2.1. Background checks will not be authorized for special duty assignments (e.g., recruiters or training instructors). **(T-0).** The FAP staff will not conduct background checks for security clearances, criminal investigations, clients requesting or receiving prevention (NPSP or FAST) services, EFMP assignment coordination process including overseas clearances and facility determination inquiries, or Privacy Act or Freedom of Information Act (FOIA) requests. **(T-0).** Central Registry checks for Sexual Assault Prevention and Response (SAPR) office staff or volunteers will not be authorized. **(T-1).**

8.2.2. Minors entered into the Central Registry as alleged child sexual abuse offenders can petition to be removed from the Central Registry at 18 years of age. The AF Chief, FAP, makes the final decision regarding removal after reviewing all facts of the case (e.g., age the incident occurred, if subsequent acts of misconduct have occurred, completion of treatment, etc.).

8.3. Expedited Transfer (ET). The Air Force has established a standardized ET process for a member of the Air Force who is a victim of sexual assault or physical domestic violence committed by the spouse or intimate partner of the member (regardless of whether the spouse or intimate partner is a member of the Armed Forces). This instruction also allows the transfer of a member of the Air Force whose dependent is the victim of sexual assault perpetrated by a member of the Armed Forces who is not related to the victim. ET provides active component victims who file an unrestricted report of partner sexual abuse (UCMJ Articles 120, 120a and 120c) or physical domestic violence the option of a permanent change of station or a temporary or permanent change of assignment to a location that will assist with the immediate and future welfare of the victim, while also allowing them to move to locations that can offer additional support to assist with healing, recovery, and rehabilitation. One ET may be facilitated for an unrestricted report of partner sexual or physical abuse.

8.3.1. When an unrestricted report of partner sexual or physical abuse is filed with FAP by an active component victim, the victim shall be informed of the ET process option by the FAP provider, DAVA, SVC or the victim's CC (or equivalent), at the time of the initial report, or as soon as practicable. **(T-0).**

8.3.2. ET requests will be initiated by the victim with the FAP provider or DAVA, and facilitated with the SQ/CC (or equivalent) IAW the ET request process. **(T-0).**

8.3.3. The FAP provider or DAVA will advise the victim that the installation portion of the ET request and approval process must be completed within 72 hours of initiating the ET request. **(T-1).**

8.3.4. The victim may request an ET prior to the Central Registry Board determination on the alleged incident. A presumption shall be established in favor of transferring an active component member (who initiated the transfer request) following a credible report of sexual assault or physical domestic violence. **(T-0).** The CC (or equivalent), or the appropriate approving authority, shall make a credible report determination at the time the expedited request is made after considering the advice of the FAP provider or DAVA, the supporting judge advocate, or other legal advisor concerned, and the available evidence based on an Military Criminal Investigation Office investigation's information (if available). **(T-0).**

8.3.5. The installation or host WG/CC shall consider potential transfer of the active component alleged offender instead of the victim if appropriate. **(T-0).** Alleged offender reassignments are handled IAW AFI 36-2110. This requirement may be delegated to the WG/CV but not further.

8.3.6. Once an ET has been approved, the change of assignment is handled IAW AFI 36-2110.

8.3.7. The SARC or SAPR VA will assist sexual assault victims filing an Unrestricted Report with the SAPR Program IAW AFI 90-6001 and are not handled by FAP. **(T-1).**

8.4. The Air Force Domestic Violence and Child Maltreatment Fatality Review Board (FRB).

8.4.1. The FRB will convene annually to review fatalities and develop the annual report for submission to the Under Secretary of Defense for Personnel and Readiness (USD (P&R)) IAW DoDI 6400.06. **(T-0).**

8.4.2. Fatality reviews are conducted to assess homicides resulting from domestic abuse, child maltreatment, and maltreatment-related suicides. The AF FAP Clinical Director is responsible for coordinating and chairing the FRB. The FRB will include senior representatives from: Air Force Personnel Center, AF Security Forces, AF Chief of Chaplains, Military Domestic Abuse Victim Advocate, Office of Special Investigations, Forensic Child Abuse Pediatrician, Psychiatry or Family Medicine provider, ADAPT representative, CCF representative from the Office of the Chief Master Sergeant of the Air Force, the office of The Judge Advocate General, and AF FAP. **(T-0).**

8.4.3. AF FAP will request the FAP, ADAPT, MHC and electronic health records on all family members when there is a maltreatment related fatality in preparation for the FRB. **(T-0).** The Installation FAP staff will be responsible for securing and mailing copies of all available records to AF FAP. **(T-0).**

8.4.4. AF FAP will support fatality review efforts of Departments of Navy and Army by retrieving from the installation and forwarding Service HQs FAP the AF FAP records on Army, Marine or Navy families assigned to AF installations at the time of the fatality IAW DoDI 6400.06. **(T-0).**

8.5. Research and Program Evaluation.

8.5.1. The FAP sponsors targeted and system-wide research and program evaluation of the FAP prevention and intervention services. Research projects and quality assurance initiatives may be conducted through collaborative partnerships with military and civilian researchers who understand the unique needs of military families. The AF FAP oversees AF-wide FAP activities of program evaluation, accountability, and quality assurance, and provides consultation to MTF quality assurance activities. Projects are selected or sponsored based on their potential to inform and improve the FAP programs and practices in service of military families, or other healthcare delivery and military community readiness initiatives.

8.5.2. AF FAP maintains databases on prevention services provided, including NPSP, and on domestic abuse and child maltreatment cases IAW DoD guidance. AF FAP manages access to all data collected IAW DoD and AF requirements.

8.5.3. Statistical reports are generated from Central Registry, NPSP, and secondary prevention data to assess trends, respond to OSD, DoD, AF senior leaders, and media queries, and to support population-based health interventions, process outcomes, and compliance improvement.

8.5.4. The FAP clinical providers and FAPAs will consistently participate in the program evaluation initiatives mandated by AF FAP. **(T-1).** FAPAs will administer the Milner Questionnaire to adults in the household where a child maltreatment allegation is received and to adult FAST clients who present with parent-child issues at intake and again after treatment is complete, at case closure. **(T-1).** FAPAs will administer the Couples Satisfaction Index to adults who are referred for domestic abuse allegations and to adult FAST clients who present with couple-relational issues at intake and again after treatment is complete, at case closure. **(T-1).** The FAP providers will administer the 4-question outcome rating scale at the beginning of every therapy session and the 4-question session rating scale at the close of every therapy session (use in group therapy is optional). **(T-1).** The FAP provider will immediately discuss

with clients the scores on the outcome rating scale/session rating scale and record them on the myoutcomes.com database. **(T-1).**

8.6. Military Rule of Evidence.

8.6.1. The Military Rule of Evidence 513, Psychotherapist-Patient Privilege, protects confidential communications made to a psychotherapist or an assistant to a psychotherapist if the communication was made for the purpose of facilitating diagnosis or treatment of the patient's mental or emotional condition. Communications between FAP clinical providers and offenders or victims may be subject to this privilege. If records or testimony potentially subject to the privilege are sought, the FAP provider may assert the privilege on the patient's behalf and refuse to disclose the record. There is no privilege when the communication is evidence of child abuse or neglect, or in a proceeding in which one spouse is charged with a crime against a child of either spouse. Consult the installation SJA on all issues involving the psychotherapist-patient privilege. **(T-1).**

8.6.2. The Military Rule of Evidence 514: Victim Advocate – Victim Privilege. For cases arising under the UCMJ, the victim has the privilege to refuse to disclose and to prevent any other person from disclosing, any confidential communication made between the victim and a DAVA if the communication was made for the purpose of facilitating advice or assistance to the victim. The DAVA must make every attempt to ask the victim if they would like to invoke the privilege; however, if this is not possible, the DAVA can invoke the privilege on behalf of the victim. **(T-0).** DAVAs will consult with the FAO and the FAO will consult with the installation SJA on all issues involving the victim advocate – victim privilege. **(T-1).**

8.6.3. FAP maltreatment and prevention records are subject to the Privacy Act and HIPAA, and information will only be released IAW Federal laws, DoD, and AF Directives, to include the Privacy Act and HIPAA Privacy Rule, DoDI 6400.01, DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs,* DoDM 6400.01 Volume 1, DoDM 6400.01 Volume 2, and DoDI 6400.06. **(T-0).**

8.6.4. When a request for a FAP record is submitted to FAP by the subject(s) of the record, whether from a sponsor or other family member, information will not be released unless appropriate documentation is submitted and signed IAW DoDM 5400.07 or AFI 33-332. **(T-0).** The FAO will review all requests for information and consult with the office of the installation SJA or Medical Law Consultant. **(T-1).** Release authorities need to assess whether any information contained in the record has the potential to increase the risk of further maltreatment or be detrimental to the requester or other family members. If deemed necessary, and proper under applicable law and regulation, redaction of some material may be appropriate. If a local FAP or MTF OI is published on the topic, it should include procedures for release of FAP records with, at a minimum, the following elements:

8.6.4.1. Provider review of the entire FAP record.

8.6.4.2. Medical Law Consultant consultation and review.

8.6.4.3. Potential redaction of material properly withheld under applicable law.

8.6.4.4. A signed request or written authorization.

8.6.5. When a DoD investigatory agency, court, or other military or civilian agency, including Command authority, requests FAP information, the letter of request will be filed in the FAP, NPSP or FAST Services Record. **(T-1).** The letter of request will include: appropriate signature, the requesting agency case number (when applicable), and the purpose of the request for information (i.e., why the records are required). **(T-0).** All requests for FAP information will be forwarded to the installation SJA for determination of releasability. **(T-1).** When SJA gives FAP authority to release the FAP record, a copy may be offered to the requester. If the original record is removed from the FAP by proper authority, a copy of the record will be kept on file in the FAP office. **(T-1).** Only those records that are minimally required to meet the intended use will be disclosed. **(T-0).**

8.6.6. Information on adults may only be released to other adult family members when:

8.6.6.1. The adult family member concerned has provided written authorization for the release of information about him or herself IAW local MTF guidelines; or

8.6.6.2. The requested records cannot properly be withheld under applicable law. The FAO will review all requests for information and consult with the installation SJA, and all requests for FAP information will be forwarded to the installation SJA for their determination. **(T-1).**

8.6.7. The FAO will review the release of FAP information rules with the installation SJA annually. **(T-1).**

8.6.8. Clients can request release of information under the FOIA and/or Privacy Act. The Privacy Act covers records held by the government that are retrievable by an individual's name or personal identifier. FAP records are retrieved by the name and social security number of the sponsor and/or the sponsor's spouse. Having both spouse's names on the FAP record provides equal access to the information under the Privacy Act. When the record is labeled and retrieved by the non-active component member's name, it becomes a Privacy Act protected record for the non-active component member as well.

8.6.9. FAP records may be subject to exemptions from certain privacy protections under the Privacy Act Title 5 United States Code 552a(k)(2) and (5). The exemptions apply to investigatory material compiled for law enforcement purposes or for the purpose of determining suitability, eligibility or qualifications for employment. The exemptions are not absolute. Consult with your servicing legal office before claiming an exemption.

8.6.10. Information is releasable if both adults give written consent to release the information or when a proper subpoena or order signed by a judge is presented from a court of competent jurisdiction. Anytime FAP receives a subpoena it should be immediately forwarded to the installation SJA for advisement.

8.7. Criminal Convictions. If or when FAP is notified of a Civilian (Federal, State, or Local) conviction for a crime of domestic violence, the FAO will provide notification of the conviction to the Air Force Indexing Cell via encrypted email: AF-CJIC (**AF.CJIC@us.af.mil**). **(T-0).** The notification must be accompanied by a copy of the completed court results of trial showing the conviction for entry into the NICS. **(T-0).**

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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DoDM 6400.01, Volume 2, *Family Advocacy Program (FAP): Child Abuse and Domestic Abuse Incident Reporting System*, 11 August 2016

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The Joint Travel Regulations (JTR), Uniformed Service Members and DoD Civilian Employees, 1 August 2019

10 U.S.C. § 928b: Art.128b, *Domestic Violence*

10 U.S.C. § 9013, *Secretary of the Air Force*

2014 National Defense Authorization Act, Section 1743

Prescribed Forms

AF Form 2522, *Family Advocacy Program Intake*

AF Form 4400, *New Parent Support Program, How Can We Help - Father*

AF Form 4401, *New Parent Support Program, How Can We Help - Mother*

AF Form 4402, *Family Advocacy Informed Consent - Prevention*

AF Form 4403, *New Parent Support Program (NPSP), Family Information Form*

AF Form 4404, *Family Advocacy Program Referral Form*

AF Form 4405, *Family Advocacy Program (FAP) Client Information Form Maltreatment Intervention Services*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

DD Form 2873, *Military Protective Order (MPO)*

Abbreviations and Acronyms

ADAPT—Alcohol and Drug Abuse Prevention and Treatment

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMRA—Air Force Medical Readiness Agency

AFOSI—Air Force Office of Special Investigation

AFPC—Air Force Personnel Center

AFRC—Air Force Reserve Command

AHT—Abusive Head Trauma

ANG—Air National Guard

AO—Alleged Offender

CAB—Community Action Board

CAN/DA—Child Abuse Neglect or Domestic Abuse

CAT—Community Action Team

CC—Commander

CCC—Command Chief Master Sergeant

CCF—First Sergeant

CCIR—Commander's Critical Information Requirement

CCS—Clinical Case Staffing

CPO—Civilian Protective Order

CPS—Child Protective Services

CRB—Central Registry Board

CSC—Community Support Coordinator

CSMRT—Child Sexual Maltreatment Response Team

C-SSRS—Columbia-Suicide Severity Rating Scale

DAVA—Domestic Abuse Victim Advocate

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDEA—Department of Defense Education Activity

DoDI—Department of Defense Instruction

DoDM—Department of Defense Manual

EFMP—Exceptional Family Member Program

EHR—Electronic Health Record

EPC—Emergency Placement Care

ET—Expedited Transfer

FAC—Family Advocacy Committee

FACAT—Family Advocacy Command Assistance Team

FAIS—Family Advocacy Intervention Specialist

FAN—Family Advocacy Nurse

FAO—Family Advocacy Officer

FAOM—Family Advocacy Outreach Manager

FAP—Family Advocacy Program

FAPA—Family Advocacy Program Assistant

FAPNet—Family Advocacy Program Network

FASOR—Family Advocacy System of Records

FAST—Family Advocacy Strength-based Therapy

FATM—Family Advocacy Treatment Manager

FNS—Family Needs Screener

FOIA—Freedom of Information Act

FTT—Failure to Thrive

HIPAA—Health Insurance Portability and Accountability Act

HRVRT—High Risk for Violence Response Team

IAW—In Accordance With

ISD—Incident Status Determination

ISDR—Incident Status Determination Review

MAJCOM—Major Command

MH—Mental Health

MHC—Mental Health Clinic

MOU—Memorandum of Understanding

MPO—Military Protective Order

MTF—Military Treatment Facility

NAW—No Assessment Warranted

NPSP—New Parent Support Program

OCONUS—Outside Continental United States

OPR—Office of Primary Responsibility

OPREP—Operational Reporting

OSD—Office of the Secretary of Defense

PCS—Permanent Change of Station

PPMC—Prevention Planning and Management Council

PSB-CY—Problematic Sexual Behavior in Children and Youth

RR—Restricted Reporting

SAPR—Sexual Assault Prevention and Response

SAPR VA—Sexual Assault Prevention and Response Victim Advocate

SARC—Sexual Assault Response Coordinator

SBS—Shaken Baby Syndrome

SFS—Security Forces Squadron

SG—Surgeon General

SJA—Staff Judge Advocate

SPaCE—Secondary Prevention and Client Engagement

SQ/CC—Squadron Commander

SVC—Special Victims Counsel

UR—Unrestricted Reporting

USAF—United States Air Force

USC—United States Code

VPI—Violence Prevention Integrator

VWAP—Victim Witness Assistance Program

Terms

Change Step—A curriculum for treatment of adult males who are domestically abusive to their intimate partner or spouse. Twelve topic areas are covered in group or individual treatment. Group treatment typically consists of 18-24 weekly sessions. Change Step treatment is provided by AF FAP licensed social workers who have received training from the Domestic Abuse Project (DAP) to facilitate Change Step. When there are 2 group facilitators, the primary facilitator must have the DAP training. If the co-facilitator is not DAP-trained, he or she cannot lead the group alone.

Child—An unmarried person under 18 years of age for whom a parent, guardian, foster parent, caregiver, employee of a residential facility, or any staff person providing out-of-home care is

legally responsible. A biological child, adopted child, stepchild, foster child, ward, a sponsor's family member (except the sponsor's spouse) of any age who is incapable of self-support because of a mental or physical incapacity, and for whom treatment in a DoD medical treatment program is authorized.

Child Abuse—The physical or sexual abuse, emotional abuse, or neglect of a child by a parent, guardian, foster parent, or by a caregiver, whether the caregiver is intra-familial or extra-familial, under circumstances indicating the child's welfare is harmed or threatened. Such acts by a sibling, other family member, or other person shall be deemed to be child abuse only when the individual is providing care under express or implied agreement with the parent, guardian, or foster parent.

Did Not Meet Criteria—The status of a child or partner maltreatment incident wherein the preponderance of the evidence indicates the incident does not meet DoD-established criteria for abuse or neglect..

DoD-sanctioned Activity—A U.S. Government activity or a nongovernmental activity authorized by appropriate DoD officials to perform supervisory functions over programs that provide care and supervision of children or youth on DoD controlled property. The care and supervision of children or youth may be either its primary function or incidental in carrying out another mission (e.g., medical care). Examples include child development centers, DoD dependents schools, or youth activities, school age latch key programs, family child care providers, and child care services that may be conducted as a part of a chaplain's program or as part of another morale, welfare, or recreation program.

Domestic Abuse—Domestic violence or a pattern of behavior resulting in emotional or psychological abuse, economic control, and/or interference with personal liberty that is directed toward a person who is a: Current or former spouse. Person with whom the alleged abuser shares a child in common. Current or former intimate partner with whom the alleged abuser shares or has shared a common domicile. Person who is or has been in a social relationship of a romantic or intimate nature with the accused and determined to be an intimate partner (as defined in this issuance).

Domestic Abuse Victim Advocate—A FAP staff member who provides domestic abuse victim advocacy services to victims of domestic abuse.

Domestic Abuse Victim Advocacy Services—Services that are offered to victims of domestic abuse with the goal of increasing victim safety and autonomy. Services shall include, but not necessarily be limited to, responding to victims' emergency and ongoing safety concerns and needs, providing information about programs and services available to victims and their children both in the civilian and military communities, and providing victims with ongoing support and referrals.

Domestic Violence—An offense under the United States Code or the Uniform Code of Military Justice, violation of Article 128b, Section 928b of Title 10, U.S.C. or State law, any person who: (1) Commits a violent offense against a spouse, an intimate partner, or an immediate family member of that person; (2) With intent to threaten or intimidate a spouse, an intimate partner, or an immediate family member of that person: (a) Commits an offense under this chapter against any person; or (b) Commits an offense under this chapter against any property, including an animal; (c) With intent to threaten or intimidate a spouse, an intimate partner, or an immediate family member of that person, violates a protection order; (d) With intent to commit a violent

offense against a spouse, an intimate partner, or an immediate family member of that person, violates a protection order; or (e) Assaults a spouse, an intimate partner, or an immediate family member of that person by strangling or suffocating; shall be punished as a court-martial may direct.

Family—For the purpose of defining eligibility for the FAP services, includes spouse or intimate partner of an active component member, and dependent child(ren). (Intimate partners and their children who are non-beneficiaries are eligible for the FAP assessment, safety planning and referrals to local community resources).

Family Advocacy Automation Systems—Combination of Family Advocacy Systems of Records (FASOR) and FAP Network (FAPNet) to implement, monitor, and manage the Program.

HealthCare Provider—Someone who provides direct healthcare services to military health system beneficiaries in military medical treatment facilities.

Household Member—An individual who lives in the home as part of the family or a member of the extended family who is staying in the home for longer than a brief visit.

Intervention—An activity, process, event, or system that is designed to correct a problem, change a situation or improve a condition. Professional FAP staff plan and develop a broad range of intervention strategies from preventing maltreatment to direct clinical treatment.

Intimate Partner—A person who is or has been in a social relationship of a romantic or intimate nature with the accused, as determined by the length of the relationship, the type of relationship, and the frequency of interaction between the person and the accused. An intimate partner is informed by, but not limited to these factors: (a) Consensual intimate or sexual behaviors.

(b) History of ongoing dating or expressed interest in continued dating or the potential for an ongoing relationship (e.g. history of repeated break-ups and reconciliations). (c) Self-identify by the victim or alleged abuser as intimate partners or identified by others as a couple. (d) Emotional connectedness (e.g. relationship is a priority, partners may have had discussed a future together).

(e) Familiarity and knowledge of each other's lives.

Intimate Partner Physical Injury Risk Assessment Tool—An actuarial tool that predicts the risk of future physical injury due to domestic abuse. This tool was developed by DoD FAP in collaboration with family violence researchers at Kansas State University and Northern Illinois University (Stith and Milner) and is mandatory for use across DoD FAP.

Maltreatment—A general term encompassing child abuse or neglect and partner abuse or spouse neglect.

Maltreatment Clinical Intervention—Direct clinical services to families identified as experiencing maltreatment. Also called tertiary prevention in some references.

Met Criteria—The status of a child or partner maltreatment report or incident. This is an administrative term rather than legal definition and means the preponderance of evidence in a report or incident indicates that it meets specified DoD criteria for abuse or neglect.

Outreach—Activities in support of maltreatment prevention. Usually provided by the Outreach Program Manager and take the form of primary and secondary prevention activities. Does not include tertiary prevention (usually referred to as maltreatment intervention).

Prevention—Activities with and for families undertaken prior to the report of abuse. May be primary prevention (activities for all families) or secondary prevention (activities for families identified to be at risk for maltreatment).

Problematic Sexual Behavior in Children and Youth—Behaviors initiated by children and youth under the age of 18 that involve sexual body parts (genitals, anus, buttocks, or breasts) in a manner that deviates from normative or typical sexual behavior and are developmentally inappropriate or potentially harmful to the individual initiating the behavior, the individual(s) impacted by the behavior or others. Sexual behaviors initiated by a child or youth under the age of 18 are more likely to deviate from normative or typical sexual behavior and be developmentally inappropriate and/or potentially harmful when they are characterized by one or more of the following:

- Occur at a higher frequency than is typical given the child's or youth's age and development.

Are preoccupying or are a greater focus of the child's or youth's interactions and interests than other behaviors.
Interfere with the child's or youth's social development and/or general functioning.
Do not respond to caregiver or other adult intervention.
Involve sexual knowledge, language and/or behaviors that are inappropriate for the child's or youth's chronological or developmental age.
Include aggression, force, threats, or coercion.
Include intrusive sexual behavior, such as penetration.
Are deliberative rather than spontaneous or exploratory in nature.
Include alcohol or other mind-altering substances.
Involve aggressive or violent pornography.
Engender strong upset feelings in any other child or youth involved in the behaviors.
Are non-mutual.
Occur between children or youth who are distinct in terms of age, cognitive, social, and/or physical development or otherwise demonstrate developmental inequalities.

Reasonable Suspicion—Available information is sufficient to cause an objective individual to believe that maltreatment may have occurred by acts of commission or omission.

Sexual Assault Response Coordinator—The single point of contact at an installation or within a geographic area who oversees sexual assault awareness, prevention, and response training; coordinates medical treatment, including emergency care for eligible sexual assault victims identified in policy; and tracks the services provided, from the initial report through final disposition and resolution.

Sexual Assault Prevention and Response Program—A program that reinforces the Air Force's (AF) commitment to prevention through the development, implementation and assessment of policies and programs to prevent and respond to sexual assault. Installation SARCs implement the SAPR Program and provide 24-hour response to non-intimate partner sexual assault victims

Sexual Assault Prevention and Response Victim Advocate—A trained, certified individual that provides non-clinical crisis intervention, referral, and ongoing non-clinical support to adult sexual assault victims. The SAPR VA, on behalf of the sexual assault victim, provides liaison assistance

with other organizations and agencies on victim care matters and reports directly to the Sexual Assault Response Coordinator (SARC) when performing victim advocacy duties.

Significant Clinical Observation—Indicators of possible physical or psychological conditions requiring medical assessment, treatment, or follow-up, and/or high risk for harm indicators, to include Suicidal Ideation or Homicidal Ideation.

Trauma Informed—An approach to services that, in alignment with the Substance Abuse and Mental Health Services Administration's definition, acknowledges the widespread impact of trauma and understands the potential paths for recovery. Such an approach recognizes signs and symptoms of trauma in clients and families and factors this knowledge and awareness into procedures, assessment processes, care delivery, etc. to actively resist re-traumatization.

Triennial Review—A complete review of an existing support agreement conducted at intervals of no more than three years.

Vista—A curriculum for treatment of adult females who are domestically abusive to their intimate partner or spouse or abusive to their child(ren). Twenty topic areas are covered in group or individual treatment. Group treatment typically consists of 20 weekly sessions. Vista treatment is provided by AF FAP licensed social workers who have received training from the Course developer, Lisa Larance, to facilitate Vista. When there are 2 group facilitators, the primary facilitator must have the Vista training. If the co-facilitator is not Vista-trained, he or she cannot lead the group alone.

Attachment 2

EXAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN THE [FIRST PARTY (INSTALLATION)] AND THE [SECOND PARTY (VICTIM ADVOCACY SERVICES AGENCY)] FOR (INSERT SUBJECT) AGREEMENT NUMBER

This is a Memorandum of Understanding (MOU) between the (INSTALLATION) and the (VICTIM ADVOCACY SERVICE AGENCY). When referred to collectively, the (INSTALLATION) and the (VICTIM ADVOCACY SERVICE AGENCY) are referred to as the "Parties".

A2.1. BACKGROUND: This Memorandum of Understanding (MOU) does not create additional jurisdiction or limit or modify existing jurisdiction vested in the parties. This MOU provides guidance and documents an agreement for general support between (INSTALLATION) and (VICTIM ADVOCACY SERVICES AGENCY).

A2.2. PURPOSE: To establish a written agreement between (INSTALLATION) and (VICTIM ADVOCACY SERVICES AGENCY) defining procedures for the coordination of emergency shelter, safe housing, medical services, support, and referral services for victims of domestic violence who are eligible for military medical treatment.

A2.3. UNDERSTANDING OF THE PARTIES:

A2.3.1. The (INSTALLATION) agrees to the following provisions:

A2.3.1.1. When responding to or investigating domestic violence cases or providing medical or other services for domestic violence victims, personnel from Security Forces Squadron (SFS), Air Force Office of Special Investigations (AFOSI) Detachment, Family Advocacy Program (FAP) personnel, and military treatment facility (MTF) personnel shall provide victims of domestic violence with basic referral information for (VICTIM ADVOCACY SERVICES AGENCY), including telephone hotline number and a general description of the shelter, support and victim advocacy services offered by that organization.

A2.3.1.2. When a victim of domestic violence determines that he or she would like to seek shelter at (VICTIM ADVOCACY SERVICES AGENCY) or meet with (VICTIM ADVOCACY SERVICES AGENCY) staff regarding other victim advocacy services, transportation to the shelter shall be arranged, when necessary, from the SFS or local law enforcement.

A2.3.1.3. **(INSTALLATION)** will work with the FAP to publicize resources available through the (VICTIM ADVOCACY SERVICES AGENCY) and how victims can access those services.

A2.3.1.4. The FAP will provide training to (VICTIM ADVOCACY SERVICES AGENCY) staff, as needed, on the resources available to victims of domestic violence through the FAP and through other programs and agencies located on (INSTALLATION).

A2.3.1.5. Access will be provided to (INSTALLATION) for (VICTIM ADVOCACY SERVICES AGENCY) staff providing services to military victims of domestic violence.

A2.3.2. The (DOMESTIC VIOLENCE SHELTER) agrees to the following provisions:

A2.3.2.1. When (VICTIM ADVOCACY SERVICES AGENCY) receives a referral from (INSTALLATION) at the request of a victim, or when (VICTIM ADVOCACY SERVICES AGENCY) identifies a victim of domestic violence as an individual eligible for military medical treatment, (VICTIM ADVOCACY SERVICES AGENCY) will provide the same services to that victim as it provides to all other clients, IAW the victim's wishes and needs. Services provided by (VICTIM ADVOCACY SERVICES AGENCY) include: [A detailed list of specific services offered by the shelter can be inserted here.]

A2.3.2.2. When (VICTIM ADVOCACY SERVICES AGENCY) receives a referral from (INSTALLATION) or when (VICTIM ADVOCACY SERVICES AGENCY) identifies a victim of domestic violence as an individual eligible for military medical treatment, (VICTIM ADVOCACY SERVICES AGENCY) staff shall provide that victim with information regarding the FAP and other resources available to victims of domestic violence on (INSTALLATION). (VICTIM ADVOCACY SERVICES AGENCY) staff shall also inform victims that they are not excused from work related responsibilities, or, if an active component member, from duty or from complying with unit recall notification policies while staying at (VICTIM ADVOCACY SERVICES AGENCY).

A2.3.2.3. **(VICTIM ADVOCACY SERVICES AGENCY)** staff will work with the FAP to train base staff, including, but not limited to, personnel from the SFS, AFOSI, FAP, Special Victims' Counsel (SVC), and MTF, on resources available through the (VICTIM ADVOCACY SERVICES AGENCY) and how victims can access those services.

A2.3.3. Privacy Interests:

A2.3.3.1. Victim's information will be maintained IAW the Privacy Act Title 5 United States Code 552a(k)(2) and (5).

A2.3.3.2. The (VICTIM ADVOCACY SERVICES AGENCY) shall not disclose the victim's identity and/or specifics about the victim's circumstances to (INSTALLATION) personnel, including, but not limited to, the FAP staff , SFS, or AFOSI Detachment without the written consent of the victim, unless otherwise required to do so by state or federal law. A victim must sign an authorization for the Release of Information prior to the exchange of any information regarding that victim. Once the "Release of Information Form" has been signed, information shall be exchanged for the purposes of referral, treatment, and intervention planning and coordination efforts.

A2.3.3.3. The victim's identity and/or specifics about the victim's circumstances shall not be disclosed by (INSTALLATION) personnel, including, but not limited to, the FAP staff, SFS, or to the (VICTIM ADVOCACY SERVICES AGENCY) without the written consent of the victim, unless otherwise required to do so by state or federal law. A victim must sign a "Release of Information Form" prior to the exchange of any information regarding that victim. Once the "Release of Information Form" has been signed, information shall be exchanged for the purposes of referral, treatment and intervention planning and coordination efforts.

A2.3.3.4. Copies of original signed "Release of Information Forms" shall be kept on file with the initiating organization and a copy will be transmitted to the receiving party.

A2.3.3.5. **(VICTIM ADVOCACY SERVICES AGENCY)** shall provide non-identifying statistical information to (INSTALLATION) regarding the victims to whom it provides services on a (PERIODIC) basis.

A2.3.3.6. Personnel from the (INSTALLATION) and (VICTIM ADVOCACY SERVICES AGENCY) shall meet, as necessary and appropriate, to share information regarding individual cases after having received signed "Release of Information Forms" from the victims and to generally discuss and review quality of services provided to victims.

A2.4. PERSONNEL: Each Party is responsible for all costs of its personnel, including pay and benefits, support, and travel. Each party is responsible for supervision and management of its personnel.

A2.5. GENERAL PROVISIONS:

A2.5.1. POINTS OF CONTACT: The following points of contact will be used by the Parties to communicate in the implementation of this MOU. Each Party may change its point of contact upon reasonable notice to the other Party.

A2.5.1.1. For the (INSTALLATION)

A2.5.1.1.1. Primary:

A2.5.1.1.2. Alternate:

A2.5.1.2. For the (VICTIM ADVOCACY SERVICES AGENCY)

A2.5.1.2.1. Primary:

A2.5.1.2.2. Alternate:

A2.5.2. CORRESPONDECE: All correspondence to be sent and notices to be given pursuant to this MOU will be addressed, if to the (INSTALLATION), to:

A2.5.2.1. (INSTALLATION mailing address and email address)

And, if to the (VICTIM ADVOCACY SERVICES AGENCY), to:

A2.5.2.2. (VICTIM ADVOCACY SERVICES AGENCY mailing address and email address)

A2.6. FUNDS AND MANPOWER: This MOU does not document nor provide for the exchange of funds or manpower between the Parties nor does it make any commitment of funds resources.

A2.7. MODIFICATION OF MOU: This MOU may only be modified by the written agreement of the Parties, duly signed by their authorized representatives. This MOU will be reviewed annually on or around the anniversary of its effective date, and triennially in its entirety.

A2.8. DISPUTES: Any disputes relating to this MOU will, subject to any applicable law, Executive order, directive, or instruction, be resolved by consultation between the Parties or IAW AFI 25-201, *Intra- Service, Intra-Agency, and Inter-Agency Support Agreement Procedures.*

A2.9. TERMINATION OF UNDERSTANDING: This MOU may be terminated in writing at will by either Party.

A2.10. TRANSFERABILITY: This MOU is transferable except with the written consent of the Parties.

A2.11. ENTIRE UNDERSTANDING: It is expressly understood and agreed that this MOU embodies the entire understanding between the Parties regarding the MOU's subject matter.

A2.12. EFFECTIVE DATE: This MOU takes effect beginning on the day after the last Party signs.

A2.13. EXPIRATION DATE: This MOU expires on _____.

A2.14. CANCELLATION OF PREVIOUS MOU: This MOU cancels and supersedes the previously signed MOU between the same parties with the subject _____, Serial # _____ and effective date of _____. [use only when needed to cancel a previous MOU]

A2.15. APPROVED: [APPROVAL AUTHORITY SIGNATURES WILL NEVER BE ALONE ON A BLANK PAGE]

_____	_____
FOR THE (INSTALLATION) SERVICES AGENCY)	FOR THE (VICTIM ADVOCACY
_____	_____
(Date)	(Date)

Attachment 3

EXAMPLE MEMORANDUM OF UNDERSTANDING BETWEEN THE [FIRST PARTY (INSTALLATION STAFF JUDGE ADVOCATE (SJA)] AND THE [SECOND PARTY (COUNTY/CITY) DISTRICT ATTORNEY'S OFFICE)] FOR (INSERT SUBJECT) AGREEMENT NUMBER

This is a Memorandum of Understanding (MOU) between the (INSTALLATION STAFF JUDGE ADVOCATE) and the ((COUNTY/CITY) DISTRICT ATTORNEY'S OFFICE). When referred to collectively, the (INSTALLATION STAFF JUDGE ADVOCATE AND (COUNTY/CITY) DISTRICT ATTORNEY'S OFFICE) are referred to as the "Parties".

A3.1. BACKGROUND: This Memorandum of Understanding (MOU) does not create additional jurisdiction or limit or modify existing jurisdiction vested in the parties. This MOU is intended exclusively to provide guidance and documents an agreement for general support between the (INSTALLATION SJA) base legal office and the (COUNTY/CITY) DA. Nothing contained herein creates or extends any right, privilege, or benefit to any person or entity. A [Insert paragraph here defining jurisdiction for both the (INSTALLATION SJA) base legal office and (COUNTY/CITY) DA.]

A3.2. PURPOSE: To establish written procedures concerning the exchange of information, case investigation and prosecution, and coordination of efforts and assets between the (INSTALLATION Staff Judge Advocate (SJA) and the (COUNTY/CITY) District Attorney (DA) in domestic violence cases involving active component members assigned to the (INSTALLATION) and their family members, including unmarried intimate partners.

A3.3. UNDERSTANDING OF THE PARTIES:

A3.3.1. The (COUNTY/CITY) DA agrees to perform the following actions:

A3.3.1.1. When the victim in a domestic violence incident has been identified as an active component member assigned to (INSTALLATION) or a family member or unmarried intimate partner of one, the (COUNTY/CITY) DA shall provide the victim with basic information, acquired from the (INSTALLATION) base legal office (below), about (INSTALLATION) resources available to domestic violence victims.

A3.3.1.2. When investigating or prosecuting domestic violence cases, the (COUNTY/CITY) DA shall determine whether the alleged offender is an active component member assigned to (INSTALLATION). If the alleged offender is an active component member assigned to (INSTALLATION), the (COUNTY/CITY) DA shall contact the (INSTALLATION) legal office to inform the assigned (INSTALLATION) legal office of the pending investigation or prosecution. Upon request, the (COUNTY/CITY) DA shall forward copies of relevant police reports, civil protection orders, and any orders specifying pre-trial conditions to the (INSTALLATION) legal office.

A3.3.1.3. When investigating a domestic violence case involving an active component member assigned to (INSTALLATION) who is alleged to be the offender, the (COUNTY/CITY) DA shall consult with the (INSTALLATION) legal office, and the victim in cases alleging sexual assault, with respect to prosecution of the individual under the appropriate state law or under the Uniform Code of Military Justice (UCMJ).

A3.3.1.4. During the course of the (COUNTY/CITY) DA's investigation or prosecution of a crime of domestic violence allegedly committed by an active component member assigned to (INSTALLATION), the (COUNTY/CITY) DA shall keep the (INSTALLATION) legal office informed of the status of the case through regular contacts. The (COUNTY/CITY) DA shall notify the (INSTALLATION) legal office specifically of any changes in confinement status or pre-trial release conditions.

A3.3.1.5. When, after consultation, the (INSTALLATION) legal office and the (COUNTY/CITY) DA have determined that the alleged offender will be subject to procedures under the UCMJ, the (COUNTY/CITY) DA shall cooperate during the investigation and disciplinary action to the greatest extent possible by sharing information and facilitating the interviewing of witnesses.

A3.3.1.6. As new attorneys begin working in the (COUNTY/CITY) DA Office, their immediate supervisor will provide them with copies of this MOU and basic instructions for executing the provisions of this MOU.

A3.3.2. The (INSTALLATION) legal office agrees to perform the following actions:

A3.3.2.1. The (INSTALLATION) legal office shall provide the (COUNTY/CITY) DA with basic information, in the form of quick reference cards or brochures, about (INSTALLATION) resources available to domestic violence victims.

A3.3.2.2. When investigating a domestic violence case involving an active component member assigned to (INSTALLATION) who is alleged to be the offender, the (INSTALLATION) legal office shall, in cases where the state has jurisdiction, consult with the (COUNTY/CITY) DA to determine whether the individual will be prosecuted under the appropriate state law or whether the command will pursue disciplinary action under the UCMJ.

A3.3.2.3. Upon request, the (INSTALLATION) legal office shall forward copies of relevant police incident reports and military protection orders to the (COUNTY/CITY) DA.

A3.3.2.4. When, after consultation, the (COUNTY/CITY) DA and the (INSTALLATION) legal office have decided that the alleged offender will be prosecuted under state law, the (INSTALLATION) legal office shall cooperate during the investigation and prosecution to the greatest extent possible by sharing information and facilitating the interviewing of witnesses.

A3.3.2.5. As new personnel begin duty with the (INSTALLATION) bas legal office, their immediate supervisor will provide them with copies of this MOU and basic information on executing the provisions of this MOU. All actions by the Installation SJA office will be in compliance with AFI 51-201.

A3.4. PERSONNEL: Each Party is responsible for all costs of its personnel, including pay and benefits, support, and travel. Each party is responsible for supervision and management of its personnel.

A3.5. GENERAL PROVISIONS:

A3.5.1. POINTS OF CONTACT: The following points of contact will be used by the Parties to communicate in the implementation of this MOU. Each Party may change its point of contact upon reasonable notice to the other Party.

A3.5.1.1. For the (INSTALLATION) SJA

A3.5.1.1.1. Primary:

A3.5.1.1.2. Alternate:

A3.5.1.2. For the (COUNTY/CITY) DA

A3.5.1.2.1. Primary:

A3.5.1.2.2. Alternate:

A3.5.2. CORRESPONDECE: All correspondence to be sent and notices to be given pursuant to this MOU will be addressed, if to the (INSTALLATION SJA), to:

A3.5.2.1. (INSTALLATION SJA mailing address and email address)

And, if to the (VICTIM ADVOCACY SERVICES AGENCY), to:

A3.5.2.2. **(COUNTY/CITY)** DA mailing address and email address)

A3.6. FUNDS AND MANPOWER: This MOU does not document nor provide for the exchange of funds or manpower between the Parties nor does it make any commitment of funds resources.

A3.7. MODIFICATION OF MOU: This MOU may only be modified by the written agreement of the Parties, duly signed by their authorized representatives. This MOU will be reviewed annually on or around the anniversary of its effective date, and triennially in its entirety.

A3.8. DISPUTES: Any disputes relating to this MOU will, subject to any applicable law, Executive order, directive, or instruction, be resolved by consultation between the Parties or IAW AFI 25-201.

A3.9. TERMINATION OF UNDERSTANDING: This MOU may be terminated in writing at will by either Party.

A3.10. TRANSFERABILITY: This MOU is transferable except with the written consent of the Parties.

A3.11. ENTIRE UNDERSTANDING: It is expressly understood and agreed that this MOU embodies the entire understanding between the Parties regarding the MOU's subject matter.

A3.12. EFFECTIVE DATE: This MOU takes effect beginning on the day after the last Party signs.

A3.13. EXPIRATION DATE: This MOU expires on _____.

A3.14. CANCELLATION OF PREVIOUS MOU: This MOU cancels and supersedes the previously signed MOU between the same parties with the subject _____, Serial # _____ and effective date of _____. [use only when needed to cancel a previous MOU]

A3.15. APPROVED: [APPROVAL AUTHORITY SIGNATURES WILL NEVER BE ALONE ON A BLANK PAGE]

_____	_____
FOR THE (INSTALLATION SJA)	FOR THE (COUNTY/CITY DA)
_____	_____
(Date)	(Date)

Attachment 4

EXAMPLE OF MEMORANDUM OF UNDERSTANDING BETWEEN THE [FIRST PARTY (INSTALLATION LAW ENFORCEMENT OFFICE)] AND THE [SECOND PARTY (CITY, COUNTY OR STATE) LAW ENFORCEMENT AGENCY] FOR (INSERT SUBJECT) AGREEMENT NUMBER

This is a Memorandum of Understanding (MOU) between the (INSTALLATION LAW ENFORCEMENT OFFICE) and the ((CITY, COUNTY OR STATE) LAW ENFORCEMENT AGENCY). When referred to collectively, the (INSTALLATION LAW ENFORCEMENT OFFICE) and the ((CITY, COUNTY OR STATE) LAW ENFORCEMENT AGENCY) are referred to as the "Parties".

A4.1. BACKGROUND: This Memorandum of Understanding (MOU) does not create additional jurisdiction or limit or modify existing jurisdiction vested in the parties. This MOU is intended exclusively to provide guidance and documents an agreement for general support between the (INSTALLATION) Law Enforcement Office and (CITY, COUNTY, or STATE) Law Enforcement Agency. Nothing contained herein creates or extends any right, privilege, or benefit to any person or entity.

A4.1.1. [Insert paragraph here defining response and investigation jurisdiction for the (INSTALLATION) Law Enforcement Office and (CITY, COUNTY, or STATE) Law Enforcement Agency.]

A4.2. PURPOSE: To establish written procedures concerning the exchange of information, case investigation, cases involving civilian alleged offenders, jurisdiction, and coordination of efforts and assets between the (INSTALLATION) Law Enforcement Office and (CITY, COUNTY, or STATE) Law Enforcement Agency in domestic violence cases involving active component members assigned to the (INSTALLATION) and their family members or unmarried intimate partners.

A4.3. UNDERSTANDING OF PARTIES:

A4.3.1. The (CITY, COUNTY, or STATE) Law Enforcement Agency agrees to perform the following actions:

A4.3.1.1. When responding to or investigating domestic violence cases, the (CITY, COUNTY, or STATE) Law Enforcement Agency will ascertain whether the alleged offender is an active component member assigned to (INSTALLATION). If the alleged offender is an active component member assigned to (INSTALLATION), the responding officer(s) will note on the top of the incident/investigation report "Copy to the (INSTALLATION) Law Enforcement Office" and the designated records personnel will ensure the copy is forwarded.

A4.3.1.2. When responding to or investigating domestic violence cases, the (CITY, COUNTY OR STATE) Law Enforcement Agency will ascertain whether the victim is an active component member assigned to (INSTALLATION). If the victim is an active component member assigned to the (INSTALLATION), the responding officer(s) will seek the victim's consent to forward a copy of the incident/investigation report to the (INSTALLATION) Law Enforcement Office so that it can be provided to the victim's

(INSTALLATION) CC. If the victim so consents, the responding officer(s) will note on the top of the incident/investigation report "Copy to the (INSTALLATION) Law Enforcement Office" and the designated records personnel will ensure the copy is forwarded. If the victim does not consent, the responding officer(s) shall note in the body of the incident/investigation report that the victim did not consent to forwarding the report to the (INSTALLATION) Law Enforcement Office and shall not direct records personnel to forward the report.

A4.3.1.3. When the (CITY, COUNTY, or STATE) Law Enforcement Agency receives a copy of a temporary or permanent civil protection order (CPO) issued by a court of competent jurisdiction, the responding officer(s) will ascertain whether the alleged offender is an active component member assigned to (INSTALLATION). If the alleged offender is an active component member assigned to (INSTALLATION), the responding officer(s) will note on top of the CPO "Copy to the (INSTALLATION) Law Enforcement Office" and the designated records personnel will ensure the copy is forwarded. [This paragraph may not be necessary if the (INSTALLATION) has an MOU with the (CITY, COUNTY, or STATE) local court specifying that the (CITY, COUNTY, or STATE) local court will forward copies of such CPOs to the assigned to the (INSTALLATION).]

A4.3.1.4. When the (CITY, COUNTY, or STATE) Law Enforcement Agency receives a copy of a temporary or permanent CPO, the responding officer(s) will ascertain whether the victim is an active component member assigned to (INSTALLATION). If the victim is an active component member assigned to (INSTALLATION), the responding officer(s) will seek the victim's consent to forward a copy of the CPO to the (INSTALLATION) Law Enforcement Office. If the victim so consents, the responding officer(s) will note on the top of the CPO "Copy to the (INSTALLATION) Law Enforcement Office" and the designated records personnel will ensure the copy is forwarded. If the victim does not consent, the responding officer(s) shall not request that a copy of the CPO be forwarded to the (INSTALLATION) Law Enforcement Office.

A4.3.1.5. The (CITY, COUNTY, or STATE) Law Enforcement Agency shall designate an employee from records who will be directly responsible for forwarded copies of incident/investigation reports and CPOs to the (INSTALLATION) Law Enforcement Office when directed to do so by notations at the top of the reports or CPOs. The employee shall also be responsible for receiving and processing military protection orders (MPOs) forwarded from the (INSTALLATION) Law Enforcement Office.

A4.3.1.6. When the (CITY, COUNTY, or STATE) Law Enforcement Agency becomes aware of a violation of a term or provision of an MPO, the responding officer(s) shall notify the designated representative from the (INSTALLATION) Law Enforcement Office of the violation.

A4.3.1.7. The (CITY, COUNTY, or STATE) Law Enforcement Agency shall provide the (INSTALLATION) Law Enforcement Office with an area for (INSTALLATION) Law Enforcement Investigators to conduct interviews of active component members assigned to (INSTALLATION) and their family members or unmarried intimate partners who are involved in domestic violence incidents.

A4.3.1.8. The (CITY, COUNTY, or STATE) Law Enforcement Agency will, when appropriate, conduct joint investigations with the (INSTALLATION) Law Enforcement

Office if incidents of domestic violence involve active component members assigned to (INSTALLATION) and their family members or unmarried intimate partners.

A4.3.1.9. When the victim in a domestic violence incident has been identified as an active component member assigned to (INSTALLATION) or a family member or unmarried intimate partner of one, the (CITY, COUNTY, or STATE) Law Enforcement Agency responding officer(s) shall provide the victim with basic information, acquired from the (INSTALLATION) Law Enforcement Office (below), about (INSTALLATION) resources available to domestic violence victims.

A4.3.1.10. As new law enforcement officers begin duty with the (CITY, COUNTY, or STATE) Law Enforcement Agency, their immediate supervisor will provide them with copies of this MOU and basic instructions for effectuating the provisions of this MOU.

A4.3.2. The (INSTALLATION) Law Enforcement Office agrees to perform the following actions:

A4.3.2.1. The (INSTALLATION) Law Enforcement Office shall designate an individual to act as liaison to the (CITY, COUNTY, or STATE) Law Enforcement Agency and to receive copies of incident/investigation reports stemming from an incident occurring off of the (INSTALLATION) and CPOs involving active component members assigned to (INSTALLATION) and their family members or unmarried intimate partner.

A4.3.2.2. Upon receipt of a copy of an incident/investigation report stemming from incidents occurring off of the (INSTALLATION) or a CPO involving an active component member assigned to (INSTALLATION) and his or her family member or unmarried intimate partner, the (INSTALLATION) Law Enforcement Office shall immediately notify the active component member's (INSTALLATION) Command.

A4.3.2.3. When the (INSTALLATION) Law Enforcement Office receives a copy of an MPO from an active component member's (INSTALLATION) Command, and if that active component member assigned to (INSTALLATION) is living off of the (INSTALLATION), the (INSTALLATION) Law Enforcement office shall forward a copy of the MPO to the (CITY, COUNTY, or STATE) Law Enforcement Agency with jurisdiction over the area in which the active component member resides.

A4.3.2.4. The (INSTALLATION) Law Enforcement Office shall provide the (CITY, COUNTY, or STATE) Police Department with an area for Police Department officers or investigators to conduct interviews of active component members assigned to (INSTALLATION) and their family members or unmarried intimate partner who are involved in domestic violence incidents.

A4.3.2.5. The (INSTALLATION) Law Enforcement Office will, when appropriate, conduct joint investigations with the (CITY, COUNTY, or STATE) Law Enforcement Agency if incidents of domestic violence involve active component members assigned to (INSTALLATION) and their family members or unmarried intimate partner.

A4.3.2.6. The (INSTALLATION) Law Enforcement Office will assist the (CITY, COUNTY, or STATE) Law Enforcement Agency when investigating cases that occurred off the (INSTALLATION) by providing information such as electronic health records, service records, and incident/investigation reports from incidents occurring under the

jurisdiction of the (INSTALLATION) Law Enforcement Office IAW the Privacy Act Title 5 United States Code 552a(k)(2) and (5) and HIPAA.

A4.3.2.7. The (INSTALLATION) Law Enforcement Office shall provide the (CITY, COUNTY, or STATE) Law Enforcement Agency with basic information, in the form of quick reference cards or brochures, about (INSTALLATION) resources available to domestic violence victims.

A4.3.2.8. [Insert a paragraph here stating proper (INSTALLATION) procedure for responding to domestic violence incidents occurring on (INSTALLATION) involving civilian alleged offenders.]

A4.3.2.9. As new personnel begin duty with (INSTALLATION) Law Enforcement Office, their immediate supervisor will provide them with copies of this MOU and basic instructions on effectuating the provisions of this MOU.

A4.4. PERSONNEL: Each Party is responsible for all costs of its personnel, including pay and benefits, support, and travel. Each party is responsible for supervision and management of its personnel.

A4.5. GENERAL PROVISIONS:

A4.5.1. POINTS OF CONTACT: The following points of contact will be used by the Parties to communicate in the implementation of this MOU. Each Party may change its point of contact upon reasonable notice to the other Party.

A4.5.1.1. For the (INSTALLATION) Law Enforcement Office

A4.5.1.1.1. Primary:

A4.5.1.1.2. Alternate:

A4.5.1.2. For the (CITY, COUNTY, or STATE) Law Enforcement Agency

A4.5.1.2.1. Primary:

A4.5.1.2.2. Alternate:

A4.5.2. CORRESPONDECE: All correspondence to be sent and notices to be given pursuant to this MOU will be addressed, if to the (INSTALLATION), to:

A4.5.2.1. (INSTALLATION mailing address and email address)

And, if to the (CITY, COUNTY, or STATE) Law Enforcement Agency, to:

A4.5.2.2. (CITY, COUNTY, or STATE) Law Enforcement Agency mailing address and email address)

A4.6. FUNDS AND MANPOWER: This MOU does not document nor provide for the exchange of funds or manpower between the Parties nor does it make any commitment of funds resources.

A4.7. MODIFICATION OF MOU: This MOU may only be modified by the written agreement of the Parties, duly signed by their authorized representatives. This MOU will be reviewed annually on or around the anniversary of its effective date, and triennially in its entirety.

A4.8. DISPUTES: Any disputes relating to this MOU will, subject to any applicable law, Executive order, directive, or instruction, be resolved by consultation between the Parties or IAW AFI 25-201.

A4.9. TERMINATION OF UNDERSTANDING: This MOU may be terminated in writing at will by either Party.

A4.10. TRANSFERABILITY: This MOU is transferable except with the written consent of the Parties.

A4.11. ENTIRE UNDERSTANDING: It is expressly understood and agreed that this MOU embodies the entire understanding between the Parties regarding the MOU's subject matter.

A4.12. EFFECTIVE DATE: This MOU takes effect beginning on the day after the last Party signs.

A4.13. EXPIRATION DATE: This MOU expires on _____.

A4.14. CANCELLATION OF PREVIOUS MOU: This MOU cancels and supersedes the previously signed MOU between the same parties with the subject _____, Serial # _____ and effective date of _____. [use only when needed to cancel a previous MOU]

A4.15. APPROVED: [APPROVAL AUTHORITY SIGNATURES WILL NEVER BE ALONE ON A BLANK PAGE]

_____	_____
FOR THE (INSTALLATION)	FOR THE (CITY, COUNTY, or STATE) Law Enforcement Agency
_____	_____
(Date)	(Date)

Attachment 5

GUIDELINES FOR MANAGING CHILD SAFETY AND UTILIZING EMERGENCY PLACEMENT CARE (EPC) AT FOREIGN LOCATIONS

A5.1. EPC Training. The Family Advocacy Program (FAP) will provide installation specific EPC training to installation commanders, unit commanders and first sergeants (or equivalents) within 90 days of arrival and annually thereafter. **(T-1)**

A5.2. Applicable law. At foreign locations, the Host Nation (HN) laws apply to, and HNs maintain jurisdiction in, all civil matters, including cases where a child's welfare is at risk, unless otherwise agreed in a Status of Forces Agreement (SOFA), Memorandum of Agreement (MOA), or other applicable treaty or international agreement. **(T-1)** Where an agreement does not exist, installation commanders may explore the feasibility of negotiating and concluding a standing agreement with HN authorities. **(T-1)** DODI 5530.03, *International Agreements*, and AFI 51-403, *International Agreements,* provide the applicable guidance on negotiating and concluding international agreements. Such agreements may be particularly appropriate at locations where the HN is unwilling or unable to exercise its authority. **(T-0)**

A5.3. Separating alleged offender (AO) from child. Because HNs have jurisdiction in child welfare matters, the Air Force has, outside of emergency situations, limited authority to separate a child from an AO where there are general allegations of child abuse. Accordingly, the Air Force shall defer to HN authorities unless emergency conditions require immediate action.

A5.3.1. If the installation commander determines, after consultation with the Family Advocacy Officer (FAO), Medical Group (MDG), and Staff Judge Advocate (SJA), that there is substantial reason to believe the child is at risk of imminent death or serious bodily harm or neglect:

A5.3.1.1. The installation commander may direct the separation of the AO for up to 48 hours and may extend that direction for an additional 48 hours in cases where the installation commander is preparing the necessary paperwork to have the child and the family returned to the United States under the jurisdiction of a State child protective service (CPS).

A5.3.1.1.1. The FAO initiates liaison with the gaining State or home of record CPS or judicial system and identifies appropriate escorts for the child when not able to be accompanied by a parent/guardian.

A5.3.1.2. If unable to return the child to the United States under a State CPS's jurisdiction within 48 hours, the FAO immediately coordinates with the HN CPS equivalent.

A5.3.1.3. The 48-96 hour window to return a child to the United States under the jurisdiction of a State CPS may be extended where, after reasonable inquiry, the HN is unwilling or unable to exercise jurisdiction.

A5.3.1.4. The installation commander must consult with the FAO and SJA prior to making any separation arrangements.

A5.3.1.4.1. The FAO may facilitate coordination with the appropriate CPS authorities and provide consultation and guidance, but is not authorized to remove or take custody of the child.

A5.3.1.5. Separation immediately ceases when the child is returned to the United States under a State's CPS jurisdiction; the HN CPS exercises its jurisdiction and makes appropriate arrangements for the welfare of the child; or the immediate threat of harm has passed and the child can be safely returned to the family unit or a non-offending parent/guardian.

A5.3.2. In separating an AO from the child, the installation commander may consider, but is not limited to, the following measures:

A5.3.2.1. Restricting the AO from the child, leaving the child with a non-offending parent/guardian. The installation commander may do so by restricting the AO to the installation, or parts of an installation; issuing the AO a no contact order; or similar mechanism to ensure the safety of the child;

A5.3.2.2. Initiating the family care plan (with at least one parent/guardian's consent);

A5.3.2.3. Placing the child with a family relative/friend/co-worker (with at least one parent/guardian's consent);

A5.3.2.4. Utilizing a sister service or MDG if available options;

A5.3.2.5. Activating an EPC foster family placement as an option of last resort.

A5.4. Parallel processes. While the appropriate authorities process the case, the installation commander, FAO, and AO's unit commander and first sergeant (or equivalents) may consider, and/or begin processing, the following options:

A5.4.1. Early return of dependents in accordance with the Joint Travel Regulation and AFI 36-3012;

A5.4.2. Sponsor-requested humanitarian reassignment in accordance with AFI 36-2110; or

A5.4.3. Command-requested humanitarian reassignment.

A5.4.4. Make such arrangements in coordination with the SJA, Child & Youth Programs, installation helping agencies, HN authorities, gaining State or home of record CPS, MAJCOM Behavioral Health Consultant, AF FAP and AFPC, as appropriate.

A5.5. Unit FAP checklist. Unit commanders and first sergeants ensure their FAP checklist includes the following**:**

A5.5.1. Current family care plans;

A5.5.2. Families with a history of abuse, dual military families, and single parent families;

A5.5.3. Current unit commander and first sergeant ECP training; and

A5.5.4. Current list of FAP, SJA, and HN CPS contact information.

A5.6. The following indicators of risk should be considered when determining whether separating an AO from a child is appropriate:

A5.6.1. Injury under 14 months of age--unexplained injuries considered suspicious for abuse.

A5.6.2. Child has non-accidental injury, and:

A5.6.2.1. No non-offending parent/guardian is in the home.

A5.6.2.2. AO denies knowledge of maltreatment, refuses responsibility, or states child is lying.

A5.6.2.3. AO appears angry with child, expresses no remorse/empathy/compassion for child.

A5.6.2.4. AO refuses to discontinue corporal punishment until assessment complete.

A5.6.2.5. AO threatened to kill child or inflict bodily harm for non-compliance or disclosure.

A5.6.2.6. Bizarre or ritualistic acts performed by AO as part of abuse.

A5.6.2.7. Serious injury requiring medical treatment, and AO still has access.

A5.6.2.8. Non-offending parent/guardian doesn't believe child or voices support for AO.

A5.6.3. Subsequent physical injury on open physical abuse case.

A5.6.4. Sexual abuse occurred and the AO was alleged to be involved or permitted it to take place.

Attachment 6

PSB-CY GUIDE

Sexual Behaviors Guide

Ages 2-4 Years

Normative "Common" Sexual Behaviors

- ☐ Masturbating or touching genitalia in public or private
- ☐ Touching or looking at their own, familiar adults (e.g., parents, caregivers), or children's (e.g., siblings, peers) genitalia, breasts, or buttocks
- ☐ Enjoys being nude
- ☐ Displaying genitalia area to others
- ☐ Stands too close or displays poor physical boundaries
- ☐ Has erections
- ☐ Uses elimination words for bathroom and sexual functions (e.g., pee pee, poo poo)
- ☐ Plays doctor or nurse inspecting others' body parts
- ☐ Explores differences between males and females
- ☐ Interested but does not seek ways to watch people going to the bathroom
- ☐ Wanting to learn about genitals, intercourse, babies

Cautionary "Less Common" Sexual Behaviors

- ☐ Continues to masturbate, in public or private, or touch genitals after adult redirection and beyond developmental expectations
- ☐ Continues to touch adults (e.g., parents, caregivers), or other children's (e.g., siblings, peers) genitalia, breasts, or buttocks after adult redirection and beyond developmental expectations
- ☐ Rubs their genitalia against others
- ☐ Attempts to kiss others using tongue
- ☐ Undresses in public after adult redirection and beyond developmental expectations
- ☐ Has frequent erections
- ☐ Asks adults or children to take their clothes off
- ☐ Continues to ask questions related to genital differences and/or sexual content when all questions have been answered
- ☐ Seeks ways to watch people going to the bathroom after adult redirection and beyond developmental expectations

Problematic "Uncommon" Sexual Behaviors

- ☐ Penetration of self or others with an object to genitals or rectum
- ☐ Inserts objects or fingers into genitalia
- ☐ Touches unfamiliar adults, peers, and/or animal's genitalia
- ☐ Tries to engage in intercourse with an adult or another child
- ☐ Has mouth to genitalia contact with other children or adults
- ☐ Exhibits fear or emotional distress of having an erection
- ☐ Imitates adult sexual behavior
- ☐ Pretends toys are having intercourse or performing sexual acts
- ☐ Asks adults or other children to engage in specific sexual acts
- ☐ Asks unfamiliar adults sexual questions
- ☐ Forces other children to engage in sexual play/games
- ☐ Has advanced knowledge about sexual acts
- ☐ Engages repeatedly in a variety of sexual acts or behaviors
- ☐ Uses coercion to get others to engage in sexual acts (e.g., forces child to take clothes off and play doctor)
- ☐ Asks to watch sexually explicit material on television or the internet
- ☐ Accesses sexual material online or offline (i.e., access is accidental or child is exposed to it deliberately by an adult)

Sexual Behaviors Guide

Ages 5-9 Years

Normative "Common" Sexual Behaviors

- ☐ Occasionally self-touches and masturbates in private
- ☐ Awareness of privacy about bodies
- ☐ Kissing or holding hands
- ☐ Kisses/hugs familiar adults and children
- ☐ Has erections
- ☐ Uses profanity for bathroom and sexual functions
- ☐ Telling inappropriate jokes and/or uses sexually explicit gestures
- ☐ Plays games with peers related to sex and sexuality (e.g., Show me yours, I'll show you mine behavior)
- ☐ Playing doctor or nurse inspecting others' body parts
- ☐ Conversations about genitalia, breasts, or buttocks with peers
- ☐ Interested in watching/peeping at people who are nude or going to the bathroom
- ☐ Wanting to learn about genitals, intercourse, babies
- ☐ Interest in breeding behavior of animals
- ☐ Draws genitals on human figures for artistic expression or because figure is portrayed in the nude
- ☐ Looks at nude pictures on the internet, videos, magazines, etc.
- ☐ Accidently accesses pornography online or offline

Cautionary "Less Common" Sexual Behaviors

- ☐ Masturbates, touches/rubs, or exposes genitalia in public
- ☐ Kisses/hugs unfamiliar adults and children
- ☐ Touches other children's or animals' genitalia, breasts, or buttocks, clothed or unclothed
- ☐ Occasional incidents of looking at others' genitalia, breasts, or buttocks; showing their own genitalia, breasts, or buttocks; or rubbing their own genitalia, breasts, or buttocks on others, after adult redirection and beyond developmental age expectations
- ☐ Frequently uses sexual language that makes other children uncomfortable
- ☐ Wants to play games related to sex and sexuality with children much younger in developmental age
- ☐ Engages in foreplay with dolls or peers with clothes on
- ☐ Engages in sexually explicit conversations with peers
- ☐ Draws genitals that are disproportionate on nude or clothed figures
- ☐ Sends or asks to receive pictures of genitalia, breasts, or buttocks
- ☐ Shows interest in and/or accesses pornography

Problematic "Uncommon" Sexual Behaviors

- ☐
- ☐
- ☐ Compulsive masturbation in private or public
- ☐ Mutual masturbation with a peer or group
- ☐ Masturbation that includes vaginal or anal penetration and/or the use of objects
- ☐ Any genitalia injury or bleeding not explained by an accident
- ☐ Repeatedly touches others' genitalia, breasts, or buttocks
- ☐ Has mouth to genitalia contact with other children
- ☐ Repeatedly looks at others' genitalia, breasts, or buttocks; shows their own genitalia, breasts, or buttocks; or rubs their own genitalia, breasts, or buttocks against others, after adult redirection and beyond developmental age expectations
- ☐ Engages in sexually explicit conversations with peers after adult redirection and beyond developmental age expectations
- ☐ Forcing others to touch or expose private parts or play sexual games
- ☐ Has advanced knowledge about sexual acts
- ☐ Draws sexual images (e.g., intercourse, group sex, sex with animals, sadism, etc.) and/or genitals stand out as most prominent feature
- ☐ Taking and/or sharing nude sexual images of themselves or others with or without their knowledge on social media, text, and/or internet
- ☐ Meets *friends* met online face to face (risk of sexual assault)
- ☐ Asks to watch sexually explicit material on television or the internet
- ☐ Accesses or shows pornography to others

- ☐ Engages in oral or vaginal penetration or sexually exploratory behaviors with another child who is at a younger developmental age
- ☐ Painful erections or hurting self to stop erections
- ☐ Imitates sexual behavior (e.g., simulating intercourse unclothed with dolls, peers, or animals)
- ☐ Participates or engages in sexually explicit conversations with varying age groups
- ☐ Intentionally accesses pornography and/or plays violent or sexual video games
- ☐ Sexual play or masturbation with an object that involves anal or vaginal penetration

Sexual Behaviors Guide

Ages 10-12 Years

Normative "Common" Sexual Behaviors

- ☐ Masturbating or touching their own private parts in private
- ☐ Wanting privacy
- ☐ Kissing, holding hands, flirting
- ☐ Occasional flashing or mooning
- ☐ Using profanity
- ☐ Telling inappropriate jokes and/or uses sexually explicit gestures
- ☐ Discussing genitals or reproduction
- ☐ Plays games with same aged peers related to sex and sexuality (e.g., Show me yours, I'll show you mine behavior)
- ☐ Increases in sexual thoughts and feelings
- ☐ Observing sexual content through media (e.g., magazine or television)
- ☐ Having own social media accounts that are supervised by parents/caregivers
- ☐ Access to pornography

Cautionary "Less Common" Sexual Behaviors

- ☐ Masturbates, touches/rubs, or exposes genitalia in public
- ☐ Occasional incidents of looking at others' genitalia, breasts, or buttocks; showing their own genitalia, breasts, or buttocks; or rubbing their own genitalia, breasts, or buttocks on others, after adult redirection and beyond developmental age expectations
- ☐ Attempts to expose other's genitals
- ☐ Simulating foreplay or intercourse with peers, clothed
- ☐ Discussing fear of getting pregnant or a sexually transmitted infection
- ☐ Taking nude, sexual images of themselves
- ☐ Voluntarily exchanges sexual content (text or images) via cell phone or internet
- ☐ Secretive about using the internet/social media (risk of being groomed or exploited)
- ☐ Seeking out pornography (e.g., non-accidental, finds ways to watch pornography)

Problematic "Uncommon" Sexual Behaviors

- ☐ Compulsive masturbation in private or public
- ☐ Sexual play or masturbation with an object that involves anal or vaginal penetration
- ☐ Self-touch that causes harm or damage
- ☐ Mutual masturbation with a peer or group
- ☐ Engages in unwanted touches of others' genitalia, breasts, or buttocks
- ☐ Penetration of dolls, other children, or animals
- ☐ Engages in sexual behaviors with another child who is at a much younger developmental age
- ☐ Making written or verbal sexually explicit threats
- ☐ Degrading/humiliation of themselves or others using sexual themes
- ☐ Taking and/or sharing nude sexual images of themselves or others without their knowledge on social media, text, and/or internet
- ☐ Bullied, forced, or coerced others to send sexual content (text or images) via cell phone or internet
- ☐ Repeatedly seeks out adult pornography
- ☐ Interest in child pornography

(cognitive, language, social emotional, motor development)
- ☐ Simulating or actual intercourse or foreplay with peers, clothed or unclothed
- ☐ Repeatedly looks at others genitalia, breasts, or buttocks; shows their own genitalia, breasts, or buttocks; or rubs their own genitalia, breasts, or buttocks against others, after adult redirection and beyond developmental age expectations
- ☐ Forcing or coercing others to participate in any sexual behavior (e.g., undress, watch pornography, expose genitals or private parts)
- ☐ Forces or coerces others to watch pornography
- ☐ Meets *friends* met online face to face (risk of sexual assault)

Sexual Behaviors Guide

Ages 13-18 Years

Normative "Common" Sexual Behaviors

- ☐ Masturbating in private
- ☐ Need for privacy
- ☐ Kissing, hugging, holding hands
- ☐ Voluntarily shared engagement in sexual intercourse or sexual activity with a partner of similar developmental age
- ☐ Participating in sexually explicit conversations or obscenities with peers
- ☐ Telling inappropriate jokes
- ☐ Sexual teasing and flirting
- ☐ Sending/receiving sexual images of others or sexual material (e.g., pornography, pictures, movie, or television clips) with their knowledge
- ☐ Viewing sexual content through media such as pornography, pictures, television for arousal (e.g., viewing movies with sexual content)

Cautionary "Less Common" Sexual Behaviors

- ☐ Masturbates, touches/rubs, or exposes genitalia in public
- ☐ Engages in unsafe sexual behavior (e.g., multiple sexual partners)
- ☐ Preoccupied with or anxious about sex
- ☐ Spying on others who are nude or engaged in sexual activity
- ☐ Attempts to expose others' genitals
- ☐ Engages in frequent sexual relationships about which they feel uncomfortable
- ☐ Using themes or obscenities involving sexual aggression

Problematic "Uncommon" Sexual Behaviors

- ☐ Compulsive masturbation in private or public
- ☐ Self-touch that causes harm or damage
- ☐ Engages in unwanted touching of others' genitals, breasts, or buttocks
- ☐ Penetrating another person forcefully
- ☐ Engages in sexual behaviors with another individual who is at a much younger or older developmental age
- ☐ Repeatedly looks at others' genitals, breasts, or buttocks; shows their own genitals, breasts, or buttocks; or rubs their own genitals, breasts, or
- ☐ Displaying exhibitionism or voyeurism or sexually harassing others
- ☐ Taking sexual images of others to exploit them, with or without their knowledge
- ☐ Taking and/or sharing nude sexual images of themselves or others without their knowledge on social media, text, and/or internet
- ☐ Bullied, forced, or coerced others to send sexual content (text, videos, or images) via cell phone or internet
- ☐ Having nude images of others without their knowledge

buttocks against others, after adult redirection and beyond developmental expectations

- ☐ Sexual contact with animals
- ☐ Making written/verbal sexually explicit threats
- ☐ Making obscene sexual phone calls or texts
- ☐ Accesses sexually aggressive/violent pornography and/or child pornography

Attachment 7

COMMANDER'S CRITICAL INFORMATION REQUIREMENT (CCIR) TEMPLATE FOR SEXUAL ASSAULTS

A7.1. The Installation CC will: complete the CCIR and submit to the Installation Command Post via an unclassified email. **(T-1)** CCIRs are not completed for restricted reports.

A7.1.1. Incident type to include which of the four criteria identified is met.

A7.1.2. Who is involved:

A7.1.2.1. Alleged offender(s). Provide grade, gender, unit of assignment, position, and any other relevant information.

A7.1.2.2. Victim(s). Provide generic identifiers only (e.g., grade or rank; gender). Do not include names, addresses, and any other personally identifiable information, even if public knowledge or in the news.

A7.1.3. What: description of incident (short narrative case synopsis);

A7.1.4. When: date and time of incident and/or report;

A7.1.5. Where: location of incident (no personal addresses);

A7.1.6. Actions Taken: response to date, if applicable; and,

A7.1.7. Any Other Factors: e.g., international interest.